Reducing professional boundaries between doctors and nurses is essential if the health service is to improve patient care while making efficiency savings.

**Breaking down boundaries between medicine and nursing**

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**In this article...**

- The challenge of workforce planning and changing NHS services
- Why the perceived boundaries between medicine and nursing must be broken down
- How extending nursing roles can help meet service demands and improve patient care

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Continual changes in the NHS mean primary and acute care providers must look more closely at their services, and who provides them. This article explores how these changes will affect medical and nursing roles, and discusses how clinicians and managers can meet the challenge of improving services while saving money.

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NHS chief executive Sir David Nicholson has said NHS trusts must deliver up to £20bn in efficiency savings between 2011 and 2014 (Nicholson, 2009). In addition, recent Department of Health reports have made it clear the NHS must provide quality patient care at the highest value for money (DH, 2010a; 2010b). These reports built on previous government initiatives, such as the commissioning of a patient-led NHS (DH, 2005).

In May 2010, health secretary Andrew Lansley outlined his vision for locally led NHS service changes. He said new, strengthened criteria that he expected decisions on NHS service changes to meet must focus on:

- Improving patient outcomes;
- Considering patient choice;
- Applying sound clinical evidence;
- Gaining support from GP commissioners (DH, 2010c).

The vision set out in *Equality and Excellence: Liberating the NHS* can only be achieved if healthcare providers employ staff with the appropriate skill mix to deliver high-quality services to patients in every circumstance (DH, 2010d).

**Workforce planning**

Nurses account for over a quarter of NHS trust spending, and the number of nurses has increased significantly in recent years. However, fluctuations in workforce supply and demand, along with policy changes affecting the nursing profession, make workforce planning and analysing nurses’ future roles a challenge.

With an ageing population, the increasing numbers of patients being treated by the NHS have long-term and increasingly complex health conditions. This puts pressure on employers to examine how the nursing workforce should be configured to meet future service demands.

In order to remain financially viable, trusts will need to run efficiently and make the best use of their resources, especially staff (Audit Commission, 2010). One way of achieving this is by redesigning patient pathways – designing better, more efficient packages of care involving different specialist providers at different stages (InPharm, 2010).

To ensure services are effective and efficient, care providers will also need to look at where care is given and who will provide it. The move away from primary care trust commissioning to clinical commissioning consortia means care is likely to be put out for tender from a wider range of public and private providers and social enterprises.

**Changing services**

As well as social and economic factors, legislative measures play an important part in driving change. The 2009 report *Building a Society for all Ages* outlined the government’s vision for addressing the demographic changes and opportunities of an
Nursing Practice

Discussion

5 key points

1. Policy changes and fluctuations in workforce supply and demand make workforce planning a challenge.

2. To ensure services are effective and efficient, care providers need to look at where care is given and who provides it.

3. Improving services will mean breaking down boundaries between medicine and nursing; senior nurses already carry out tasks associated with junior doctors, such as assessment, diagnosis and prescribing.

4. Creating new roles for nurses would enable them to expand their practice and deliver critical elements of care, but they will have to delegate more tasks to healthcare assistants.

5. Clinicians and managers need to understand assistant practitioner and healthcare assistant roles if they are to be successfully embedded in practice.

The roles and competencies of specialist nursing teams must also be looked at to determine whether staff are being used to their optimum ability.

Perceived boundaries in medicine and nursing will also have to be broken down, and tasks reassessed. Fewer junior doctors will mean nurses taking on roles that historically belonged to the medical profession, and nurses will have to delegate more tasks to healthcare assistants (HCAs) than they do at present. For this to be accomplished, NHS workers will need to radically change the way they think and work.

Historically, nurses were the monitors and observers of a patient’s condition. However, the evolution of nurse-run units and clinics has seen the profession expand into new fields, including the interpretation of investigative results, diagnosis and prescription of treatment. According to Sharples et al (2002), the availability of highly trained and experienced nurses, along with a reduction in junior doctors’ hours, means the needs of patients with routine outpatient appointments may be better met by appropriately trained nurse practitioners.

Nurse-led clinics and services have grown steadily over the past decade, indicating that nurses’ extended skills are increasingly recognised. Research has shown that nurses are significantly better than doctors in complying with hand hygiene standards and their success in leading infection prevention and control initiatives prompted the previous government to look for other areas where they could take leading roles (Lomas, 2009). This support of nurse-led services has encouraged innovation across the spectrum of all practice areas (Hatchett, 2008).

Extended nursing roles

The Modernising Nursing Careers programme aims to create a more flexible and competent workforce, updating career pathways and better preparing nurses for leadership (NHS Employers, 2009). Wannless (2002) said nurses need to move quickly to take on advanced skills in clinical decision-making and lead service transformation, and that they should become vocal champions for the best way to deliver high-quality patient care.

According to Hatchett (2008), discussions about expanding nursing roles often involve debates about whether nurses can, or cannot, replace doctors. However, Raftery (cited in Lomas, 2009) said nursing is not in competition with medicine; it is not about nurses being “mini doctors” but about considering who can provide the most appropriate patient care and
extending nursing practice to increase patient access to services.

**Advanced nurse practitioners**

The Royal College of Nursing supports the advanced nurse practitioner (ANP) role:

“The ANP offers a complementary source of care to that offered by medical practitioners and other healthcare professionals. ANPs augment the care that a team can deliver. This will encompass evidence-based individualised care for patients whose issues fall within the following categories: urgent/facultative episodes, long-term conditions and health promotion” (RCN, 2010).

There are many examples in the nursing press of how ANPs have improved patient care, such as prescribing medication faster and introducing admission protocols. Where care has been transferred from consultant lists and clinics to ANPs, it has proved to be financially viable; when South Devon Healthcare Foundation Trust transferred eight lists from a consultant anaesthetist to an ANP it proved to be particularly cost effective (Skills for Health, 2010).

These are the types of innovations that are safe, patient-centred and have good benchmarking outcomes at which purchasers of care will be looking closely.

**Clinical nurse specialists**

As practitioners and partners at the heart of multidisciplinary teams, clinical nurse specialists (CNSs) and ANPs have influence and credibility across the care pathway. They take on leadership roles, and make demonstrable contributions to effectiveness, patient experience and patient safety (National Cancer Action Team, 2010). According to Wanless (2002), around 20% of the work of junior doctors and GPs could shift to nurses without compromising quality or safety. Nicholson D (2009) The Year: NHS Chief Executive’s Annual Report 2008/09. London: DH.tinyurl.com/DH-annual-report

In a budget briefing, The King’s Fund (2010) said challenges in healthcare are happening against a backdrop of global fiscal meltdown, unprecedented budget cuts and the first coalition government since the NHS was born.

For change to happen, and for recent government initiatives to become a reality, NHS employers must ensure that roles are attractive and empowering to the individuals they wish to recruit and retain (DH, 2010e). They must also pay attention to the development needs and career aspirations of the workforce, and ensure flexible career pathways are available for existing employees (Fieldwater, 2010).

**Conclusion**

As patient and service needs change, and professional boundaries merge, it will become increasingly necessary for health professionals to relinquish old practices and embrace new ways of working. To achieve this, we will need to have the right skills in the right place at the right time, using the workforce to its full potential while also ensuring patient safety. ANPs and CNSs should continue to lead the way in creating future nursing roles and nurses must work together as an energised collective to achieve their full potential.

References


