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Guest editorial

The practice and regulation of non-medical healthcare professionals in community-based and primary care: maintaining old landscapes or encouraging creativity?

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Continuous exhortations to innovate and modernise health care are producing significant changes to the delivery of services, and far-reaching effects on how health professionals work in primary and community-based care.

Changes to services that have led to reductions in waiting times, increased patient choice, and encouraged community-based care are rightly applauded, but the systemic effect of these changes on the practice of healthcare professionals is somewhat less well planned and often leaves health professionals in a position of playing 'catch up'. I wish to suggest and describe some strategic opportunities to re-energise the practice and regulation of non-medical healthcare professionals in primary care.

To consider the necessary workforce in community-based and primary care, there are two important points of focus. The first is the commissioning and employment of a new workforce, the second, the continuous professional development (CPD) and deployment of an existing workforce.

The existing workforce is constantly replenished by new education commissions, and the required workforce is estimated to continue to increase somewhat over the next five years. The balance of where these staff will work, in the acute or primary and community care setting, is less well articulated. As this paper is being written, significant changes are expected from the Lord Darzi second-stage review. Few if any stones have been left unturned by that review, and some issues previously thought of as 'too difficult' are being addressed. Tomorrow's clinicians, education funding support and workforce planning are all under review, and the consequences could be far reaching.

Are we doing things the 'wrong way round'?

There is a series of questions that might be asked of the commissioning and safe preparation of a new workforce.

If community-based intervention and care is one of the characteristics of the new NHS, it must eventually follow that community-based care will become the 'usual', and hospital-based care the 'unusual'.

Equally, in preparing tomorrow's healthcare professionals, initial programmes of education leading to registration might need to make primary and community-based care 'normal' and an ability to work in acute care 'specialist', thus turning our present conceptual and educational models on their head.

Community-based nursing offers an interesting example. The historical retraining of the qualified nurse workforce to make them fit for practice in the community is both wasteful and unnecessary. The present practice of preparing nurses for three years to work in hospitals, then retraining them for a further six months or a year to work in the community is not longer sustainable. The three-year programmes of preparation for nurses offer some exposure to community-based practice, but this is often short and has sometimes been reported as unsatisfying.

Graduates emerge with considerable experience of acute inpatient care, some elder care experience, but more commonly a much smaller exposure to community-based nursing. There are well-documented explanations of limited community experience, and a shortage of well-mentored placements and the sheer

numbers of students seeking to use them has proved difficult. A lack of investment in developing and sustaining placement opportunities for students undertaking training is largely to blame. It is all too easy to succumb to the tendency to blame universities for this poor investment. However, education commissioners must bear equal responsibility for funding inertia and poor foresight, and they should try harder to resolve these difficulties.

The re-education of nurses to make them fit for purpose to work in community-based and primary care is wasteful of scarce resources. It is technically possible to work within existing professional regulations to prepare students who are able to work in either a hospital or a community setting on graduation. The University of Lincoln has an undergraduate degree programme in place that does just this, and while placement development has been challenging, students who are able to practise in either acute inpatient care or primary care will graduate during 2008. Interestingly, the establishment of this programme from the original idea to the emergence of the first graduating students has taken six years, which shows that the planning horizons are inevitably long term. That six-year period has passed through two NHS reorganisations, and so continued support from education commissioners has been important in those somewhat uncertain times.

Some funding issues

Funding for education is presently unequally available across the professions and between hospitals and community and primary care. The SIFT levy (Service Increment For Teaching) that supports specialist medical training has no equivalence in the other health professions. There are two strategic possibilities to redress this imbalance, the first is to rebase SIFT funding to develop placements for all the health professions. The second will require any rebasing exercise to shift some larger element of SIFT funding into community and primary care services. This is a difficult political decision and will require planning bravery from government and (in England) the strategic health authorities.

Professional responsibility to teach

There is also reported unwillingness on the part of some qualified staff in community-based and primary care to take on the roles of teachers and mentors. This is surely a necessary obligation of professional practice and it should be exceptional rather than usual for qualified staff to opt out of teaching and mentorship. Such professional obligations are significantly important in primary care and community settings where placement opportunities are presently so scarce. There are also issues about payment for teaching and offering placements. I would suggest that teaching is a necessary obligation of professional practice and should not require additional payment, other than for placement development. A setting without students and teaching is 'deadened' by their absence, and no reasonable service would want to exist with that deadening effect.

It is possible to offer some reasonable ground rules for the preparation of the non-medical healthcare profession workforce of tomorrow.

1 Education commissioners and the healthcare professions must assume the commonsense position that community and primary care is fast becoming 'usual', and acute hospital-based care is becoming specialised, and plan new workforce requirements and education programmes accordingly.
2 Healthcare professions must take responsibility for mentorship and teaching in the community; to not do so is unprofessional.
3 Financial investment from the education funding levy to support placement development must be distributed more equitably amongst the professions and focused more purposefully on community and primary care settings.
4 Professional and regulatory requirements must recognise and embrace shifts in working practices that will increasingly move towards community and primary health care.

Sustaining and developing the existing workforce

The second strand of investment and development rests on the already qualified workforce. There will be those employers who wish to give scant attention to this, but all the available evidence suggests that staff who receive regular investment in CPD are more likely to stay with an employer and be less likely to move elsewhere. Difficulty with support for CPD opportunities is a frequently reported source of employee dissatisfaction, particularly in general practice. Others are on the lookout for our staff: the USA and Canada have variously estimated that they will require one and half million new nurses by 2010, and temptations for staff to move prompted by aggressive recruitment campaigns will increase considerably. UK nurses and other community-based health professionals are an attractive proposition to employers in other countries.

Responsibility for continuously developing the existing workforce of healthcare professionals is, on the one hand, a clear and obligatory requirement for professional re-registration, but on the other, a little opaque as to who has the necessary responsibility for making sure that it happens. This opacity increases on the journey from large acute general hospitals into general practice.

Clearly, prime responsibility rests with individual professionals, but if they get no support or investment to achieve necessary CPD opportunities then it becomes difficult for them to meet their professional obligations.

It is possible to offer some reasonable requirements for the CPD of non-medical healthcare professionals working in community-based and primary care.

1 The individual responsibility of staff for CPD and therefore re-registration must be clearly understood by individual practitioners.
2 Employer responsibility for creating and allowing necessary CPD is clear; good employer practices are binding on the largest of community services or the smallest single-handed general practices.
3 Human resources (HR) practices are becoming more and more sophisticated. It behoves primary care trusts to be sure that the services they purchase are embraced by good HR.

What does all this mean for regulation?

The detail of professional self-regulation and its oversight by the newly emerging responsible bodies is presented in detail elsewhere in this special edition.

Regulation has a singularly important responsibility at its heart, that of the safety of the public, patients and their families.

I have suggested here that the workforce in community-based and primary care will face changes to its education and practice on a significant scale. Regulation of that practice is therefore important. Regulation should not stultify changes to practice and indeed it usually does not. It can be used as a convenient (but unreasonable) shelter for those who wish to sustain the status quo. 'No change' is not an option in a modernising NHS; it requires continuous innovation and improvement that breaks boundaries and offers a challenge to service and education commissioners as well as to those who provide service. To undertake this adventure safely is the biggest challenge of all. Professional development and regulation lie at its very heart.

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