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Despite its modern-sounding title, General Practice Nursing in the 21st Century: A Time of Opportunity shows an outdated vision of future working based on current limitations in our traditional roles, the fear of change and an unsophisticated understanding of the changing needs of user-led primary services.

The survey highlights objections to the idea of a future merger of practice nursing and district nursing roles. But simply calling for more of the same – more practice nurses (PNs) and district nurses (DNs) – isn’t the solution to developing a future workforce which is truly fit for purpose.

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This sort of 21st-century thinking seems even more vital given that one third of PNs are nearing retirement and require better support to fulfil their potential, a situation which is similar across district nursing.

With careful local planning of education and service development,

For the sake of the NHS we have to save bursaries, says Susan Osborne

Brexit, Trump and migration dominate the news, burying coverage of the doctors’ strike, dental charge rises and the new nursing associate role. Meanwhile, the budget’s £650 million NHS savings loom.

Following consultation on the nursing associate role, the next is on proposed nurse education changes: bursaries v tuition fees. Tuition fees are another cost-saving travesty. Once funding for bursaries transfers to the Treasury, there will be no going back.

A nursing degree is very different to, say, an English degree. There is no time for nursing students to earn extra cash due to their vital clinical placements commitments.

Most registrants will earn £25,000 a year, and have incurred debt, thanks to their student loans, which will affect future credit ratings and the ability to buy property or a car.

No consideration has been given to clinical placements, registered nurse supervision and associated costs. Universities will treat nursing degrees as part of their business. If courses lose money, they will cease to exist, with no consideration given to workforce planning.

The Nursing and Midwifery Council is doing nothing to stop this, nor is it addressing the severe shortage of registered nurses and midwives.

When the bursary consultation starts, it’s vital every registrant supports bursaries, reinforcing that we need registered nurses and midwives, not replacement nursing associates, to provide a safe NHS.

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The NHS is good at joined-up working, said a social worker friend. If you have an accident requiring treatment from different disciplines – say neurology and orthopaedics – there is well-established co-operation on all sides.

It’s good to hear the NHS praised, especially from someone who works alongside it... and he’s right. This is where it often excels. But there is a glaring exception: psychiatry.

Mental health provision shortfalls have been well documented in recent
shared roles may be advantageous for both registrants and support roles, as populations increasingly require more streamlined primary care.

According to the QNI report the idea of combining practice nursing and district nursing was met with ‘incredulity’. However there was recognition that the reinstatement of co-location of PNs and DNs would enable closer team working.

**Workforce practices**

Co-location may be helpful but in itself means nothing without the right sort of thinking. We’ve all experienced the health centre where ‘co-location’ just means a patient attends a GP reception desk, then waits at another desk for the community nurses. What is more relevant is shared thinking about what is needed in joining up workforce practices when user perspectives shape service delivery.

It is exactly this sort of innovative thinking about working ‘outside the box’ which the Community Education Provider Networks (CEPNs) are tasked with developing.

For example, the Islington CEPN is encouraging nurse leaders to support practice nurses (and other staff groups) to lead change through partnership working across a whole spectrum of care provision, with the support of higher education.

This has initiated a ‘super hub’ to help transform thinking and practice. It has subsequently widened access to electronic databases to encourage evidence-based practice in primary care nursing, placed nursing students inside care pathways integrating primary and secondary care providers and is helping to enable students – our future workforce – to foster a more sophisticated understanding of how this spectrum of care provision integrates across localities when addressing patients’ care needs.

Only when this more forward looking vision is developed, focusing on what can and should be possible in service delivery (not solely reliant on ‘traditional’ work roles) will there be a more 21st-century understanding of how we get to where we want to be.

The emerging CEPNs can be instrumental in helping to deliver such developments in both our thinking and practice.

Kevin Corbett is a senior lecturer at Middlesex University, Jenny Finch is a manager in the Islington Clinical Commissioning Group

months, even by royalty, and about time. The Mental Health Foundation in England says one in four will experience this kind of problem in any given year.

Even at the ‘milder’ end of the spectrum, any disorder of the mind can be life-changing; complicating or running concurrently with our physical wellbeing.

Patient A needs urgent cancer treatment, but has addiction issues. The problem, she realised, was that the bully’s victims had been too terrified to complain. And so Lisa hatched a plan. In her own care home, she would speak up for herself and her residents individually to satisfy herself that nothing like this had happened to her aunt, how it had upset her, and how she regretted not noticing the signs. Then she asked me, ‘Did you really miss it? It was staring me right in the face.’

Lisa blamed herself for what happened to her Aunt Flora.

In no way was it her fault. But the evidence was there, and she’d missed it. Distance had been a factor – her aunt lived in a nursing home, hundreds of miles away. All the same, when Lisa’s parents told her what was happening, Lisa reckoned she should have made a connection. After all, care homes had been her life, ever since she’d moved across country to run one of her own.

What were her parents telling her? They said Flora had developed a nervous habit since moving into the home. If one of them entered her room she’d flinch, and no one could fathom why.

Does it seem so obvious that someone was tormenting her? Hindsight is a wonderful thing, said Lisa. But yes, a sadistic care assistant had taken to hurting one or two of the frailer residents, even threatening to smother them if they breathed a word.

When the truth came out, Flora’s family were devastated. But Lisa took it especially badly.

‘I’d been running a care home for years,’ she told me. ‘How did I miss it? It was staring me right in the face.’

The problem, she realised, was that the bully’s victims had been too terrified to complain. And so Lisa hatched a plan. In her own care home, she would speak up for each of her residents individually to satisfy herself that nothing like this was happening. Which was how the story came to me – my mum being a resident in Lisa’s care home.

‘Lisa asked me outright,’ my mum told me one day. ‘She described what had happened to her aunt, how it had upset her, and how she regretted not spotting the signs. Then she asked me straight. Has anyone here ever been cruel or unkind to me?’

My mum’s answer? An emphatic ‘No.’ Nevertheless, Lisa knows such things happen. ‘But not on my watch,’ she said. ‘I now know what to look out for, and I won’t miss it again.’

David Newnham is a freelance journalist