

The role of the community nurse in primary care led commissioning

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Primary care policy and practice in Northern Ireland is unique for two main reasons: unlike elsewhere, Northern Ireland has an integrated health and social services system and the primary care reforms witnessed in many countries have not, as yet, taken place in Northern Ireland. This paper is based on a study in Northern Ireland that aimed to review the role and function of community nursing with reference to new developments in practice, education, research and policy. Service commissioning was one of many areas explored within the study and is the main focus of this paper. The study commenced with focus groups of community nurses ($n = 38$), general practitioners (GPs) ($n = 14$) and public representatives ($n = 8$). This was followed by a two-stage Delphi investigation using self-report questionnaires. In addition, data from 34 senior policy makers were collected using semi-structured interviews. The research was primarily carried out in Northern Ireland but involved GPs, community nurses and members of the public from the Republic of Ireland. Findings from all these data sources suggest that there is a perception that community nurses do not have the skills to take a lead role in the commissioning of services, that they require intensive training to take on such roles, and those who do should have equal remuneration with GPs who are involved in service commissioning. Recommendations are offered in the form of action points to guide future practice and policy.

Key words: multidisciplinary research; public views; role expansion; service commissioning

Introduction

Service commissioning has been defined as:

a set of planned activities undertaken with the intended outcome of measurable improvement in the health and wellbeing of resident populations, involving implementation of change to secure the most effective and efficient use of resources

(DHSS, 1998: p. 11)

Previously, Balogh (1996) defined commissioning as:

... maintaining and improving the Health and Social wellbeing of individuals and communities ... through the strategic and

effective use of all available resources, based on an equitable and just assessment of need.

As a term, commissioning replaced purchasing as a descriptor of how services are contracted from service providers. However, it is much broader than purchasing. It embraces:

- The assessment of need and strategy development;
- The identification of priorities and investment planning;
- Service specification and contracting;
- Service monitoring activities for individuals and populations;
- The evaluation of service developments/project;
- The development of best practice guidelines and quality standards.

The New NHS (Department of Health, 1997) states that community nurses will play a lead role in commissioning services. According to Spurgeon (1997)

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nurses have traditionally played no formal role in commissioning and as a result were unable to influence strategy. Harvey (1994) has pointed out that a perception exists that nurses do not think strategically. Nurses may also lack the interest and enthusiasm for the commissioning function due to their reluctance to explore the unknown despite the skills and knowledge they have to offer (Benton 1993). This has been challenged by Kaufman (1998: 36) who maintained that nurses' 'clinical knowledge and experience and awareness of different groups will support their commissioning role in areas of needs assessment, standard setting, negotiating with providers and monitoring quality'.

Not involving nurses in service commissioning may have detrimental effects on patient care. It has been argued that nurses working within primary care have a broad knowledge of the local community and therefore can make an important contribution to both needs assessment and to the design, monitoring and evaluation of care, all core elements in the commissioning process (SHSSB, 1997). According to Bradley (1998) nurses can bring the following to the commissioning process:

- Application of professional knowledge;
- Important source of information to support decision making;
- Identification of health and social needs;
- Advocacy on behalf of individuals and communities;
- Ensuring nursing and midwifery services are effective, evidence based and robust to audit;
- Developing quality standards, service protocols and integrated packages of care;
- Ensuring health promotion, targeting health and social need and community development approaches are incorporated into service agreements.

More recently the DHSSPS (2000) saw the contribution of nurses to commissioning to be at three levels:

- Level one – general awareness of the commissioning process and the contribution of nurses, midwives and health visitors to commissioning health and social services.
- Level two – nurses who wish to contribute to the commissioning process.
- Level three – nurses who commission health and social services.

At level one, nurses would understand the commissioning process and be aware of the nurses' roles and responsibilities in commissioning services for local populations. At level two, nurses would be involved in, identifying need, budget and financial analysis, information and technology management, quality and performance monitoring, teamwork and involving local communities in commissioning health and social services. At level three, nurses would be involved in developing leadership skills – professional and corporate, evidence based commissioning, negotiation skills, practice and service development, corporate management, strategic planning and the development of networks (DHSSPS, 2000).

Antrobus and Brown (1997) assert that the importance placed upon commissioning will have implications in relation to the functions of each professional group. They state that nurses are 'relatively naive in matters outside the immediate province of patient care and have suffered from a lack of any real influence in the health policy arena' (p. 309). They continue by acknowledging that nurses must understand and take part in the debate surrounding commissioning, otherwise they will have little influence over the development of health services and patient care.

While it has been suggested that community nurses have expressed a 'lack of knowledge' regarding commissioning arrangements (SHSSB, 1997), there is a view that GPs who have been involved in fundholding or Total Purchasing Pilots (TPP) already have the knowledge and requisite knowledge and skills to exploit the opportunities offered by the new commissioning proposals. However, this is by no means assured: TPPs were very restrictive in what they purchased (fundholders more so) and are not the ideal template for locality commissioning arrangements.

There is some confusion as to the role nurses can undertake in primary care commissioning. Questions have been asked such as: What education will primary care commissioning nurses require? How will nurses be selected to serve on primary care groups and trusts? Will they be full-time or part-time members? How can one or two nurses be aware of the requirements of the needs of the local community and the 'broad family' of community nurses? What kind of advisory group will these nurses require? Will their role result in the disenfranchisement of Health Authority/Board

nurses? Will they be paid the same as GPs who serve on the same commissioning group? Will the nurse members take the lead on clinical governance in these groups? Can nurses chair the group? These and other questions illustrate the uncertainty surrounding the nurses' role in primary care commissioning.

As alluded to above, nurses are an important source of information and advice on planning and resource constraints, overall population needs and the health and social care aspirations of the population. The empowerment of these professionals is an essential element in the development of good quality commissioning. Community and caseload profiling should help to consolidate the nurse commissioning role, enabling more meaningful participation in the identification and monitoring of need. However, they must do more than simply determine needs in order to shape the delivery of services: they must continue to expand and develop in response to changing circumstances with the aim of providing more holistic, flexible and focused care (DHSS, 1998).

Kaufman (1998) states that this is an exciting time for community nurses with challenges arising in taking on commissioning roles and shaping patterns of local care. She asserts that '... community nurses must articulate how nursing knowledge, skills and values can influence positively the commissioning agenda and overcome forces that may constrain their contribution – otherwise the health needs of the communities we serve may be inadequately addressed' (p. 37).

Methodology

The overall study aimed to review the role and function of primary care services and community nursing with reference to developments in practice, education, research and policy. Commissioning was one of several areas explored within the study and is the main focus of this paper. The research was carried out over two years (1999–2001). The aim of this paper is to highlight what the views of community nurses, GPs and senior policy makers are and that these views guide further discussions and engender recommendations that will help prepare nurses better for such roles.

This study used three different research methods – focus groups, the Delphi technique, and semi-

structured interviews. The reasons for using three different methods are as follows. The focus groups were used to collect qualitative data from the participants to formulate the statements for the Delphi questionnaire. The Delphi questionnaire was used to gain consensus from the sample on a range of issues highlighted from the focus groups. Semi-structured interviews were used with the senior policy makers as it was considered the most appropriate way of collecting data anonymously from senior figures in nursing in Northern Ireland.

The sample for the focus groups and the 'Delphi' consisted of 38 community nurses, 14 general practitioners (GPs) and eight public representatives (n = 60). Having been purposefully sampled, all specialties of community nursing were represented. Purposive sampling techniques (Parahoo, 1997) mean that respondents were selected to suit the purpose of the study and comprised those who could contribute to the discussion from their specialist background. Directors of Nursing in five community trusts were asked to nominate nurses representing all community nursing specialties. The 14 GPs were divided equally among fundholders and nonfundholders, were actively involved in commissioning and represented the views of GPs in this area. It was important to have some representation from GPs in the border region between Northern Ireland and the Republic of Ireland as without this the views gathered in the north west region would not have been complete. GPs were purposively sampled through contacts at Health and Social Services Boards. While the members of the public were recruited through the Health and Social Services Councils, they were not council representatives, but ordinary members of the public who were willing to participate in the study.

In this study the focus groups took place at two different venues geographically convenient for participants. There were two GP focus groups, two community nurse focus groups and one with members of the public. The decision to separate the groups in this way was based on the possibility that some people may find the experience intimidating and may not be forthcoming in their responses. Each focus group had an independent facilitator and a reporter who audiotaped and took shorthand notes of the discussions. The questions and probes used in the focus groups emanated from the literature. The data from the focus groups were transcribed and input into NUD*IST, a computer

software package for the analysis of qualitative data where the data was analysed for themes.

The literature and the findings from the focus groups formed a basis for the questionnaire used in the first round of the 'Delphi', and as such had content validity. Participants who had attended the focus groups were asked to complete the first round of the Delphi questionnaire. This secured a response rate of 100%. Feedback was provided and the round two questionnaires were mailed to the sample. The response rate for round two was 97% ($n = 58$). Data were analysed using SPSS (version 9.0) to provide descriptive statistics for round two feedback and to provide consensus figures after round two.

Semi-structured interviews were undertaken with senior policy makers in Northern Ireland and with two participating Health Boards in the Republic of Ireland. A total of 34 individuals were interviewed including Chief Executives of Health and Social Services Boards, Chief Nurses, DHSS Nursing Officers, University Heads of Nursing and other senior policy makers. A semi-structured interview schedule was used for each interview. The questions were formulated from the literature, the results from the focus groups and the Delphi questionnaires. Each interview lasted half an hour to an hour and each interview was audiotaped with the consent of the participant. These data were also transcribed and analysed using the NUD*IST software package in the same manner as the focus groups were analysed.

Informed consent was obtained from all respondents. Confidentiality was maintained with the Delphi responses. Participants were anonymous to each other but known to the researcher as this is a necessary element of the Delphi technique in order to provide individual and group feedback at the end of each round. Participants were guaranteed that at no time within the research would they be identified to anyone other than the researcher. In addition assurances of confidentiality were honoured in the focus groups and the interviews with policy makers. Respondents were informed that they could leave the study at any time.

Results

Within the present study the Delphi questionnaire sought agreement or disagreement from respon-

dents on a number of statements regarding commissioning. It should be pointed out at this stage that an important issue among researchers planning to use the Delphi technique is the understanding of what is meant by 'consensus'. Loughlin and Moore (1975) suggested that this should be equated with 51% agreement among respondents. Other authors have suggested that the level of consensus should be higher. There is no universal agreement on what the level of consensus should be. In this study, the researchers decided that the level of consensus would be 51% as this is over half of the sample in agreement. However, many of the statements which gained consensus in this study did so at a much higher level than 51%. It should also be noted that the existence of consensus from a Delphi process does not mean that the correct answer has been found (Keeney *et al.*, 2001).

Community nurses do not have the skills to take a lead role in commissioning

It is evident from Table 1 that by round two, 61.5% of GP participants were in agreement that community nurses do not have the skills to take a lead role in commissioning. At the same stage of the Delphi, 60.5% of community nurses disagreed that they do not have the skills to take a lead role in commissioning as did 57.3% of the public representatives. No consensus was gained on this issue through this Delphi questionnaire but the findings raise interesting questions.

The focus group data provides some insight into the fact that GP participants do not feel that community nurses could take a lead role in commissioning. Their responses fell into two main categories as follows:

- If nurses get involved in commissioning, GPs will be pushed out;
- Nurses must understand that this is not a role for them.

Community nurses offered their own perspectives within the focus groups resulting in the following themes emerging:

- Whoever is fit for the job should take on the role;
- Consensus should be gained by nurses on who should take on the role would be the best way forward for community nursing.

The comments from the GP focus group participants illustrate the concern that GPs have

Table 1 Delphi responses to commissioning statement 1
Community nurses do not have the skills to take a lead role in commissioning

	Round 1, Responses (%)				Round 2, Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	64.3	29.0	0	33.4	61.5	29.0	14.3	33.5
Undecided	14.3	7.9	25.0	11.7	15.4	10.5	28.6	13.3
Disagree	21.4	63.2	75.0	55.0	23.1	60.5	57.3	50.0

regarding nurses becoming involved in something they see as their role. Community nurses appear to show a hesitancy to project themselves forward into a lead role in commissioning. The public representatives discussed very little on this issue during the focus groups. This may signal a lack of understanding or confusion over the whole area of commissioning.

Interviews with senior policy makers provided further insight into the issue of community nurses taking the lead role in commissioning. A Director of Nursing in one of the Health and Social Services Trusts commented:

In some instances community nurses will be able to take a lead role in commissioning. It is more about the right person in the right place at the right time though. However, people who have been community based for many years will need some exposure to the acute sector.

In a different Health and Social Services Trust another Director of Nursing echoed a similar view:

The person who takes the lead role should be the person who is most skilled. I'm not saying the community nurse nor am I saying the GP. But the person who has the most skill and the most knowledge.

Both Director of Nursing comments are in line with the comments made by community nurses in the focus groups that the best person for the job should be taking the lead on commissioning and not necessarily having to be one profession or the other.

This view was also expressed by a Chief Nurse in one of the Health and Social Services Boards in Northern Ireland:

Community nurses can take a very major role in commissioning. It would be a mistake to think that nurses were the only people involved in commissioning. Obviously the contribution of general practice, public health and the community itself, all have a contribution to make.

Comments were also made regarding the training and knowledge of community nurses in relation to commissioning. One Health and Social Services Board Chief Executive commented:

With training, community nurses could make significant contributions to commissioning. The difficulty to date with community nurses is that their education and their exposure may have been a bit limited for the broader commissioning requirements.

A senior nurse educator made an interesting comment on the same issue:

One of the issues causing concern is the knowledge and skills required to commission and lead services. This is something which needs developed because of the lack of research and development in the primary care sector. Community nurses have a role to play in commissioning but some development work on skills and knowledge must take place first.

A participant from the Royal College of Nursing outlined their point of view as follows:

We have been fighting very hard to have community nurses involved in commissioning. You can no longer differentiate the community nursing role for the future into the provider role and the commissioning role. It is clear

that the two will feed off each other. Community nursing must be involved in the commissioning process.

Community nurses require training and education to take on new roles in commissioning

In response to the statement 'community nurses require training and education to take on new roles in commissioning', Table 2 shows the breakdown of responses. One hundred per cent of GP participants agreed over both rounds of the Delphi that training and education is required. Similarly, most community nurse participants agreed with the statement, 89.4% in round one and 97.4% in round two. The public representatives seemed to shift their views between rounds with 87.5% agreeing with the statement in round one and 100% agreeing in round two. Consensus after two rounds was that 98.3% of the sample agreed that community nurses require training and education to take on new roles in commissioning.

Within the focus groups, GPs made contradictory statements regarding the lead role for community nurses in commissioning. In relation to whether or not community nurses require training to take on new roles in commissioning, their comments fell into two categories as follows:

- Nurses definitely have a role in needs assessment and commissioning;
- At present the nursing profession is well ahead of others with commissioning skills.

Here commissioning skills refer to the assessment of needs and the setting of priorities in local communities.

Community nurse discussion within the focus

groups on the issue of training and education to take on new roles in commissioning were categorized into the following three themes:

- Nurses have been keeping GPs right all along;
- Nurses are so busy on the ground that they don't have time for commissioning;
- There is confusion over primary care groups and commissioning among nurses at present.

The community nurse participant comments again show the confusion and uncertainty over commissioning and commissioning roles among community nurses at present.

During the interviews with senior policy makers they were asked what skills they felt that community nurses would need to take on a role in commissioning. Table 3 outlines their responses.

Policy makers were also asked for their views on whether community nurses have these skills at present. The comments from many of the senior policy makers reflect the view that some community nurses will have the skills needed but that many will require training and education. This view supports the views of the community nurse participants themselves and the GP participants views. The following comments from a Chief Nurse, a Chief Executive at Health and Social Services Board level and a Director of Nursing at Health and Social Services Trust level reinforce this view.

There is a proportion of nurses, in particular health visitors, who should have a range of these skills. Not sure how well developed they are among practice nurses and district nurses but it appears that we need to develop more active levels among the nursing community. (Chief Nurse)

I think there are people who have but I think

Table 2 Delphi responses to commissioning statement 2
Community nurses require training and education to take on new roles in commissioning

	Round 1, Responses (%)				Round 2, Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	100.0	89.4	87.5	81.6	100.0	97.4	100.0	98.3
Undecided	0	7.9	0	5.0	0	2.6	0	1.7
Disagree	0	2.6	12.5	10.0	0	0	0	0

Table 3 Senior policy makers views on the skills needed by community nurses to take on a role in commissioning

Ability to think laterally	Chairing boards and meetings
Ability to think outside the boundaries of the profession	Research and analytical skills
Ability to operate in a broader view rather than having a single locality focus	Understanding of local and national politics, public bodies, voluntary and statutory sector, provision of services
Negotiation skills	IT skills
Decision making skills	Excellent communication skills
Business planning, costing, financing, performance indicating skills	Ability to focus on what is good for the patient
Local knowledge of the population	Demonstrate leadership potential
Diplomacy and directing skills	Needs assessment skills
Ability to co-ordinate a multi-disciplinary workforce	Ability to manage budgets and funds effectively
People management skills	Strategic thinking and planning skills
Knowledge of the public health agenda	

the core of the workforce that would be at the centre of carrying these agenda forward, need significant investment in developing these skills.

(Chief Executive, Health and Social Services Board)

Community nurses have these skills to a certain extent but I feel they need to be honed up, particularly the negotiation skills.

(Director of Nursing)

An interesting comment from a Director of Nursing reflects a different view:

Community nurses have . . . ‘Very limited skills in this area. They are not the only profession though. The same would be said of GPs. I actually think that community nurses might have a head start’.

A Senior Nurse Manager in the Health and Social Services Executive also makes an interesting comment in a similar vein:

Nurses are as well qualified as anyone else to take on this role. If you asked me how many people in Northern Ireland have the skills to be good commissioners, I would tell you very few because up until now commissioning has been concentrated at Board level.

Community nurses must have equal remuneration with GPs for roles in commissioning

Table 4 shows that most of the community nurse participants agreed that they must have equal remuneration with GPs for roles in commissioning with 94.8% agreeing in round one and 97.4% in round two. Only 2.6% of community nurses disagreed with the statement. In round one 87% of public representative participants agreed and this was reduced slightly to 85.7% in round two. Interestingly, the 12.5% of public representative participants who were undecided in round one disagreed with the statement in round two, again showing the influence of the feedback from round one.

GP participants were split in agreement over this statement. In round one 42.9% agreed with the statement and this figure rose slightly to 46.2% in round two. Thirty-five per cent of GP participants disagreed with the statement in round one. This also rose to 38.5% in round two. However, overall there was consensus after two rounds that ‘community nurses must have equal remuneration with GPs for roles in commissioning’.

There was little discussion in any of the focus groups on this topic and none of the participants were keen to discuss it.

However, in direct relation to the commissioning statement in Table 4, policy makers were asked

Table 4 Delphi responses to commissioning statement 3
Community nurses must have equal remuneration with GPs for roles in commissioning

	Round 1 Responses (%)				Round 2 Responses (%)			
	GP	CN	PR	Overall	GP	CN	PR	Overall
Agree	42.9	94.8	87.5	81.6	46.2	97.4	85.7	84.5
Undecided	21.4	2.6	12.5	8.3	15.4	0	0	3.4
Disagree	35.7	2.6	0	10.0	38.5	2.6	14.3	12.0

for their views on the equality of remuneration for nurses and GPs for roles in commissioning. Their responses were split into two themes – (1) unrealistic, and (2) should be equally remunerated but won't be. The following comments illustrate these points.

(1) Unrealistic

- 'It will never happen – its not very realistic' (Director of Nursing);
- 'Its about a fair salary for the job rather than finding little bits and pieces to pay them for' (Chief Executive, Health and Social Services Board);
- 'This is unrealistic. The medical profession are an exception to all the rules within the Health Service' (Chief Executive, Health and Social Services Board);
- 'They would be paid significantly for what they do but I would not see an equal remuneration' (Senior Nurse Manager, DHSS);

(2) Should be equally remunerated but won't be

- 'As a matter of principle they should be equally remunerated and in the sense of having their expertise recognized in some form monetary worth to them' (Chief Nurse);
- 'Equal pay for an equal job. Unquestioningly' (Director of Nursing);
- 'Of course they should receive equal remuneration. There is absolutely no question about it but the chances of them getting it is so remote' (Director of Nursing);
- 'In principle this should happen. The difficulty is that nurses are employees whereas GPs are independent contractors' (Senior Nurse Manager, HSSE).

Discussion

While no consensus was gained on the statement relating to whether or not community nurses have the skills to take a lead role in commissioning, this is an important finding in itself. GPs and community nurses do not agree on whether community nurses have these skills. It would appear that while around 60% of each group of participants agree (GPs) or disagree (community nurses), neither group is really certain. GPs appear not to want to let go of the role to community nurses as reflected in comments made during the focus groups and community nurses seem to be uncertain as to exactly what their role will be and may prefer to let 'whoever is fit for the job' to take on the role.

One of the main findings from this study was that the participants felt that community nurses required more training and education before they should take on new roles in commissioning. A report from the Southern Health and Social Services Board (1997) supports this finding and states that community nurses expressed a lack of knowledge regarding commissioning arrangements. This was a view also echoed by the policy makers' comments asking that community nurses must be trained in these skills if they are to make a difference. This is also evident in the 98.3% agreement to the Delphi statement 'community nurses require training and education to take on new roles in commissioning'.

While the general perception among policy makers was that community nurses would need some training, there were many comments suggesting that they were very well placed to take on commissioning roles. This echoes Kaufman's (1998)

assertion that nurses have the knowledge and experience to support the commissioning role.

There was a view from nurses in the focus groups suggesting that 'whoever is fit for the job should take on the role'. This seems to indicate reluctance on their part to embrace enthusiastically a role in primary care commissioning. If so, this would support Benton's (1993) assertion that nurses may have a lack of eagerness in becoming involved with and interested in the commissioning process. This is further supported by the comment from respondents that 'nurses are so busy on the ground that they don't have time for commissioning'.

Antrobus and Brown (1997) stated that nurses have been naive in regard to service commissioning and have failed to have any real influence. This is supported in comments made during focus groups by community nurses who maintained that there was confusion among community nurses surrounding primary care groups and commissioning.

The results of this study support the literature when they highlight that there is confusion over the role that nurses will take in primary care commissioning. Furthermore, GPs and community nurses appear to have differing views of the role that nurses should play within commissioning. There was also the suggestion among nurse respondents that while they were interested in commissioning they did not wish to take an active participatory role. This supports the contention that nurses's contribution to service commissioning can be at different levels depending on expertise and career inclination (DHSSPS, 2000).

Recommendations

From the foregoing the following recommendations seems justifiable:

- Nurses and midwives must be resourced to engage in local commissioning arrangements. This includes the provision of training, time and financial recompense;
- An education and development programme should be provided to assist nurses and other health and social services personnel to engage in the commissioning process, differentiated at the following levels as specified by Mason (1999):
 - General raising of awareness of the com-

missioning agenda and process

- Full time-commissioning and public health roles
- Participation in local commissioning groups
- The findings suggested that a number of nurses and midwives would be interested in taking a central role in commissioning. Therefore, they should be facilitated to gain experience and to pursue full-time careers within commissioning bodies;
- For those nurses who wish to take on a leadership role in multidisciplinary commissioning groups, leadership experience and training should be part of the preparation.

Conclusion

Having collected data from community nurses, GPs, public representative and senior policy makers it is clear that there are areas of disagreement in relation to the community nurse's role in service commissioning. This disagreement relates to the presence of appropriate skills, the required training and the equity of remuneration. The findings are presented here in order to highlight what these views are and to allow them to guide further discussions and engender recommendations that will help prepare nurses better for such roles. It may be agreed that only if they have a key role in commissioning will community nurses be able to provide sensitive, equitable and high quality services through a range of public and private sector bodies and contribute to the empowerment of citizens for their own health care.

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