IANMP

The Irish Association of Advanced Nurse Midwife Practitioners

Independent Nursing and Midwifery Practice: A National Framework Proposal to Empower the Profession and Strengthen the System: A Response to the Expert Review Body on Nursing and Midwifery (2022)

Formal Policy Submission
to the
Department of Health, Ireland

ARROWHEALTH
Clinical Nursing in the Home

December 2025

This report is being submitted by the Irish Association of Advanced Nursing and Midwifery Practitioners (IAANMP)

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Acronyms and Full Titles

Acronym	Full Title
ANP	Advanced Nurse Practitioner
AMP	Advanced Midwife Practitioner
AN/MP	Advanced Nurse and Midwife Practitioner
APNA	Australian Primary Health Care Nurses Association
ALOS	Average Length of Stay
CNO	Chief Nursing Officer (Department of Health)
CNMO	Chief Nursing and Midwifery Officer
CST	Community Specialist Team
DPER	Department of Public Expenditure, NDP Delivery and Reform
DoH	Department of Health
DNP	Doctor of Nursing Practice
DMP	Doctor of Midwifery Practice
ECC	Enhanced Community Care
ED	Emergency Department
EDITH	Elderly Delirium Intervention and Treatment at Home programme
ERB	Expert Review Body on Nursing and Midwifery (2022)
GP	General Practitioner
HIPE	Hospital In-Patient Enquiry System
HRB	Health Research Board
HSE	Health Service Executive
ICPOP	Integrated Care Programme for Older Persons
ICN	International Council of Nurses
ICM	International Confederation of Midwives
IHFA	Irish Heart Failure Alliance
MIU	Minor Injury Unit
NMBI	Nursing and Midwifery Board of Ireland
NSP	National Service Plan
PCRS	Primary Care Reimbursement Service
PET	Patient Experience Time (ED metric)
QNI	Queen's Nursing Institute (UK)
RHA	Regional Health Area
SCA	State Claims Agency
SROI	Social Return on Investment
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive Summary

Ireland already possesses the essential components needed to activate a modern, community-based system of nursing and midwifery. The legislative authority is in place, the workforce is prepared, the evidence is compelling, and the national policy mandate is unequivocal. Ireland's challenge is no longer conceptual but administrative: the system must now use the powers it already possesses.

The NMBI *State of the Register* 2025 confirms that Ireland now has 86,948 registered nurses and midwives, with 79,194 actively practising, the largest and most qualified workforce in the State's history. This includes rapid growth in advanced practice and prescriptive authority, demonstrating a profession ready to deliver expanded autonomous and community-led care. Ireland now has the most highly educated and internationally aligned nursing and midwifery workforce in its history, uniquely positioned to deliver scalable community reform if the system allows it to do so.

The Health Act 1970, through Sections 58 and 59, already enables the HSE to contract any qualified healthcare professional. The Nurses and Midwives Act 2011 establishes autonomy, accountability, and professional governance for the professions. Current strategies, Sláintecare, the Programme for Government 2025+, the HSE National Service Plan 2025, and the Expert Review Body (2022), all call for expanded, autonomous, community-led nursing and midwifery practice. In practical terms, Ireland is reform-ready; no new legislation is required.

The pressures facing the health system make this moment urgent. HIPE and Enhanced Community Care (ECC) data confirm that nearly one-third of hospital admissions are preventable or nursing-sensitive, consuming scarce bed-days and diverting resources from acute need. Delayed discharges, Emergency Department overcrowding, and the growing burden of chronic disease persist not because of a lack of clinical capability but because community capacity cannot mobilise quickly or flexibly enough under current structures. These pressures are not caused by clinical complexity but by structural rigidity; independent practice directly addresses this bottleneck. Independent nursing and midwifery practice offers a solution by enabling rapid, accountable, high-quality care in homes and communities, supported by full professional governance. It also directly supports Department of Health and DPER fiscal priorities by shifting activity from high-cost acute settings into lower-cost, tariff-based community care, reducing avoidable bed-days, agency spending, and locum reliance.

Independent practice is already happening in Ireland. Some nurses and midwives are delivering community-based services informally, without formal commissioning pathways, because patients cannot access timely care through existing structures. Others, such as ArrowHealth, are operating within robust governance, clinical audit, digital reporting, and indemnity frameworks, demonstrating measurable reductions in hospital activity and improved outcomes for patients receiving home-based care. These real-world examples show that independent nursing practice is not an aspiration; it is an established, functioning model that requires national governance, not permission. Independent nursing and midwifery practice

complements, rather than competes with, general practice by managing defined cohorts and freeing GP time for complex and diagnostic-intensive care. It applies across all divisions of nursing and midwifery, mental health, intellectual disability, children's nursing, public health, midwifery, emergency care, older-persons services, and migrant and prison health, enabling practitioners at every level to work to the full scope of their education and competence. This ensures a whole-profession model that is equitable, scalable, and aligned with national service priorities.

As clinical leaders in nursing, Advanced Practitioners can model autonomous, evidence-based decision-making, setting a clear standard for safe and effective independent nurse-led practice. They mentor and coach teams, build clinical confidence, and support the transition from traditional to advanced roles. By driving quality improvement, shaping protocols, and collaborating across disciplines, they create the systems and culture needed for nurse-led services to thrive. Importantly, independent practice is not limited to advanced roles: all grades of nurses and midwives can work independently within the scope of their education and competence. As generalist–specialist practitioners, they can deliver adaptable, agile care that responds to patient need, supports continuity, and strengthens the overall capacity of the community health system.

Even within existing constraints, the impact of advanced practice is well established. Advanced Nurse and Midwife Practitioners have demonstrated substantial system-level gains: reductions of 25–35% in avoidable admissions; prevention of 161 ICU admissions through critical-care outreach; reductions in Patient Experience Times of up to two hours and forty-three minutes; continuous removal of patients from waiting lists; and a strong economic return, with every €1 invested in community nursing generating €5.10 in social value. Patient satisfaction remains consistently high. These results have been achieved while significant diagnostic and referral barriers remain in place. Removing these barriers through independent practice would amplify these gains. By enabling high-volume removal of low- to moderate-complexity cases from acute pathways, independent practice accelerates progress on national Waiting List Action Plan targets and reduces bottlenecks in elective care.

Ireland is reform-ready. The legislation exists, the workforce exists, and the evidence is unequivocal. What is missing is the administrative activation of powers the State already holds. Independent nursing and midwifery practice is not merely a workforce initiative; it is a transparency and value reform that finally enables Ireland to cost, measure, and reward the clinical contribution of the professions.

The proposed model is a three-tier continuum of practice, generalist, specialist, and advanced, integrating publicly employed and independently contracted nurses and midwives under a single governance and digital framework. This continuum enables hospital avoidance at scale, reduces Emergency Department dependency, and ensures genuine delivery of care closer to home. It strengthens continuity for older adults, people living with chronic disease, women and infants, and those requiring palliative or reablement services. Critically, it also allows

experienced practitioners to remain in the workforce through flexible, meaningful roles rather than exiting early due to structural constraints.

Achieving this reform requires a modernised leadership architecture. Establishing a Chief Nursing and Midwifery Officer (CNMO) within HSE operations, introducing Clinical Academic Consultant-style contracts, developing a national Doctor of Nursing or Midwifery Practice pathway, and extending ANP/AMP diagnostic and referral authority will create a self-sustaining pipeline of clinical and academic leaders across the Regional Health Areas. This is essential if Ireland is to realise the scale and ambition of its health-system reform agenda.

Importantly, operationalising this reform requires only six administrative decisions rather than new legislation. A joint circular from the Department of Health, HSE, and DPER can activate existing statutory powers. A national independent provider framework can structure governance, tariffs, and entitlements. Consultant-style contracts and a CNMO position can embed professional parity. Sláintecare-aligned pilots can begin implementation in 2026, and HRB-led evaluation can guide national scaling.

For Government, this reform is a credible, low-cost, high-impact opportunity to deliver visible progress on long-standing system challenges. It aligns fully with Sláintecare and the ERB, leverages existing statutes, and delivers measurable improvements in hospital avoidance, access, continuity, equity, and workforce sustainability. Independent practice also equips Ireland's nursing and midwifery workforce to lead digitally enabled, AI-supported, virtual and community-based care models, a critical requirement for population ageing, climate resilience, and the future demands of integrated care. In short, independent nursing and midwifery practice is the reform that enables Ireland to deliver real healthcare transformation, immediately, safely, and affordably.

1.0 Introduction

Ireland's health system cannot continue to search in the same places for solutions to its ongoing crisis. Unlike other services where patients may safely wait, those who require a nursing intervention cannot: without a nurse, treatment stalls, discharge halts, and recovery is delayed. A health system without accessible nursing and midwifery is a health system that cannot function. This crisis cannot be resolved by hospital expansion alone; it requires rebalancing care towards community-led, nurse-delivered intervention.

The central solution is clear and already within reach. Ireland must fully integrate independent nursing and midwifery practice into its community, primary care, and statutory service structures. This reform, long recognised in legislation but not yet operationalised, offers immediate system capacity, improved access, and the workforce flexibility required to meet rising demand. Indeed, independent nursing and midwifery practice is not theoretical. It is already occurring across Ireland, sometimes covertly because current structures provide no

commissioning pathway, and sometimes explicitly through regulated, governance-aligned models such as ArrowHealth.

These services are delivering earlier intervention, reducing unnecessary acute attendances, preventing deterioration, strengthening continuity, and supporting patients who would otherwise default to Emergency Departments or repeated GP visits. The system is already relying on independent practice; it simply has not yet formalised it. Because gaps in community capacity, GP availability, and public-sector service hours leave many patients without timely access to essential care, the system has already become dependent, by necessity rather than design, on independently practising nurses and midwives to maintain continuity, prevent deterioration, and keep patients safely at home.

The NMBI *State of the Register 2025* confirms that Ireland now has 86,948 registered nurses and midwives, with 79,194 actively practising, the highest numbers ever recorded. This represents a nationally distributed, clinically mature workforce capable of delivering integrated, community-based services at scale, provided that the system enables practice to full professional scope.

This proposal provides the Chief Nursing Officer with a practical route to deliver that reform. It sets out how nurses and midwives, practising within their defined professional scope, can expand reach, strengthen community resilience, and ensure that no patient is left without timely clinical care at home. It moves beyond aspiration to implementation, enabling the CNO to lead a decisive shift aligned with Sláintecare and the Programme for Government 2025+.

Ireland's future health system will depend on digitally enabled, data-driven models of care. Independent practice equips nurses and midwives to lead virtual wards, remote monitoring, AI-supported triage, and predictive community interventions, capabilities essential to population ageing, chronic disease management, and climate-related health pressures.

Nurses and midwives already form a continuum of professional expertise, from graduate practitioner to specialist and advanced practice, integrated rather than hierarchical. This continuum underpins a population-centred health service and is essential to delivering care *"at the lowest level of complexity, as close to home as possible."* Yet current HSE structures do not allow this continuum to operate to full effect. Workforce shortages, ECC pressures, delayed discharges, and persistent community service gaps show that existing models cannot meet current or future demand.

Accordingly, this proposal advances a model, originally articulated by the Irish Association of Advanced Nursing and Midwifery Practitioners (IAANMP), that builds on existing roles and introduces a structured pathway for independent private practitioners**,** similar to physiotherapists, GPs, and other contracted health professionals. This evolution is a natural next step for the professions and an essential enabler of system reform.

The case for integrated independent practice is grounded in:

1. Legislative authority**:** the Nurses and Midwives Act 2011 (autonomy, accountability) and the Health Act 1970 (Sections 58 and 59, authorising HSE contracting of any qualified healthcare professional);
2. Policy coherence with the Sláintecare Implementation Strategy, the HSE National Service Plan 2025, and Department of Health research priorities; and
3. Robust domestic and international evidence that nurse-led care improves access, efficiency, safety, and patient outcomes (WHO, 2021; OECD, 2022; QNI, 2023; HSE ECC Evaluations, 2023).

The ERB (2022) provides the principal policy mandate. Recommendations 1, 7–9, 13, 18–19, 28 and 31 explicitly recognise nurses and midwives as autonomous practitioners and call for the development and evaluation of independent practice models. Implementing these recommendations through contractual reform will embed professional parity, expand community capacity, and enable nursing and midwifery to fully realise their potential as leaders of integrated healthcare in Ireland.

1.1 Purpose of this Proposal

Ireland's health system cannot deliver Sláintecare without accessible nursing and midwifery at the point of need. This proposal sets out a pathway for fully integrating independent nursing and midwifery practice, within existing legislation and aligned to national policy, to expand access, improve continuity, and strengthen community-based care. It operationalises ERB Recommendations 1, 7–9, 13, 18–19, 28 and 31 through contractual reform that recognises all registered nurses and midwives as autonomous practitioners. By enabling the full professional continuum, from graduate to advanced practice, to deliver care at home and in primary/community settings, Ireland can unlock system capacity, reduce hospital pressure, and ensure timely care for patients who cannot wait. This is a practical, evidence-based reform that equips the CNO to lead transformational change.

2.0 Legislative and Policy Foundations

Ireland already possesses the legislative, regulatory, and strategic frameworks required to support independent nursing and midwifery practice. The statutory basis is clear, and national policy direction is consistently aligned with this evolution of the professions.2.1 Statutory Authority

2.1 Statutory Authority

Three existing instruments together establish the legal authority for independent practice and HSE contracting of nurses and midwives:

1. **Health Act 1970 (Sections 58, 59, 67)**
   These provisions empower the HSE to enter into contractual agreements with *any* qualified healthcare professional for publicly funded services. They underpin current

PCRS arrangements for GPs, dentists, pharmacists, and optometrists. Extending these mechanisms to nurses and midwives requires no new legislation, only administrative activation**.**

2. **Nurses and Midwives Act 2011**
   This Act defines autonomy, accountability, scope of practice, and the statutory governance of the professions through NMBI. It establishes that nurses and midwives are professionally responsible for their clinical decisions and practise within a peer-regulated framework, providing the necessary assurance for independent contracting.
3. **Enhanced Nurse and Midwife Contract (2019)**
   This contract explicitly recognises independent clinical judgement and flexibility to practise across acute, primary, and community settings, further reinforcing the statutory basis for autonomous practice.

Together, these instruments form a sufficient legal foundation for PCRS-funded nurse- and midwife-led service provision within the State's existing contracting powers.

2.2 Policy Alignment

Independent practice is fully coherent with Ireland's national health-policy architecture and advances core system priorities:

1. Sláintecare Implementation Strategy & Action Plan 2021–2023
   Embeds the principle of "care at the lowest level of complexity, as close to home as possible," positioning nurse- and midwife-led services as central to community reform.
2. Programme for Government 2025+ – Path to Universal Healthcare
   Commits to expanding nurse-led and multidisciplinary community services as foundational to universal access.
3. HSE National Service Plan 2025
   Prioritises workforce innovation, contractual flexibility, and strengthened Enhanced Community Care (ECC)—all dependent on an empowered, integrated, and flexible nursing and midwifery workforce.
4. Expert Review Body on Nursing and Midwifery (ERB, 2022)
   Recommendations 1, 7–9, 13, 18–19, 28 and 31 explicitly recognise nurses and midwives as autonomous practitioners and call for evaluation and expansion of independent practice models.
5. Department of Health Statement of Research Priorities 2023–2025
   Identifies system reform, population health, ageing well, and health equity as key priorities, domains demonstrably advanced by nurse- and midwife-led community services (WHO 2021; OECD 2022).
6. Programme for Government This reform operationalises the Programme for Government commitment to expand community-based, nurse-led care and deliver universal access *"at the lowest level of complexity, as close to home as possible".*

Despite this strong legislative and policy foundation, nurses and midwives still lack a direct mechanism to be recognised and reimbursed for the clinical care they deliver. Under current arrangements, nursing activity is absorbed into hospital "bed and board" charges or delivered indirectly through agency contracting, rendering the professions' contribution financially invisible. Unlike GPs, dentists, pharmacists, and optometrists, nurses and midwives have no PCRS-style billing pathway. Establishing such a mechanism does not require new legislation; it requires administrative activation of existing statutory powers so that the State can finally measure, cost, and commission nursing and midwifery services transparently, in line with Sláintecare and the ERB (2022).

3.0 Alignment with National Priorities and the Expert Review Body (2022)

Ireland's strategic health-policy architecture strongly supports the development of independent nursing and midwifery practice as a key mechanism for system reform, workforce sustainability, and equitable access to care. Across the Department of Health, the HSE, and national reform programmes, the direction of travel is clear: increasing community capacity, strengthening autonomy, and ensuring that patients receive timely care at the lowest level of complexity.

3.1 Alignment with Department of Health and HSE Priorities

The Department of Health Statement of Research Priorities 2023–2025 identifies Population Health, System Reform, Ageing Well, Resilience, and the Future of Healthcare as central domains of national concern. Each of these areas depends fundamentally on a strong community-based nursing and midwifery workforce practising at the top of licence. The Department's emphasis on integrated care, chronic disease management, digital innovation, women's health, and addressing health inequities aligns closely with existing nurse- and midwife-led service models already embedded across the HSE.

National and grey-literature evaluations confirm the effectiveness of these models. The Enhanced Community Care programme, Clinical Nursing in the Home pilots (ONMSD, 2022), the Integrated Care Programme for Older Persons, and independent analyses such as ArrowHealth (2023) consistently demonstrate that nurse-led interventions deliver safe, efficient, patient-centred care. Hospital-avoidance rates of 25–35 per cent, coupled with exceptionally high patient satisfaction, illustrate that nurses and midwives already function with substantial autonomy within multidisciplinary teams. Extending PCRS reimbursement to these roles is therefore not a disruptive shift but a logical and necessary evolution of an already established practice paradigm.

The HSE National Service Plan 2025 reinforces this direction by prioritising workforce innovation, contractual flexibility, and the continued strengthening of Enhanced Community Care. Likewise, Sláintecare and the Programme for Government 2025+ articulate a clear mandate for delivering care close to home and for expanding the role of nurses and midwives

in community settings. Taken together, these frameworks provide both strategic intent and operational legitimacy for an independent practice model.

A central weakness in Ireland's current funding model is that nursing and midwifery activity is almost entirely subsumed within global hospital and community cost centres. Nursing appears in budgets as a fixed staffing expense rather than as a set of discrete, measurable episodes of care. This obscures productivity, prevents attribution of hospital-avoidance and chronic-disease outcomes to nursing interventions, and makes it difficult for the State to quantify the return on investment from its largest professional workforce. Independent practice, with PCRS reimbursement and defined tariffs, would convert nursing activity into visible, evaluable service units, enabling more accurate costing, benchmarking, and value-based planning.

3.2 Alignment with the Expert Review Body on Nursing and Midwifery (2022)

The Expert Review Body on Nursing and Midwifery (ERB, 2022) provides the most explicit national mandate for enabling independent nursing and midwifery practice. Central to this mandate is Recommendation 28, which calls for the evaluation, development, and implementation of independent practice models across the Irish health system. This recommendation directly supports the activation of existing statutory powers under Sections 58 and 59 of the Health Act 1970 to enable publicly reimbursed, independently contracted services aligned with the Nurses and Midwives Act 2011 and NMBI's Scope of Practice Framework.

Recommendation 28 is closely interlinked with a broader suite of ERB recommendations that collectively describe a modernised, autonomous, and system-shaping professional landscape. These include:

- **Rec. 1** (professional autonomy and parity of esteem);
- **Recs. 7–9** (strengthened leadership and formal representation in governance);
- **Rec. 13** (expansion of advanced practice);
- **Recs. 18–19** (education, research, and advanced-practice pathways);
- **Rec. 31** (top-of-licence working across integrated systems).

Together, these recommendations articulate a coherent vision in which nurses and midwives lead care, influence governance, and drive system reform.

This submission operationalises Recommendation 28 by outlining a national framework that activates the State's contracting powers, embeds a tiered model of generalist, specialist, and advanced practice roles, introduces Consultant-style contracts and a national DNP/DMP pathway to support advanced clinical scholarship, strengthens governance through proposals such as a Chief Nursing & Midwifery (Clinical) Officer at HSE Executive level, and establishes pilot sites aligned with Sláintecare for evaluation and scalable implementation. Delivering Recommendation 28 in this structured manner will improve access, reduce hospital dependency, expand community capacity, and ensure workforce alignment with WHO, OECD, and UNFPA/ICM global directives.

3.3 Alignment with IAANMP Members: Insights from the National ANP Workforce Survey

To ensure alignment with frontline professional experience, a national survey (see Appendix 1) was undertaken among Advanced Nurse Practitioners. The survey attracted 205 responses from a clinically mature and academically advanced cohort, three-quarters of whom were fully registered RANPs. Although 91 per cent hold Master's degrees, only a small minority intend to progress to Level 10, with nearly half undecided. The data indicates that this hesitation stems not from a lack of ambition but from structural barriers, including limited time, insufficient funding, inconsistent employer support, and a lack of clarity regarding doctoral pathways. A notable proportion of respondents highlighted the absence of a clinical doctorate option in Ireland, and more than 40 per cent expressed a preference for a practice-focused DNP or DMP.

The survey also highlights a clear mismatch between prescribing authority and diagnostic access. While more than 92 per cent of ANPs possess prescriptive authority, illustrating strong clinical autonomy, only 14 per cent report unrestricted access to radiological referral pathways, with nearly 80 per cent identifying blocked or constrained access. This inconsistency significantly impedes their ability to practise to full scope and undermines the efficiency and continuity of patient care.

Overall, the findings reflect a workforce that is highly capable, academically prepared, and strongly motivated for progression, yet constrained by structural limitations. They confirm the need for clearer national doctoral pathways, protected educational time and funding, and the removal of diagnostic barriers, reforms that are fully coherent with the independent practice model proposed in this report. The survey reinforces that Ireland's nursing and midwifery workforce is ready for the next stage of professional evolution; the system now needs to enable it.

The legislative authority, national policy direction, and workforce evidence outlined in this section demonstrate that Ireland is ready to activate independent nursing and midwifery practice. The next section sets out the operational model required to translate this readiness into a functioning, scalable service aligned with Sláintecare.

4.0 International Evidence and Alignment

Extensive international evidence confirms that independent, generalist nursing and midwifery practice is safe, effective, and scalable within publicly funded health systems. Across the OECD, direct reimbursement mechanisms for nurse-led services form a core component of integrated care**,** enabling earlier intervention, stronger continuity, and more efficient management of chronic and complex needs. These mechanisms closely mirror the ambitions of Sláintecare and the HSE National Service Plan 2025.

Comparable jurisdictions consistently demonstrate that enabling nurses and midwives to practise autonomously within national reimbursement frameworks improves access, strengthens continuity, and reduces avoidable hospital demand. In the United Kingdom, community nurses and independent nurse prescribers manage defined caseloads under NHS contractual arrangements. Evaluations by the Queen's Nursing Institute (QNI, 2023) show reductions in unscheduled admissions, enhanced continuity, and high patient satisfaction, confirming the reliability of nurse-led models within publicly funded systems.

In Australia and New Zealand, nurse-led primary care clinics reimbursed through Medicare and Primary Health Organisations have delivered measurable gains in prevention, chronic disease management, and adherence to treatment pathways. Evidence from the Australian Primary Health Care Nurses Association (APNA, 2022) reports improvements of 20–40 per cent across screening, monitoring, and longitudinal follow-up, benefits directly relevant to Ireland's chronic-disease and community-care priorities.

In Canada, publicly funded nurse-led community health centres have demonstrated superior performance in managing multimorbidity and addressing social determinants of health. Evaluations by the Canadian Health Services Research Foundation (CHSRF, 2021) consistently show higher levels of continuity of care, stronger patient-reported outcomes, and comparable or improved clinical metrics relative to traditional physician-centred models.

The Nordic countries, particularly Finland and Sweden, offer additional evidence through municipal-funded home-care nursing contracts that provide comprehensive community services for older adults. OECD (2023) analyses highlight reductions in institutionalisation rates, improved functioning, and enhanced quality of life, outcomes that align closely with Sláintecare's integrated-care and ageing-well agendas.

In the United States, 28 states now provide full practice and reimbursement parity for Advanced Practice Registered Nurses (APRNs) under the CMS framework. Research by Auerbach et al. (Health Affairs, 2020) demonstrates that nurse-led care achieves clinical outcomes equivalent to physician-led services but at a lower cost per episode, offering a scalable solution for high-demand, resource-constrained systems.

Across these international examples, a consistent pattern emerges: direct reimbursement unlocks the full value of nursing and midwifery practice, enabling generalist, specialist, and advanced practitioners to deliver timely care in homes, communities, and primary care settings. These outcomes align directly with Ireland's commitment to delivering "care closer to home" and with the HSE National Service Plan 2025 priorities of workforce innovation, community expansion, and integrated care pathways.

Finally, alignment with ERB Recommendations 2–6 further strengthens the relevance of international evidence to Ireland's context. The expansion of safe-staffing frameworks, enhanced national workforce datasets, strengthened retention policies, structured recruitment supports, flexible contractual pathways, and improved wellbeing measures all reinforce the

conditions required for independent nursing and midwifery practice to thrive. These reforms stabilise the workforce, reduce attrition, and expand the community-based capacity necessary to embed independent practice as a core component of national healthcare reform.

Internationally, Ireland is now an outlier, not because it lacks evidence or legislative authority, but because it has not yet created a reimbursement mechanism that allows nurses and midwives to practise independently within the public system**.** With global evidence showing clear, safe, and scalable results, Ireland is well positioned to implement a model that reflects international best practice while addressing domestic workforce and system demands.

The next section sets out this proposed model and outlines how it can be implemented within existing structures to deliver measurable improvements for patients, staff, and the wider health system.

5.0 Addressing the Greatest Challenges in the HSE

Ireland's health system continues to face persistent challenges in leadership structures, service capacity, and workforce sustainability. Independent nursing and midwifery practice, enabled under existing legislation, offers a practical, evidence-based response to these pressures. Crucially, it is the only reform that simultaneously tackles hospital congestion, unlocks community capacity, and creates a transparent way for the State to commission and reimburse nursing and midwifery activity as discrete episodes of care rather than as an invisible staffing cost. It directly supports the HSE National Service Plan 2025 and the Expert Review Body on Nursing and Midwifery (ERB, 2022), both of which call for innovation, flexibility, and community-led care.

5.1 Rationale: Quantitative Evidence from HIPE Data

Recent analysis of Hospital In-Patient Enquiry (HIPE) data from 2019–2025 provides compelling quantitative support for a tiered, integrated model of nursing and midwifery practice that combines public and independent structures.

Across major diagnostic categories, including chronic disease, frailty, wound care, and post-discharge follow-up, between 28% and 34% of hospital admissions appear clinically preventable or suitable for nurse-led community management. However, the data must be interpreted with caution. Activity undertaken by Advanced Nurse and Midwife Practitioners (AN/MPs) is often recorded under the supervising medic's name, leading to systematic under-representation of nursing contributions. HIPE coding does not consistently capture presenting diagnosis or care pathway, and community-sector activity data remain limited and inconsistently collected. These gaps make it difficult to determine precisely which episodes could have been safely managed in primary or community care and highlight the need for improved data governance, coding accuracy, and robust community datasets (OECD, 2022). In this sense, the estimate that 28–34% of admissions are potentially suitable for nurse-led

community management is conservative; better coding and community data would almost certainly increase this proportion.

Despite these limitations, several trends are clear. Ambulatory-care-sensitive conditions (ACSCs) such as COPD, heart failure, and diabetic complications account for approximately 65,000 admissions annually, representing an estimated €480 million in potentially avoidable inpatient expenditure (DoH/HIPE 2024). Post-acute readmissions within 30 days, especially among older adults and those with chronic disease, represent 11.3% of all discharges, a rate that falls significantly in sites where community nurse-led follow-up is in place (HSE ECC, 2023). Length-of-stay analyses show that patients who receive early nursing-led home interventions have a median reduction of 2.4 inpatient days, translating to €1,800–€2,200 savings per episode (HSE Costing Unit, 2023). Taken together, these findings substantiate the case for a tiered, integrated nursing model that combines the flexibility of independent contracting under the Health Act 1970 with the governance and leadership of HSE-based teams.

These results are all the more striking because they are generated within a system that does not currently cost nursing interventions as separate episodes. ANP and CNS activity is recorded and funded through general hospital and community budgets, meaning that savings in bed-days, ICU admissions, and waiting-list reductions are rarely attributed directly to nursing-led care. Independent practice would correct this by creating a transparent link between nursing input, patient outcomes, and expenditure, allowing the State to recognise and scale high-performing nurse-led pathways on the basis of robust cost and outcome data.

5.1.1 Quantitative Workforce Evidence (Prescribing Growth)

National workforce data demonstrate the growing scope, capability, and statutory contribution of nurses and midwives. By June 2025, 2,963 nurse prescribers and 132 midwife prescribers were registered, representing year-on-year increases of 15% and 26% respectively (NMBI, 2025). This expansion in autonomous prescribing reflects both the demand for advanced clinical decision-making and the readiness of the professions to work within enhanced and independent models of care.

A major constraint on current ANP/AMP practice is restricted access to diagnostics and referral pathways, despite full prescriptive authority. This structural misalignment limits efficiency, delays care, and reduces the system-wide impact of advanced practice. Independent practice introduces a unified entitlement structure that restores full scope, enabling ANPs and AMPs to function as intended within integrated care pathways.

5.2 Irish Public Service / HSE Pilot Evidence Supporting ANP-Led Models

Multiple Irish pilot initiatives provide strong and consistent evidence that Advanced Nurse Practitioners (ANPs) deliver safe, effective, and efficient care across community, chronic

disease, and urgent-care settings. These models demonstrate high public confidence, measurable reductions in acute hospital pressure, and clear alignment with national policy.

5.2.1 Advanced Practice Roles in Primary Care Centres

In HSE Primary Care Centres, ANPs provide autonomous assessment, diagnosis, prescribing, and review for both acute and chronic presentations. Independent evaluations report safe clinical decision-making across a broad range of conditions, fewer referrals to Emergency Departments and specialist outpatient clinics, and patient satisfaction consistently above 90%**.** These roles also fully operationalise the Department of Health's Graduate to Advanced Practice Policy (2019) and align directly with the Enhanced Community Care (ECC) programme, illustrating how ANPs expand timely community access while alleviating pressure on GP and hospital services.

5.2.2 Community Assessment Hubs – COVID-19

During the COVID-19 pandemic, Community Assessment Hubs (CAHs) were established nationwide to assess patients with confirmed or suspected infection who did not require immediate hospitalisation. ANPs and CNSs led clinical assessment, triage, and treatment. Evaluations confirmed that CAHs prevented substantial numbers of unnecessary ED presentations, safely managed acute respiratory illness in the community, and integrated seamlessly with general practice, public health, and community pathways. Patient satisfaction ratings approached 90%**,** demonstrating strong public trust in nurse-led urgent-care services and confirming that ANPs can safely lead high-volume assessment services in crisis and routine contexts.

5.2.3 Fracture Liaison Services (FLS)

Fragility fractures are increasing rapidly as Ireland's population ages, with significant implications for individuals and for health and social care services. Preventing painful, debilitating repeat fractures is essential to healthy ageing. Evidence shows that 50% of secondary fragility fractures occur within two years of the initial event (Health Service Executive & National Clinical Programme for Trauma and Orthopaedic Surgery, 2025), highlighting the need for early assessment and timely intervention.

The Irish Fracture Liaison Service Database Annual Report 2025 demonstrates that ANP-led Fracture Liaison Services (FLS) are highly effective during this critical risk period by ensuring systematic patient identification, comprehensive bone health and falls assessment, timely diagnostics, initiation of osteoporosis treatment, and coordinated follow-up (Health Service Executive & National Clinical Programme for Trauma and Orthopaedic Surgery, 2025). International evidence reinforces this approach: secondary fracture prevention models that incorporate systematic assessment and treatment significantly reduce re-fracture rates and care delays (Kanis et al., 2021).

National activity data further highlight the scale of unmet need. In 2024, 3,335 non-hip fragility fracture patients were assessed and treated across ten hospitals, representing approximately 30% of estimated presentations (Health Service Executive & National Clinical Programme for Trauma and Orthopaedic Surgery, 2025). Fragility fractures cost the Irish health service over €460 million annually**,** largely due to avoidable repeat fractures and unplanned admissions. ANP-led FLS models provide a clinically robust and cost-effective solution by reducing secondary fracture risk, supporting falls prevention, and improving patient outcomes. This model aligns closely with Sláintecare's emphasis on prevention, advanced practice, and sustainable, community-centred care.

5.2.4 Minor Injury Units

Many of Ireland's Minor Injury Units (MIUs) are led by ANPs who manage lacerations, fractures, sprains, minor burns, and other low-acuity trauma. National HSE evaluations demonstrate patient satisfaction levels in excess of 90%**,** low re-attendance rates indicative of safe, accurate decision-making, and marked reductions in Emergency Department pressure, particularly among older adults and low-acuity presentations. Patients report shorter waiting times and a better overall experience compared with hospital EDs, underscoring MIUs as a well-established, scalable model of ANP-led urgent care.

While Minor Injury Units (MIUs) in Ireland are often described interchangeably as Injury Units (IUs), current Emergency Medicine Programme guidance confirms that all units continue to operate with a Senior Clinical Decision Maker on duty at all times**,** defined as either a Middle Grade Doctor or a Registered Advanced Nurse Practitioner (RANP), with overall clinical governance retained by the Emergency Medicine Consultant (EMP, 2019). The EMP also notes that, although ANP-led models are anticipated in future iterations, no IU in Ireland currently functions as an exclusively ANP-led service

5.2.5 Community Specialist Teams

The rapid expansion of Community Specialist Teams (CSTs) further illustrates the system-level impact of advanced and specialist nursing. In 2024, CSTs accepted 76,000 referrals for chronic disease management, up from 46,000 in 2023 (HSE, 2024a). In 2023, improved access to diagnostics and specialist consultation within CSTs generated a 40% reduction in urgent outpatient waiting times**,** especially for cardiovascular disease, type 2 diabetes, COPD, and asthma. Between 2019 and 2023, CSTs contributed to a 16% reduction in chronic disease hospital admissions**,** with 74% of patients being discharged home following community-based interventions rather than requiring inpatient care (HSE, 2024b). Timely access to community diagnostics was associated with an 89% reduction in referrals to Emergency Departments or Acute Medical Units (HSE, 2023). These outcomes demonstrate the transformative effect of nurse-led chronic-disease pathways on hospital congestion and time-to-treatment.

5.2.6 General Practice ANPs

A recent submission to the Department of Health's Strategic Review of General Practice (2024) outlines the contribution of General Practice Advanced Nurse Practitioners (GP ANPs) to primary care capacity. A one-week activity audit (October 2023) from 20 GP ANPs recorded 757 complete episodes of care**,** each comprising assessment, examination, clinical decision-making, diagnosis, prescribing, treatment, safety-netting, and follow-up. This reflects autonomous, end-to-end clinical practice and productivity levels comparable to GP consultation volumes for defined cohorts.

When extrapolated conservatively, increasing the GPANP workforce to 200, this activity equates to over 30,000 community-managed episodes per month**,** alleviating pressure on GP appointments, out-of-hours services, emergency departments, and wider system flow. The findings confirm that GP ANPs safely deliver high-volume, complex care within regulated advanced-practice frameworks and represent a scalable workforce solution if integrated into national planning.

Even without formal structural support, the current cohort is providing substantial clinical capacity. Introducing independent contracts for ANPs in General Practice would enable nurse-led clinics in obesity management, sexual health, dermatology, minor illness, women's health, and chronic disease management. Strategic investment in workforce planning, education, governance, independent practice, and funded posts would rapidly accelerate this contribution and fully align with Sláintecare's multidisciplinary primary care model.

Clear referral protocols, shared digital records, and defined clinical boundaries ensure that independent nursing and midwifery practice remains fully integrated with general practice. Complex cases continue to be escalated to GPs and consultants, preserving team-based care.

5.3 Irish Grey Evidence: Private Nurse-Led Clinics and Independent Models

Alongside public-sector pilots, Irish grey literature highlights the emergence of private nurse- and midwife-led clinics in dermatology, maternal and child health, and integrated community care. These services mirror public-sector outcomes and show that independently operated nursing practices provide safe, efficient care aligned with Sláintecare and population-health goals.

5.3.1 Dermatology and Minor Procedures

Private nurse-led dermatology clinics have expanded access to timely assessment and management of chronic skin conditions, wound complications, and minor procedures. Evaluations conducted by the HSE (2023) and professional associations show high diagnostic accuracy, low re-attendance rates, and patient satisfaction consistently above 90%**.** These services reduce pressure on GP and hospital outpatient departments by offering same-day or

short-wait appointments and by incorporating teledermatology triage to support early review and continuity of specialist input.

5.3.2 Maternal and Child Health

Midwife- and nurse-led maternal and child health (MCH) clinics provide antenatal, postnatal, breastfeeding, developmental, and early child health services in accessible community settings. ONMSD audits and HSE partnership evaluations (2022) report improved breastfeeding rates, enhanced maternal wellbeing, earlier detection of perinatal mental health concerns, and positive outcomes in parent education and infant developmental screening. These clinics improve access for women and families across urban and rural areas, offering continuity and convenience consistent with Healthy Ireland and Sláintecare objectives while reducing reliance on hospital-based follow-up.

5.3.3 ArrowHealth – Clinical Nursing in the Home

ArrowHealth, Ireland's first private *"Clinical Nursing in the Home"* model, demonstrates not only the safety and value of independently contracted nursing, but also the critical need for a generalist specialist nursing tier to work alongside specialist and advanced practice roles. While AN/MPs and specialist nurses provide high-level assessment, diagnostics, and complex care planning, it is the generalist specialist nurse who delivers the day-to-day clinical interventions, monitoring, education, and continuity required to make those specialist-led plans effective.

Since 2022, ArrowHealth has delivered more than 1,200 episodes of integrated post-acute, chronic disease, wound, and palliative nursing in partnership with GPs and consultants. Outcomes include a 25–35% reduction in hospital readmissions, an average 2.4-day reduction in length of stay for associated discharges, and over 95% patient satisfaction. A Social Return on Investment (SROI) analysis indicates a €5.10 return for every €1 invested (ArrowHealth, 2023), reflecting cost avoidance, improved wellbeing, and strengthened community capacity.

ArrowHealth therefore provides a real-world demonstration that independently contracted nurses, particularly those operating at the generalist specialist level, can safely deliver regulated, high-value community and home-based care. These practitioners translate care plans into consistent, reliable day-to-day clinical delivery, reinforcing the essential role of a strong generalist–specialist workforce within integrated care. The model is fully enabled by Sections 58 and 59 of the Health Act 1970 and illustrates that Ireland requires not only expanded specialist and advanced practice roles, but also a well-supported generalist–specialist tier to achieve true community integration. Strategic investment in GP ANPs and generalist specialists will strengthen primary care capacity, improve patient outcomes, and generate long-term system savings.

5.3.4 Chronic Disease Management Programme Outcomes

The Third Report of the Chronic Disease Management Programme (CDM) reinforces these findings at national scale. By June 2024, 443,524 patients were registered, with a 30%

reduction in Emergency Department visits, a 26% reduction in unplanned hospital admissions, and a 33% reduction in GP out-of-hours attendances between 2019 and 2023 (Department of Health, 2025). These national outcomes confirm that nurse-led chronic disease pathways, supported by GP input, consistently reduce acute-care demand and support care closer to home for people with long-term conditions.

5.4 Overall Insight and Impact

Addressing Disparities in Hub Rollout Through ANP Leadership: National rollout of community hubs has progressed unevenly, with several regions experiencing delays solely due to the lack of available consultants, despite infrastructure and staffing readiness. This creates a structural barrier that is neither clinically necessary nor internationally typical. Advanced Nurse Practitioners, already delivering consultant-equivalent decision-making within MIUs, Primary Care Centres and CSTs, could safely lead hub activity, with hospital consultants providing scheduled or virtual case discussion and escalation support. Integrated models of this type are well established internationally and are associated with reduced waiting lists, earlier diagnostics, improved continuity, and more efficient management of chronic and ambulatory conditions (Imison et al., 2016; Baird et al., 2018). ANP-led hubs would allow thousands of low- to moderate-complexity cases to be diverted from hospital pathways directly into community management, achieving immediate relief for acute services.

Taken together, public HSE programmes and private nurse-led initiatives show that nurse- and midwife-led care in Ireland is clinically safe, cost-effective, and highly valued by patients. These models deliver measurable reductions in hospital dependence, shorter waiting times, and improved continuity of care across urgent, chronic, maternal, child, and community health.

Public ANP-led pilots in Primary Care Centres, Community Assessment Hubs, Minor Injury Units, and Community Specialist Teams confirm that advanced practice nurses can provide high-quality, autonomous assessment and treatment within regulated governance structures, consistently achieving patient satisfaction rates above 90% and driving significant reductions in Emergency Department and inpatient utilisation. Complementary private models in dermatology, maternal–child health, and ArrowHealth's home-based services demonstrate that independently contracted practitioners can safely extend this excellence into the community, offering timely, personalised care that reflects Sláintecare's principle of care at the lowest level of complexity.

Collectively, this evidence confirms that activating independent nurse- and midwife-led practice under existing Health Act 1970 powers and PCRS mechanisms is a safe, scalable, and value-driven reform. It represents a coherent pathway to realise Ireland's vision of equitable, integrated, community-based healthcare led by the nursing and midwifery professions.

5.5 Proposed Tiered Model of Independent Nursing Practice *Across All Divisions of Nursing and Midwifery*

The proposed tiered model provides a structured and scalable framework for independent nursing and midwifery practice, aligning workforce capability with patient acuity and system need. It operationalises the principle of delivering care at the lowest level of complexity, as close to home as possible, enabling nurses and midwives to provide safe, evidence-based, autonomous care across three interlocking tiers, generalist, specialist, and advanced. Each tier functions within its defined professional scope while remaining connected through shared governance, interoperable digital systems, and clear referral pathways. As outlined in Table 1, this continuum expands capacity, strengthens continuity, and enhances integrated service delivery across the health system.

Table 1: Proposed Tiered Model of Independent Nursing & Midwifery Practice

Tier 1 – Generalist / Independent Nursing Practice	Tier 1 is delivered by public or independent generalist nurses practising within their scope under reimbursable PCRS contracts enabled by Sections 58 and 59 of the Health Act 1970. Services include management of ACSCs, wound and continence care, medication review, and post-discharge follow-up. Tier 1 provides rapid, flexible, and local access, especially for older adults and long-term-care residents. Diverting even 20% of COPD and CHF admissions to Tier-1 nurse-led community care could save more than 2,000 bed-days per hospital per year**,** easing pressure on acute services.
Tier 2 – Specialist/ Independent Nursing Practice	Tier 2 is delivered by public or independent specialist nurses and midwives, often working within Community Specialist Teams, Integrated Care Programmes. These practitioners coordinate complex chronic-disease care, provide home IV therapy and early supported discharge, and lead multidisciplinary case management. Tier 2 ensures equity, governance, and continuity for patients with higher acuity or multimorbidity, bridging home, primary care, and hospital services.
Tier 3 – Advanced / Independent Nursing Practice	Tier 3 is delivered by public or independent Advanced Nurse Practitioners and senior community-based teams operating within RHA hub frameworks. ANPs lead regional hubs for chronic disease, minor injuries, mental health, and child health, using HIPE and community data for predictive modelling, quality assurance, and performance-led commissioning. They drive innovation, education, and continuous evaluation across RHAs. Additional ANP-led hubs, such as private chronic disease management (GP/self-referral), cardiology prevention and rehabilitation, obesity and metabolic health, acute and minor illness clinics, and mental health and intellectual disability disparity-reduction

	services, could significantly expand capacity, reduce waiting lists, and advance universal healthcare under Sláintecare. With over 30 clinical specialties represented within IAANMP membership**,** there is a significant opportunity to establish multispecialty community hubs that co-locate chronic disease management, frailty care, urgent care, women's health, dermatology, reablement, and mental-health services in accessible settings. International evidence shows multispecialty hubs reduce fragmentation, streamline diagnostics, and improve system efficiency (Curry et al., 2021; Baird et al., 2018). Embedding ANP-led pathways within these hubs, supported by remote or scheduled consultant input, aligns with WHO guidance on maximising advanced-practice capability and strengthens continuity, access and prevention (WHO, 2020).

By reallocating just 10% of ACSC activity to community nurse-led tiers, Ireland could save approximately €48 million annually while simultaneously improving access, continuity, and outcomes. Yet a fundamental limitation in Ireland's financing model is that nursing output is not captured as clinical activity; it is absorbed as a generic staffing cost. This prevents the system from identifying the true drivers of preventable hospital activity shown in HIPE data and obscures the measurable contribution of nursing to hospital avoidance, early discharge, chronic-disease control, and prescribing optimisation.

Independent practice resolves this structural weakness by enabling tariff-based, outcome-linked episodes of care, allowing nursing and midwifery activity to be costed, evaluated, and commissioned with the same transparency as other health professions. The evidence presented across public HSE programmes, private nursing initiatives, and national HIPE and workforce datasets establishes a clear and urgent case for reform: Ireland has both the need and the capacity to implement a tiered, independent model of nursing and midwifery practice that reduces hospital demand, expands community care, and strengthens system resilience.

The scale of preventable, nursing-sensitive hospital activity revealed in HIPE data cannot be reduced through existing structures. Expanding autonomous, community-based nursing and midwifery capacity through independent practice is the only mechanism capable of achieving this safely, rapidly, and at population scale. The next section sets out the implementation framework needed to embed this model in a structured, governed, and scalable way.

Independent practice must be designed as a whole-workforce model. Nurses and midwives at all grades can deliver autonomous episodes of care within their defined scope, supported by governance, digital tools, and clear escalation pathways. This creates an adaptable generalist–specialist workforce capable of responding rapidly to patient need across settings.

Independent practice applies across all divisions of nursing and midwifery, not solely advanced practice roles. Mental health nurses, intellectual disability nurses, children's nurses, public health nurses, midwives, emergency nurses, older-persons nurses, and specialists working in disability, migrant health, prison health, and addiction services can each deliver autonomous episodes of care within their scope of practice. This ensures national equity, enables care in underserved populations, and aligns with Ireland's commitments under Sharing the Vision, the Disability Capacity Review, and the Women's Health Action Plan.

Ireland's nursing and midwifery professions span diverse clinical domains and settings, each delivering essential services that underpin the health system. Independent practice, as defined within a tiered generalist–specialist–advanced structure, must therefore apply across all divisions of nursing and midwifery, not only advanced practice roles. This ensures national equity, recognises the full breadth of expertise within the professions, and enables all practitioners to contribute to community capacity, continuity of care, and population health outcomes.

Mental Health Nursing
Mental health nurses provide complex, relationship-based, and recovery-oriented care across community, inpatient, crisis intervention, and liaison services. Independent practice enables nurse-led early intervention, medication management, crisis follow-up, harm-reduction pathways, and psychological support, strengthening delivery of *Sharing the Vision* and reducing avoidable ED presentations, unscheduled admissions, and CAMHS bottlenecks.

Intellectual Disability Nursing (ID Nursing)
Ireland is unique in Europe in maintaining a specialised ID nursing workforce. These practitioners deliver behavioural support, complex care planning, chronic disease management, communication-led assessment, safeguarding, and transitional care. Independent practice allows ID nurses to provide proactive, community-based interventions that reduce hospital dependency and enhance quality of life for people with disabilities.

Midwifery (Community and Hospital-Based Practice)
Midwives are autonomous practitioners under legislation, yet current service structures limit continuity-of-carer and community-led models. Independent midwifery practice supports antenatal and postnatal home visiting, breastfeeding support, early discharge pathways, perinatal mental health screening, and homebirth services where appropriate. This strengthens maternity reform, promotes physiological birth, and improves outcomes for women and infants.

Children's Nursing and Public Health Nursing
Independent practice enables nurse-led developmental assessments, safeguarding interventions, immunisation catch-up clinics, chronic disease support (e.g., asthma, diabetes), school health programmes, and early identification of unmet needs. These services address long-standing gaps in child health provision and align with national Healthy Ireland objectives.

Emergency and Acute Floor Nursing
ED nurses already lead streaming, minor-injury management, same-day discharge pathways, and early intervention for ambulatory-sensitive conditions. Independent practice provides the legal and contractual infrastructure for nurse-led urgent-care episodes, reducing overcrowding, length of stay, and trolley numbers, long-standing political and operational challenges.

Older Persons Nursing and Residential Care
Nurses in long-term care, dementia care, and gerontology are central to prevention of deterioration, early diagnosis of delirium/infection, falls management, skin integrity, and end-of-life care. Independent practice supports assessment-led pathways that prevent unnecessary hospital transfers and strengthen continuity for frail older adults.

Community, Migrant, Prison, and Asylum-Seeker Health Nursing
These practitioners support high-need populations affected by trauma, displacement, chronic illness, addiction, and social vulnerability. Independent practice enables proactive screening, vaccination, chronic disease monitoring, harm reduction, women's health, and mental health triage across IPAS centres, prisons, Traveller communities, and migrant health hubs, advancing national health equity goals.

In summary, independent practice is a whole-profession reform. It ensures that every nurse and midwife, whether working in mental health, disability, maternity, emergency care, child health, public health, primary care, or specialist settings, can deliver autonomous episodes of care within their scope, supported by governance, digital tools, diagnostics, and nationally consistent entitlements.

6.0 What the HIPE Data Tells Us: and Why a Tiered Nursing Structure Matters

As described in section 5.1, these conditions represent a large proportion of preventable hospital utilisation. At present, HIPE and finance data capture the cost of hospital episodes but do not differentiate the contribution of nursing interventions from other inputs. Preventable admissions and extended lengths of stay therefore appear as "hospital costs" rather than as missed opportunities for nurse-led prevention and early intervention. A national tiered nursing model, underpinned by independent practice, would allow the State to track the movement of activity and cost from acute to community settings, and to demonstrate more clearly where investment in nursing generates the greatest reduction in hospital demand.

HIPE data continues to reveal a consistent national pattern: large volumes of preventable, nursing-sensitive hospital admissions occurring across all regions. While a sample Regional Hospital dataset provides a representative snapshot, national HIPE data reinforces the same trends and highlights the scale of opportunity for nurse-led and ANP-led intervention across the country (DoH/HIPE 2024).

Emergency admission patterns continue to reflect a high burden of chronic, nursing-sensitive conditions among older adults, with prolonged lengths of stay and recurrent presentations. Table 2 summarises the top emergency diagnoses and associated ALOS, illustrating the scale of preventable demand that could be reduced through proactive, community-based nursing and midwifery interventions.

Table 2: Emergency Diagnoses and ALOS in Acute Setting

Top 5 Emergency Diagnoses (Jan–July 2025)	Admissions	ALOS (days)	Mean Age (yrs)
COPD with Lower Respiratory Infection	257	8.3	73.8
Pneumonia (Unspecified)	170	8.1	72.4
Congestive Heart Failure	129	6.2	80.4
Urinary Tract Infection	256	7.1	76.5
Acute Kidney Injury	93	8.9	73.4

Together, these five conditions account for more than one-third of emergency admissions and consume a disproportionate share of bed-days, particularly among older adults with multiple co-morbidities. Their average length of stay (approximately 7.7 days) underscores the predominance of subacute, stabilisable conditions, conditions that are ideally suited to nurse-led chronic disease, reablement, or post-discharge pathways. Timely community-based intervention could prevent many of these admissions entirely. In a tiered nursing model, Tier-1 generalist nurses could provide early stabilisation and post-discharge follow-up, while Tier-2 and Tier-3 specialist and advanced practitioners manage higher-complexity cases, preventing deterioration long before hospital admission becomes necessary.

6.1 System-Level Rationale for a Tiered Nursing Model

HIPE data highlights avoidable bed utilisation, recurrent admissions, and inefficiencies that persist because the current system is structured around hospital activity rather than the wider care continuum. HIPE captures only what happens *inside* hospitals; it cannot reflect the scale or impact of community interventions that prevent admissions or support timely discharge. This gap makes hospital activity appear inevitable, even when it is not. It also means that the impact of community nursing and midwifery is financially invisible, because there is no episode-based reimbursement to link avoided admissions or reduced length of stay to specific nurse- or midwife-led interventions.

A national, tiered model, spanning generalist, specialist, and advanced practice roles across both public and independent sectors, would extend the continuum of care into people's homes and communities. This would reduce hospital dependency, stabilise chronic illness earlier, and improve continuity for older persons. It would also generate significant national savings and expand national visibility of nursing activity through fully integrated digital systems.

A tiered model of nursing and midwifery practice delivers measurable system-wide gains by addressing the structural constraints highlighted in HIPE data. Table 3 outlines how this model

improves bed utilisation, continuity of care, cost efficiency, and data visibility across the entire patient pathway.

Table 3: Illustrative System Effects of a Tiered Model

System Domain	Current HIPE Challenge	Impact of Tiered Model
Bed Utilisation	COPD/CHF admissions averaging 8–9 days	Nursing-led stabilisation cuts LOS by 2–3 days; 15–25% fewer admissions
Older-Person Care	Recurrent admissions due to poor follow-up and medication management	Integrated contractor + ANP model ensures continuity and reablement
Cost Efficiency	€1,800–€2,200 per acute episode	€48M annual national savings if 10% of ACSC activity shifts to community
Data & Evaluation	HIPE currently captures only hospital activity	Independent + public nurses feeding into eHealth/HIPE2 expand visibility across the care continuum

6.2 The Strategic Case for a Tiered, Integrated Nursing Structure

Ireland's health system is now at a critical point where redesign is no longer optional. Workforce shortages, persistent hospital congestion, and escalating chronic-disease burdens mean the existing model cannot achieve sustainability without earlier intervention and nursing-led continuity.

The strategic case for a national tiered model, linking independent practice to public governance, is grounded in clinical necessity, operational efficiency, and economic logic.

Clinical Gains

Preventable admissions fall, readmissions reduce, continuity improves, and older adults experience safer, more predictable transitions of care. Targeted admission avoidance across AN/MP services, including Emergency Departments, delivers immediate system benefit.

Operational Gains

Hospital pressure eases. Bed occupancy stabilises. Emergency Departments experience fewer low-acuity presentations. Patient Experience Times (PET) improve as assessment, treatment, and diversion occur closer to home.

Professional Gains

Retention strengthens as nurses and midwives gain parity of esteem, expanded autonomy, and flexible service models, including virtual clinics and hybrid pathways, that reflect modern population needs and post-pandemic transformation.

Economic Gains

Investment shifts from costly inpatient episodes toward outcome-based community care. Even conservative adoption of the tiered model delivers measurable savings through earlier intervention and reduced hospital dependence.

HIPE data clearly demonstrates robust evidence that a significant proportion of Ireland's hospital activity is both preventable and nursing-sensitive. Implementing a structured, tiered nursing model, combining the agility of independent practice with the authority of public-service governance, would operationalise Sláintecare's core ambition: care delivered at the lowest appropriate level of complexity, as close to home as possible.

Embedding independent contractors alongside advanced and doctoral-level practitioners creates a balanced ecosystem, agile enough to prevent hospitalisation, accountable enough to assure quality, and integrated enough to sustain continuity from hospital to home.

ERB Recommendations 32–37 reinforce the need for upgraded leadership and grading structures across CNM3, ADON, DON, and RHA-level roles. This tiered model aligns fully with modernised leadership architecture, parity of representation at national and regional levels, and harmonised grading to support system reform.

6.3 Nursing Leadership within HSE Operations

To translate professional autonomy into system redesign, operational nursing and midwifery leadership must be fully embedded within HSE executive governance. Ireland has strong national leadership through the Chief Nursing Officer and the Assistant National Director for ONMSD, yet the absence of a Chief Nursing and Midwifery (Clinical) Officer (CNMCO) at Executive level limits the professions' influence over resource allocation, service planning, and operational delivery.

Currently, clinical operational authority resides exclusively with the Chief Clinical Officer, a medically defined role. This structural imbalance restricts the translation of national nursing and midwifery policy into service-level implementation and limits visibility at the RHA level. It hampers the design, scaling, and governance of nurse- and midwife-led models of care and perpetuates legacy hierarchies inconsistent with modern interdisciplinary practice.

Establishing a Chief Nursing and Midwifery Office (CNMO) with authority equivalent to the CCO, reporting directly to the HSE CEO, would restore parity, strengthen clinical governance, and embed nursing and midwifery expertise at the centre of system reform. This directly

responds to ERB Recommendations 7–9 and ensures that nursing and midwifery leadership shapes strategic, operational, and digital transformation across acute, community, and primary care settings.

6.4 Strengthened Leadership Structure

Effective transformation requires leadership structures that match the complexity of contemporary healthcare delivery. Nursing and midwifery, the largest professional group in Ireland's health workforce, require governance architecture that translates expertise into system impact.

A strengthened leadership model would include:

1. Chief Nursing and Midwifery Officer (National): A co-equal to the Chief Clinical Officer, accountable for integrated operational delivery, safety, and workforce optimisation across all RHAs.
2. Regional Directors of Nursing & Midwifery (RDoNMs): Responsible for service quality, workforce integration, and cross-sector alignment within each RHA.
3. Clinical Academic Nursing and Midwifery Network: Providing practice leadership, mentorship, and outcome oversight at service level.

This architecture operationalises ERB Recommendations 7–9, strengthens accountability, and embeds nursing and midwifery leadership into commissioning, resource allocation, and digital transformation across the health system.

6.5 Independent Practice as System-Capacity Reform

Allowing nurses and midwives to contract independently under the Primary Care Reimbursement Service (PCRS) would address the key operational pressures identified in the HSE National Service Plan 2025 and Sláintecare Implementation Strategy.

This reform would:

- expand nurse-led home and community capacity, reducing ED congestion and delayed discharges;
- increase system resilience by distributing regulated, high-quality care providers across all regions; and
- shift funding from high-cost inpatient episodes to value-based, community-led care.

HSE pilot programmes, including Enhanced Community Care (ECC) and Clinical Nursing in the Home models, have already demonstrated that community-based nurses deliver safe, high-quality care with measurable reductions in avoidable admissions. Internationally, jurisdictions that have implemented independent-practice frameworks report substantial improvements in access, efficiency, and cost-effectiveness (OECD 2022; WHO 2021).

Independent contracting within the PCRS framework would operationalise ERB Recommendation 28 while addressing critical system deficits. Independent practice provides a targeted mechanism to address several structural deficits within the Irish health system. Table 4 summarises how this reform strengthens capacity, governance, workforce sustainability, financial transparency, and integration across care settings.

Table 4: Overview of the Impact of Independent Practice Reform

Systemic Deficit	Impact of Independent Practice Reform
1. Integrated Access and System Continuity	Enables seamless, early access to primary and community-based care while ensuring continuity across acute, primary, and community settings through unified governance, consistent diagnostic entitlements, and national standards that reduce hospital dependence and support timely intervention.
2. Leadership Visibility	Provides formal operational representation of nursing and midwifery in service commissioning and delivery.
3. Workforce Sustainability	Strengthens retention through professional autonomy, flexible contractual models, and enhanced career progression.
4. Cost and Value Transparency	Creates a clear tariff-based mechanism to cost, measure, and commission nursing and midwifery episodes of care, enabling value-based funding and reducing hidden system inefficiencies.

The HIPE analysis, workforce evidence, and system-level insights presented in this section show unequivocally that Ireland's hospital demand is both preventable and nursing-sensitive, and that a tiered approach to nursing and midwifery practice offers a realistic, scalable solution already grounded in legislation, policy, and professional capability. With strong international alignment, proven national pilots, and a maturing workforce ready to operate at enhanced and independent levels, the conditions now exist to activate this model at national scale. The next section sets out the implementation framework required to translate this evidence into practice, detailing the contractual, regulatory, digital, and governance mechanisms necessary to embed independent nursing and midwifery practice as a core pillar of an integrated, modern Irish health system.

7.0 Medical Consultant-Style Contracts and the Doctor of Nursing Practice (DNP): Integrating Practice, Research, and Education

Ireland now requires contractual and educational models that formally recognise nurses and midwives as clinical scholars, innovators, and health-system leaders. To achieve this, a medical consultant-style contract**,** parallel in status and structure to that of medical consultants, should be introduced for senior nurses and midwives who demonstrate excellence across three interdependent domains: advanced clinical practice, research leadership, and education. These consultant-style roles are the governance and leadership anchors for independent practice, providing a nursing and midwifery equivalent to medical consultants and ensuring that

independently contracted services operate with clear clinical accountability, research-informed standards, and parity of esteem.

7.1 A New Model of Clinical and Academic Leadership

The proposed consultant-style role reflects the evolving identity of nursing and midwifery as professions that not only deliver advanced, autonomous, evidence-based care, but also generate, translate, and disseminate knowledge to advance population health. Under this model:

- **Clinical practice** remains central, with senior nurses and midwives leading high-complexity care, service improvement, and innovation.
- **Research leadership** becomes embedded in the role, ensuring that practice developments are evidence-driven and that learnings are translated back into the system.
- **Education and mentorship** are formally recognised, allowing these leaders to supervise postgraduate students, mentor early-career staff, and bridge academic–clinical boundaries.

Consultant-style contracts would be jointly funded by the HSE, the Department of Health, and higher-education partners, recognising the tripartite mission of practice, research, and education. The result would be a national cadre of Clinical Academic Nurse and Midwife Doctorates capable of shaping service design, strengthening local research capacity, and embedding innovation into everyday care. Within the proposed tiered model, these Clinical Academic leaders would act as the senior clinical decision-makers for nurse- and midwife-led pathways, overseeing quality, tariff design, and outcome measurement for generalist, specialist, and advanced independent practitioners across RHAs.

This approach directly advances ERB (2022) Recommendations 18 and 19 and aligns with Sláintecare and Programme for Government 2025+ priorities for a future-ready, research-enabled, globally competitive workforce. International models, including the UK Clinical Academic Fellowship Pathways and Australia's Nurse Consultant Awards, show clear benefits: improved retention, accelerated evidence translation, stronger interdisciplinary working, and enhanced service quality (QNI 2023; APNA 2022).

Consistent with ERB Recommendations 16–17, undergraduate and early-career curricula must also evolve. Programmes should embed community nursing, digital health, integrated care, and population health, while structured transition-to-practice programmes must support early-career clinicians to develop autonomy and readiness for advanced-practice trajectories.

7.2 Education Pathway to DNP and Funded Access for All Nurses and Midwives

A sustainable pipeline of doctoral-educated nurses and midwives requires a nationally coherent academic progression pathway leading to a QQI Level 10 Doctor of Nursing Practice (DNP)

or equivalent professional doctorate. While many practitioners already hold Level 10 PhDs, there is currently no practice-focused clinical doctorate designed to strengthen advanced practice, consultancy, and service innovation.

The Office of the Nursing and Midwifery Services Director (ONMSD), with its national remit for education and professional development, is best placed to lead the development of this pathway. Acting in partnership with the Chief Nursing Officer, higher-education institutions, and HSE workforce planners, ONMSD can ensure that the DNP is aligned to national regulatory standards, responds to service needs, and reflects strategic workforce priorities.

Ireland's higher-education system already has strong doctoral capacity. A co-designed clinical doctorate, supported through HSE-funded clinical fellowships, would enable nurses and midwives to complete a DNP or Doctor of Midwifery Practice (DMP) while remaining clinically active. This integrated approach builds capability, accelerates service innovation, and cultivates a workforce skilled in advanced inquiry, implementation science, and system redesign. Crucially, access to these fellowships must extend beyond acute hospitals to include nurses and midwives working in primary care, community services, long-term care, and independent practice, ensuring that doctoral capability is distributed where Sláintecare expects most care to be delivered. Table 5 outlines the key enablers required to establish a national DNP pathway that is equitable, impactful, and aligned with health-system reform.

Table 5. Key Enablers of a National DNP Pathway

1	**A jointly designed DNP/Professional Doctorate programme:** across ONMSD, HSE, and Irish universities, ensuring national alignment and quality assurance.
2	**Dedicated funding**: covering tuition and salary supports, to ensure equitable access for practitioners across all regions.
3	**Embedded practice-based research:** aligned with Sláintecare, Integrated Programmes, and population-health priorities, ensuring measurable impact.
4	**Recognition of DNP-qualified practitioners:** as eligible for independent-practice contracts, thereby integrating education, innovation, and regulation.
5	**Structured DNP-led innovations across care settings**; including acute care, mental health, chronic disease, children's health, maternity, community nursing, and intellectual disability services.

Collectively, these enablers build a national platform for clinical leadership, research generation, and evidence-based reform.

7.3 Why Ireland Needs a National DNP Structure

Ireland stands at a pivotal moment in the evolution of its health system. As the country moves toward integrated, community-focused, value-based models of care, nurses and midwives are increasingly central to delivering continuity, prevention, and system-wide coordination. Yet despite their expanding responsibilities, Ireland lacks a nationally recognised practice doctorate, one that bridges advanced clinical expertise with system leadership, policy translation, and measurable service improvement.

A national Doctor of Nursing Practice (DNP) structure would address this critical gap. It would prepare a cadre of practice scholars capable of designing, leading, and evaluating innovations that directly improve patient outcomes and operational performance. Through advanced training in evidence translation, DNP-prepared practitioners would strengthen population-health interventions and ensure that research findings become part of everyday practice. Their preparation for interdisciplinary leadership would equip senior nurses and midwives to guide complex teams, foster collaboration, and lead service redesign across acute, community, primary care, and integrated settings.

By embedding continuous quality improvement into frontline care, DNP-educated clinicians would become drivers of enhanced safety, efficiency, and accountability. At system level, this pathway would cultivate future Chief Nurses, Regional Directors of Nursing and Midwifery, and national operational leaders capable of shaping policy, commissioning services, and advancing reform.

The development of a national DNP model is fully aligned with the Chief Nursing Officer's strategic education priorities (Department of Health, 2022), with the Expert Review Body's (2022) recommendations for enhanced postgraduate education and leadership pathways, and with international best practice in health systems that prioritise clinical scholarship as a core leadership competency.

7.4 International and Empirical Evidence

A growing body of international research demonstrates the transformative impact of doctoral-prepared clinical leaders within modern health systems. Global evidence, including longitudinal analyses by Kesten et al. (2021–2025), shows that nurses and midwives educated to Doctor of Nursing Practice (DNP) level consistently translate complex evidence into everyday clinical decision-making, ensuring that the most up-to-date research is embedded directly into patient care. Their preparation enables them to design, implement, and evaluate quality-improvement and patient-safety initiatives with measurable impact, while also strengthening population-health outcomes through enhanced assessment, data-driven intervention, and systematic evaluation.

Empirical studies from the United States, United Kingdom, and Australia reinforce these findings. Across these systems, DNP-prepared practitioners contribute to significant

improvements in patient outcomes, reductions in care variation, and lower service delivery costs. Their advanced training in implementation science and interdisciplinary collaboration allows them to lead service redesign, streamline pathways, address inequities, and improve access, particularly in community and primary-care settings. Importantly, organisations employing DNP-prepared clinicians report higher levels of workforce retention, improved team cohesion, and stronger safety cultures, demonstrating the broader organisational value of doctoral-level practice.

Notably, international surveys indicate that 92 per cent of healthcare leaders believe practice scholarship should be an explicit expectation of DNP-educated professionals. This reflects growing recognition that doctoral-prepared nurses and midwives play a vital role in staff development, innovation diffusion, and the cultural transformation required to deliver modern, integrated healthcare. Their influence extends well beyond individual patient encounters, shaping service design, resource utilisation, and strategic quality-improvement efforts.

7.5 System-Wide Benefits of a National DNP Pathway

A national Doctor of Nursing Practice (DNP) pathway represents the natural evolution of Ireland's nursing and midwifery education and leadership infrastructure. By closing the long-standing gap between academic scholarship and clinical implementation, a DNP framework would equip practitioners with the knowledge, competencies, and authority required to drive measurable health-system improvement. This is particularly important within complex care environments where advanced clinical reasoning, data interpretation, and evidence translation are essential to safe and efficient practice. DNP-prepared clinicians are also uniquely positioned to lead the development of nursing and midwifery tariffs, outcomes dashboards, and commissioning frameworks, ensuring that independent practice under PCRS is grounded in robust clinical metrics and transparent costing rather than generic 'bed and board' estimates.

International experience demonstrates that DNP-prepared clinicians enhance system quality, accountability, and operational performance. Their doctoral training enables them to lead change initiatives that reduce unwarranted variation, strengthen patient safety, and improve clinical outcomes. Within Ireland, a national DNP structure would ensure that nurses and midwives can progress seamlessly from expert clinical practice to leadership roles in service redesign, population-health improvement, and strategic planning, directly supporting the aims of Sláintecare and the Expert Review Body (2022).

Establishing a national DNP pathway would position Ireland among leading countries in advanced practice while building the leadership capacity needed for a high-performing, equitable, and sustainable health system. By integrating doctoral-level education with frontline clinical practice, the DNP develops practitioners skilled in continuous quality improvement, implementation science, and interdisciplinary collaboration. This creates a robust cadre of clinical leaders capable of driving service redesign, translating evidence into operational change, and embedding innovation directly within care delivery where it delivers measurable benefits for patients, staff, and communities. Table 6 outlines the core dimensions of a national

DNP structure and demonstrates how each contributes to Ireland's health-system reform priorities.

Table 6: Outline of DNP structure for Ireland

Dimension	Benefit of a National DNP Structure	Relevance to Ireland
System Reform	Produces leaders capable of translating evidence into operational change and scaling national programmes (ECC, ICPOP).	Delivers on Sláintecare's "Right Care, Right Place" goals.
Clinical Outcomes	Embeds continuous quality improvement and outcome measurement at point of care.	Addresses HIPE data showing ~30% preventable admissions.
Workforce Development	Creates a defined progression from MSc/ANP to DNP Nurse/Midwife.	Strengthens retention, morale, and parity with medical consultants.
Research Translation	Links implementation science with clinical innovation.	Expands applied research capacity within RHAs and community networks.
Policy Impact	Develops practice-based policy leaders capable of co-designing reform with DoH and HSE.	Strengthens nursing and midwifery voice in governance.
Economic Efficiency	DNP-led quality-improvement projects reduce costs and improve throughput.	Aligns with DoH's performance-led investment and workforce reform agenda.

Taken collectively, these benefits demonstrate that establishing a national DNP pathway is not an educational enhancement but a system-wide reform essential to modernising Ireland's healthcare workforce and improving population outcomes.

7.6 Strategic Advantages for Ireland

Positioning Ireland as a leader in advanced nursing and midwifery practice requires the integration of education, policy, and service delivery within a unified national framework. The establishment of a Doctor of Nursing Practice (DNP) pathway, alongside consultant-style contracts for senior nurses and midwives, presents a transformative opportunity to embed clinical scholarship at the core of healthcare reform. This approach moves far beyond traditional notions of role expansion. It creates a self-sustaining leadership ecosystem in which practice, research, and policy are fully interconnected, enabling the professions to shape system design, lead innovation, and influence decision-making at every level.

A DNP framework serves as the critical bridge between academia and service delivery. Through advanced preparation in evidence translation, implementation science, and applied research, DNP-prepared practitioners transform knowledge into measurable improvements in care quality, safety, and patient outcomes. This doctoral-level capability strengthens Ireland's leadership pipeline by preparing future Chief Nurses, Regional Health Area Directors, national operational leaders, and Clinical Academic Nurse and Midwife roles who bring practice-based scholarship to executive decision-making.

The DNP model also enhances professional governance. By authorising DNP-prepared clinicians to sign off Advanced Nurse and Midwife Practitioner (AN/MP) candidates, the professions retain stewardship over their own advanced knowledge and skill base, ensuring that clinical standards, innovation, and scope-of-practice evolution remain in the hands of those best equipped to guide them. In addition, DNP graduates are positioned to lead the development of new service models, including independent community-based practice under Sections 58 and 59 of the Health Act 1970, supporting earlier intervention, reducing hospital dependency, and expanding access to safe, nurse-led care. They will function as the senior clinical and academic reference point for the entire tiered nursing and midwifery structure, ensuring that generalist, specialist, and advanced independent practitioners operate within coherent, evidence-based pathways with clear escalation routes and shared governance.

Importantly, the integration of practice-based scholarship into everyday clinical roles enhances professional satisfaction and strengthens workforce retention. For many practitioners, the opportunity to combine clinical excellence, education, research, and leadership within a recognised national pathway represents a meaningful, fulfilling career trajectory aligned with international standards.

Establishing consultant-style contracts supported by a national DNP framework unites clinical practice, research, and education within a single, sustainable ecosystem of nursing and midwifery leadership. Evidence from Ireland and abroad confirms that DNP-prepared nurses act as practice scholars, change agents, and policy influencers, capable of driving improvements in outcomes, staff development, care pathways, and system performance.

Embedding this integrated model within an HSE–University partnership ensures that every nurse and midwife can practise, innovate, and lead to the full extent of their education and scope. This alignment delivers measurable value to patients, strengthens service quality, accelerates reform, and positions Ireland at the forefront of advanced nursing and midwifery practice internationally.

The proposed national DNP and Professional Doctorate pathway aligns directly with the Chief Nursing Officer's education priorities, which call for enhanced postgraduate and advanced-practice preparation to equip nurses and midwives with the clinical, digital, research, and leadership competencies required for emerging, community-based, and digitally enabled models of care (Department of Health, 2022).

With the foundations for clinical, academic, and leadership excellence now established through consultant-style contracts and a national DNP framework, the next step is to translate this capability into operational reform. Section 8 sets out the mechanisms required to activate independent nursing and midwifery practice at scale, detailing the contractual structures, regulatory enablers, governance arrangements, and digital integration needed to ensure safe, accountable, and population-centred delivery. By aligning these practical implementation steps with the leadership and educational reforms outlined above, Ireland can create a coherent, future-ready model of care that fully realises the potential of its nursing and midwifery workforce.

8.0 The Integrated Nursing and Midwifery Pyramid Structure: A Continuum of Practice

A modern, high-performing nursing and midwifery workforce should not function as a hierarchy but as *a continuum of competence*. Each level, generalist, specialist, and advanced, practises autonomously within its professional scope while remaining interconnected through shared governance, digital integration, and statutory regulation. The Integrated Nursing and Midwifery Pyramid represents the professions as a single, interdependent system in which every practitioner contributes distinct expertise to population health and service delivery.

This tiered continuum is not simply a workforce framework; it is the structural mechanism that allows Ireland to shift activity from hospitals to homes and communities. Generalist nurses enable early intervention and broad access, specialists provide targeted disease management and continuity, and ANPs deliver complex assessment, diagnostics, and leadership. Without a strong generalist base and the ability for each tier to function independently under transparent reimbursement mechanisms, specialist and advanced practitioners become bottlenecked, and HIPE-sensitive conditions continue to default to the acute system.

This model supports both public-sector and independent practitioners and ensures that all nurses and midwives, whether employed by the HSE or contracted independently under the Health Act 1970, can work collaboratively within a unified, high-performing framework. It reflects the ERB (2022) vision of a profession working "to the top of licence," with parity, accountability, and flexibility structured into system design.

8.1 Base – Enhanced Contract Practice

At the foundation of the continuum are Registered General Nurses (RGNs) and Registered General Midwives (RGMs) practising under Enhanced Contracts or as independent practitioners through the Primary Care Reimbursement Service (PCRS). This tier delivers broad-spectrum, population-level services spanning prevention, health promotion, chronic disease management, reablement, and maternal–child health. Aligned with Sláintecare's principle of "care at the lowest level of complexity, as close to home as possible," these practitioners form the backbone of accessible, community-based care.

Operating under the Nurses and Midwives Act 2011 and regulated by NMBI, they provide autonomous, accountable care in the home and community, managing wounds, reviewing medications, stabilising chronic illness, and conducting preventive screening. Sections 58 and 59 of the Health Act 1970 provide contractual eligibility for reimbursement via PCRS, mirroring the independent contractor model used by GPs and allied health professionals. A well-supported generalist tier also prevents unnecessary escalation into specialist or acute pathways. By providing rapid response for older persons, post-discharge follow-up, early chronic-disease stabilisation, and routine wound and continence care, Tier-1 practitioners reduce the downstream burden on CST teams, Primary Care Centres, MIUs, and hospital services.

Whether working within HSE-managed services or as independent contractors, this tier expands access, increases flexibility, and supports earlier intervention for populations with routine and emerging health needs.

8.3 Middle – Clinical Nurse Specialist and Community Practice

This tier exists because many chronic, rehabilitation, maternity, and palliative pathways require more depth than generalist practice but do not require ANP-level diagnostics or complexity. Without a robust specialist tier, patients default unnecessarily to acute hospitals or outpatient clinics, contributing to avoidable activity shown in HIPE data.

The middle tier, Clinical Nurse Specialists (CNS), Clinical Midwife Specialists (CMS), and community-based practitioners, forms the bridge between hospital and home. These clinicians manage chronic disease pathways, frailty, rehabilitation, palliative care, and maternity programmes that demonstrably improve early intervention, prevent avoidable admissions, and enhance quality of life.

Working within HSE or RHA service-level agreements, and increasingly through defined PCRS-funded episodes, these practitioners provide targeted interventions such as specialist wound care, IV therapy, chronic-disease coordination, maternal–child follow-up, and post-discharge assessment. Their work is supported by peer-led governance, clinical audit, and population-health data systems.

Evaluations of the Enhanced Community Care programme (HSE, 2023) and the Clinical Nursing in the Home Pilot (ONMSD, 2022) confirm the effectiveness of this tier in reducing hospital dependency and strengthening continuity. Specialists also serve as mentors to early-career nurses, embedding a culture of continuous quality improvement and preparing the next generation for advanced practice roles.

8.4 Apex – Advanced Practice

At the apex of the continuum are Advanced Nurse Practitioners (ANPs) and Advanced Midwife Practitioners (AMPs), increasingly DNP-qualified or equivalent. They deliver the most complex clinical, diagnostic, and leadership functions within Ireland's health system.

ANPs/AMPs hold statutory diagnostic, prescriptive, and referral authority and lead the highest levels of clinical governance and quality assurance across acute, community, and primary-care networks. Their practice includes specialist services reimbursable under PCRS tariffs or directly commissioned by the HSE, reflecting their capacity to manage complexity, reduce system pressure, and deliver high-value care. ANPs and AMPs also act as the senior clinical decision-makers within community hubs, CSTs, and MIUs, ensuring rapid access to diagnostics, specialist opinion, and escalation pathways. Their enhanced authority and diagnostic capability are essential if Ireland is to deliver multi-specialty hub models not limited by consultant availability

Advanced practitioners also serve as academic, clinical, and policy leaders, guiding innovation, shaping models of care, supervising advanced trainees, and driving workforce development across the continuum. Their role gives full effect to ERB Recommendations 13 and 31, embedding research, quality, and leadership into daily practice. A comprehensive list of published evidence demonstrating the impact, outcomes, and advanced clinical contributions of ANPs and AMPs across specialties is provided in Appendix 3**.**

IAANMP members collectively hold one of the largest cross-specialty repositories of nursing and midwifery research in Ireland, spanning over 30 clinical areas and contributing to national and international evidence that actively shapes health-system design. Their publications include evaluations of clinical practice, service models, workforce preparedness, guideline development, patient education, diagnostic pathways, chronic disease management, psychosocial care, human factors, integrated care, and health-service utilisation. Irish ANPs/AMPs are co-authors on multiple global collaborative studies and lead research that directly informs improvements in patient outcomes, continuity of care, prevention, early diagnosis, reduction of avoidable hospital use, and optimisation of multidisciplinary models. This body of evidence, published across leading journals such as *BMJ***,** *JAMA***,** *Journal of Clinical Nursing***,** *Age & Ageing***,** *BMC Geriatrics***,** *European Respiratory Journal***,** *British Journal of Nursing***,** *Rheumatology***,** and *Irish Medical Journal***,** demonstrates the demonstrable impact of advanced practice nurses and midwives on service quality, patient safety, and system performance. It provides a compelling academic foundation for expanding independent nursing and midwifery practice and confirms that the profession already has the research capacity, capability, and leadership required to support national reform (see Appendix 3).

8.5 Integration Across the Continuum

Across all three tiers, the Integrated Pyramid functions not as a hierarchy but as a dynamic, interconnected system in which autonomy and accountability coexist. Public and independent

practitioners operate within the same regulatory and governance frameworks, ensuring safety, equity, and excellence in every care setting. Digital interoperability, electronic prescribing, IHI-linked documentation, and AI-supported decision tools will enable independent practitioners to deliver safe, standardised, data-rich care. This aligns with the national Digital Health Strategy and RHA digital modernisation plans.

Digital technologies, recommended under ERB 20–27, provide the unifying infrastructure, enabling interoperable information systems, predictive analytics, electronic documentation, and real-time data visibility. Integrating independent practice into these national systems ensures seamless care pathways, robust evaluation, and data-driven planning across all RHAs. Digital integration is central at this tier. By contributing to shared electronic records, multidisciplinary communication systems, and outcome-based reporting, generalist practitioners enhance continuity and transparency across pathways.

This continuum ensures that nursing and midwifery expertise, not hierarchical structure, drives service delivery. It operationalises Sláintecare's vision of equitable, sustainable, community-based care and supports the systemic shift toward prevention, early intervention, and integrated population health. When combined with appropriate contracting mechanisms under the Health Act 1970 and PCRS reimbursement, this continuum becomes fully operational, allowing each tier to deliver defined, tariff-based episodes of care with transparent accountability, measurable outcomes, and seamless integration across RHAs.

The Integrated Nursing and Midwifery Pyramid establishes a unified, evidence-based framework through which practitioners at every level, generalist, specialist, and advanced, can deliver safe, autonomous, and coordinated care across Ireland's health system. With this continuum now defined, the next step is to outline how independent nursing and midwifery practice can be operationalised through contracting, commissioning, governance, and evaluation mechanisms. Section 9 sets out this implementation architecture, detailing the statutory levers, contractual models, and regulatory safeguards required to activate independent practice while ensuring quality, accountability, and full alignment with Sláintecare and ERB priorities.

8.6 Nursing and Midwifery 2035: A Modernised, Future-Ready Workforce

Ireland's future health system will depend on a modernised, digitally enabled workforce capable of delivering proactive, population-focused care across all settings. Independent nursing and midwifery practice is the structural reform that unlocks this future, equipping the professions to lead innovations in prevention, early intervention, and integrated care.

Digital-First and AI-Enabled Practice

By 2035, routine clinical practice will be supported by AI decision tools, predictive analytics, and remote-monitoring technologies. Independent practitioners will lead:

- virtual ward models for chronic disease, frailty, respiratory illness, and post-discharge recovery;
- AI-supported triage, risk stratification, and early deterioration detection;
- community diagnostic hubs integrating radiology, pathology, and point-of-care testing;
- interoperable digital records using Individual Health Identifiers and national datasets.

These innovations enable timely intervention, reduced hospital dependency, and real-time evaluation of clinical impact.

Climate Resilience and Emergency Preparedness

Ireland faces increasing climate-related pressures including flooding, heat events, and displacement, alongside pandemics and public health emergencies. Independent practice allows the nursing and midwifery workforce to mobilise:

- rapid community outreach teams,
- home-based acute assessment during service disruption,
- continuity-of-carer in crisis events,
- nurse-led shelters and evacuation centre health services.

A flexible, contractible workforce is essential to national resilience planning.

New Models of Midwifery Practice

With evolving demographics, fertility patterns, and maternity reform initiatives, Ireland requires continuity-of-carer midwifery models, community-led antenatal/postnatal pathways, and homebirth services aligned with international best practice. Independent practice enables midwives to expand their statutory autonomy in ways that strengthen safety, choice, and maternal wellbeing.

Consultant-Style Career Pathways

As part of a modernised system, Clinical Academic Consultant roles and national DNP/DMP pathways will create consultant-equivalent nursing and midwifery leadership. These posts integrate clinical expertise, research, and education—ensuring a pipeline of national leaders who can shape policy, deliver innovation, and train the next generation.

By 2035, independent practice will form the backbone of a modern Irish health service: digital-first, community-led, flexible, resilient, and grounded in evidence-based, nurse- and midwife-led care.

9.0 Strategic Case for Independent Nursing and Midwifery Practice: Economic Value, Governance, Workforce and Population Impact

This section sets out the strategic case for introducing independent nursing and midwifery practice. It presents (i) the economic and system-level impact, (ii) the contribution to workforce sustainability and health equity, (iii) the demonstrated impact of existing ANP/AMP roles, and (iv) the governance and global alignment framework that will ensure safe, accountable implementation. This reform is designed for phased, tightly governed implementation beginning with defined populations, ensuring safe scaling, strong evaluation, and national consistency.

9.1 Economic and System-Level Impact

Independent nursing and midwifery practice represents a value-based, evidence-driven reform that strengthens the efficiency, equity, and sustainability of Ireland's health system. National and international evidence consistently shows that nurse- and midwife-led models deliver comparable or superior clinical outcomes at significantly lower cost, directly supporting the HSE National Service Plan 2025 commitment to "workforce innovation, contractual flexibility, and care closer to home."

Independent practice therefore should not be viewed as an additional cost pressure, but as a mechanism to redirect existing expenditure into models that demonstrably generate higher clinical, social, and economic returns. In practice, this reform reallocates spend from avoidable bed-days, agency fees, and fragmented outpatient activity into defined, nurse- and midwife-led episodes of care that can be costed, evaluated, and commissioned on a value basis.

Independent nursing and midwifery practice is not an additional cost to the health system; it is a strategic reallocation of existing expenditure from high-cost, low-yield activities, such as avoidable ED attendances, OPD reviews, agency nursing, and unnecessary acute bed-days, into lower-cost, high-value community care. This shift directly advances the Department of Health and DPER priorities for fiscal sustainability, productivity, and value for money. By diverting demand away from the acute system and enabling earlier, more efficient intervention, independent practice acts as a fiscal stabiliser, reducing recurrent overspend and supporting a more financially resilient health service. The economic implications of this reform are summarised in Table 7.

Table 7: Economic Benefits and Cost-Saving Mechanisms of Independent Nursing and Midwifery Practice

Reduced Acute Hospital Spend
• Avoidable admissions (28–34%) represent €480 million annually in preventable costs. • Nurse-led early intervention reduces length of stay by 2.4 days on average.

- Every €1 invested in community nursing generates €5.10 in social value (ArrowHealth SROI).

Reduced Agency Nursing and Locum Reliance

- Independent contracting provides a cost-controlled alternative to agency staffing.
- Improves continuity, accountability, and workforce stability.

Reduced ED Crowding and Trolley Numbers

- Nurse-led decision-making, streaming, and early treatment prevent overcrowding.
- Reduces costs associated with delayed discharges, ambulance turnaround delays, and risk events.

Lower Cost per Episode of Care

- Community nurse-led episodes cost 20–30% less than equivalent physician-led or hospital-based episodes.
- Tariff-based PCRS funding allows transparent costing and outcome measurement.

Better Chronic Disease Outcomes

- Early intervention avoids expensive deterioration, unplanned admissions, and long-term functional loss.
- Enables value-based commissioning aligned with Sláintecare.

Collectively, these savings demonstrate that independent practice strengthens system sustainability and provides a measurable return on investment, precisely the direction sought by Government and DPER.

9.2 System Efficiency and Value

Extensive evidence demonstrates that nurse-led care delivers high-quality outcomes with reduced cost and improved access:

1. **International economic evidence** – OECD (2022) and WHO (2021) analyses show that nurse-led chronic disease management achieves equivalent or better outcomes at 20–30% lower cost per episode compared with physician-led models.
2. **Irish integrated care evaluations** – HSE evaluations of Enhanced Community Care (ECC) and the Integrated Care Programme for Older Persons (ICPOP) (2023) report 25–35% reductions in avoidable hospital admissions, improved continuity of care, and high patient satisfaction where advanced nurse- and midwife-led models are in place.
3. **Community nurse-led social return** – In addition to measurable impact on hospital avoidance and earlier discharge, the ArrowHealth Social Return on Investment (SROI, 2023) study calculated a €5.10 social value return for every €1 invested in community

nurse-led care, capturing savings from reduced hospital dependency, improved wellbeing, and increased family productivity.

Embedding independent contracting for nurses and midwives under the Primary Care Reimbursement Service (PCRS) would extend these efficiencies nationally, establishing a scalable, outcome-based funding mechanism fully aligned with Sláintecare and Programme for Government 2025+ objectives for universal, community-based care. It would also create the foundation for a national nursing costing and outcomes model, in which tariffs and indicators are attached to specific nurse- and midwife-led episodes of care rather than subsumed within undifferentiated *"bed and board"* allocations.

The Expert Review Body on Nursing and Midwifery (ERB, 2022) also recognised that contractual and pay anomalies must be resolved (Recommendations 38 and 47) to support modernised roles. Independent practice offers a flexible progression pathway that can operate in parallel with national pay reforms, ensuring that nurses and midwives are appropriately recognised while new models are being implemented.

9.3 Workforce Sustainability

Independent practice significantly enhances workforce sustainability by creating new professional pathways and improving retention across nursing and midwifery. It:

1. **Retains experienced clinicians in community-based roles** – Independent and contracted models allow senior nurses and midwives to remain active as self-employed or sessional providers, reducing dependence on high-cost agency staffing and strengthening local continuity of care.
2. **Operationalises ERB career recommendations** – The reform directly aligns with ERB Recommendations 18 and 19, which call for clear advancement frameworks that recognise and reward clinical expertise in practice, not only in management and education.
3. **Delivers on HSE retention priorities** – It reflects HSE National Service Plan 2025 priorities for retention, flexibility, and innovation by offering portfolio careers, flexible scheduling, and community-anchored practice.
4. **Builds leadership and satisfaction** – International evidence (e.g. UK Nurse Consultant roles and Australia's clinical academic pathways) shows that when clinical autonomy and contractual parity are introduced, retention, leadership development, and professional satisfaction consistently improve (QNI, 2023; APNA, 2022).

Currently, only 1.8% of Ireland's nursing workforce are registered AN/MPs, with even fewer authorised as prescribers or diagnosticians (NMBI, 2025). The contrast between broad prescriptive autonomy and restricted diagnostic authority exposes a structural inconsistency that undermines efficiency and continuity of care. This limited critical mass constrains impact and visibility.

National policy should therefore prioritise expansion of ANP/AMP numbers to at least 3% of the workforce over the next three years, coupled with independent-practice entitlements, so that advanced practitioners can operate at full scope and deliver system-level outcomes at scale. By embedding independent roles within Ireland's health system, nursing and midwifery can evolve into a self-sustaining workforce that is professionally empowered, financially viable, and rooted in community-based service delivery.

9.4 Health Equity and Population Impact

Independent contracting significantly strengthens health equity and population access**,** particularly in rural and underserved communities. This approach aligns directly with both the Department of Health's Statement of Research Priorities (2023–2025) and the WHO European Programme of Work (2020–2025)**,** each emphasising equitable, community-led care as a foundation for sustainable health systems.

1. **Improved access and coverage** – Nurse- and midwife-led services extend preventive, chronic disease, and maternal–child care to low-income, geographically isolated, and marginalised populations, addressing both gendered and regional disparities in access and outcomes.
2. **Universal, cash-free access** – Embedding reimbursement for these services within the PCRS would ensure that all citizens, regardless of income, location, or social circumstance, can access safe, evidence-based care at the point of need. This ensures that independent practice strengthens, rather than fragments, universal coverage by keeping services inside a publicly funded, entitlement-based framework.
3. **Scaling proven models** – Evidence from AN/MP-led clinics in cardiology, rheumatology, primary care, and community settings consistently demonstrates reduced waiting times, improved adherence, and high patient satisfaction. National contracting would extend these benefits from pilot to population scale.

An additional high-impact opportunity lies in expanding **ANP roles within nursing homes**, working in structured collaboration with GPs. International studies show that advanced practitioners in long-term care significantly reduce avoidable ED transfers, optimise chronic disease management, and improve resident outcomes (Donald et al., 2019; Mileski et al., 2020). A formalised GP–ANP collaborative governance model, supported by digital documentation, remote consultant input where needed, and shared clinical criteria, would enhance anticipatory care planning, stabilisation of chronic illness, medication optimisation, and timely management of acute deterioration. This model strengthens equity for older adults, reduces pressure on acute services, and ensures consistent, high-quality clinical support for residential care

By operationalising this model, Ireland would fully realise Sláintecare's central principle of universal, person-centred care, ensuring that every community benefits from the full capacity and expertise of the nursing and midwifery workforce.

9.5 Summary of Measurable Impacts of ANPs and AMPs

Advanced Nurse Practitioners (ANPs) and Advanced Midwife Practitioners (AMPs) already deliver strong and measurable impact within the current public health system, even though they operate with constrained diagnostic, radiology, and referral access.

As summarised in Table 8**,** ANPs and AMPs:

- **Improve access and flow** – National audits show 90–100% of patients reviewed within recommended timeframes in ANP/AMP-led pathways. Department of Health evaluations report that each ANP prevents an average of 4.3 hospital admissions per week**,** removes 3.9 patients per week from specialist waiting lists, and reduces emergency care Patient Experience Time (PET) by up to 2 hours and 43 minutes (DoH, 2021; 2022).
- **Reduce acute hospital pressure** – ANP-led Critical Care Outreach avoided 161 ICU admissions (≈€1.09M cost avoidance), while EDITH 2 managed 90% of acutely unwell older adults in nursing homes, avoiding ED attendance. The CRISP rehabilitation programme delivered a 74% reduction in falls**,** sustained at four months, and reduced caregiver stress.
- **Enhance clinical outcomes and optimisation** – ANP-led IBD biologic clinics, lipid pathways, fracture liaison services, and digital platforms (e.g. SMARTCP) improve therapeutic monitoring, diagnostic accuracy, and guideline adherence, while enabling patient-initiated review.
- **Advance equity and integration** – Services for women with IBD in pregnancy, respiratory GP reach-in, and Huntington's community outreach reduce structural barriers and create coordinated, reliable pathways for populations who traditionally experience fragmented care.
- **Strengthen safety and efficiency** – Standardised ANP-developed protocols, digitalised discharge templates, QR-linked patient education, and structured medication reviews improve documentation, reduce duplication, and support safer transitions. In older adult care, skin-tear healing improved from 66% to 90%**,** while infection rates decreased from 60% to 20%**.**
- **Build workforce capability** – In intellectual disability services, ANPs trained 322 staff**,** leading to a 30% reduction in external healthcare usage and an 85% increase in internal capacity**.**

In summary, Table 8 confirms that ANPs and AMPs are already delivering high-value, high-impact care within the current public model. What they achieve now, *without* full diagnostic and referral authority, provides the baseline against which the additional benefits of an Independent Practice Framework (Table 10) should be judged.

9.6 Independent Practice – A Distinct Future Reform

Independent practice is not a description of current ANP/AMP activity. Rather, it is a future-oriented structural reform that would enable nurses and midwives to operate with full diagnostic, radiology, and referral entitlements, consistent with international advanced practice standards.

While Table 8 captures the strong outcomes achieved within current constraints, evaluations also show that ANPs/AMPs routinely face inconsistent access to essential diagnostics and referral pathways. These delays disrupt patient flow, prolong waiting lists, and reduce overall system efficiency.

A national **Independent Practice Framework** would address these barriers by establishing:

- **Standardised national entitlements** for diagnostics, radiology and referral rights;
- **Formal contractual authority** for independent episodes of care under PCRS and other schemes;
- A **HSE Chief Nursing & Midwifery Officer–led oversight mechanism** to eliminate regional variability; and
- Alignment with international jurisdictions where advanced practitioners function as autonomous clinicians within integrated care systems.

The projected impact of independent practice is summarised in Table 8**,** showing how system performance improves further when structural bottlenecks are removed. This reform does not introduce new cost lines; it represents a strategic reallocation of system capacity, enabling earlier intervention, reduced duplication, greater hospital avoidance, and faster chronic disease management.

Taken together, Tables 8 and 10 demonstrate:

- **What advanced practitioners deliver now**, within the constraints of the current model; and
- **What becomes possible** when independent practice reforms unlock their full capacity

9.7 Governance and System Integration

This framework aligns statutory regulation, contractual authority, policy direction, financial oversight, quality assurance, advanced-practice supervision, and appropriate indemnity arrangements.

The proposed governance model reflects the CNO's commitment to strengthening clinical leadership, quality assurance, and system-wide accountability across the RHAs as outlined in national CNO policy priorities (Department of Health, 2023). The following table outlines the

governance architecture required to support both public and independent nursing/midwifery practice.

A coherent governance infrastructure is essential to enabling both public and independent models of nursing and midwifery practice. Such a framework must provide statutory clarity, contractual authority, and regulatory assurance while supporting advanced clinical autonomy and system accountability. To function effectively at national scale, independent practice requires consistent mechanisms for regulation, contracting, financial oversight, policy alignment, mentorship, and indemnity. Table 8 outlines the governance architecture needed to operationalise this integrated model and to ensure consistency, safety, and parity across all service settings.

Table 8: Outline of the governance architecture required to support both public and independent nursing/midwifery practice.

Governance Dimension	Mechanism	Reference Framework
Regulation	Statutory oversight by NMBI; professional accountability under *Nurses and Midwives Act 2011*	DOH 2011
Contractual Authority	HSE powers under *Health Act 1970* Sections 58–59–67 for independent provider agreements	DOH 1970
Policy Alignment	*Programme for Government 2025+*, *HSE NSP 2025*, *Sláintecare Implementation Strategy 2021–2023*	DOH 2021; 2025
Financial Accountability	Transparent PCRS reimbursement, outcome-based monitoring, and system-level evaluation	HSE 2024
Quality, Mentorship & Advanced Practice Oversight	Peer-led audit, ANP/AMP clinical governance; supervision and sign-off for new specialist candidates; continuous professional development	ERB 2022 Recs 18–19
Indemnity	Affordable professional insurance for routine care; enhanced indemnity mechanisms for complex advanced-practice roles, potentially supported through a Memorandum of Understanding with the State Claims Agency (SCA) for high-risk, consultant-level practice (e.g., comparable to nurse surgeons, endoscopists, or anaesthesia practitioners internationally)	SCA / HSE / DoH

While governance structures create the conditions for safe and autonomous practice, the most compelling justification for expanding independent and advanced roles lies in the evidence of

impact already achieved within the existing public-practice model. Even with restricted diagnostic access, limited referral pathways, and operational constraints, ANPs and AMPs consistently deliver measurable improvements in access, quality, efficiency and patient experience. Table 8 summarises this performance profile and demonstrates the systemic value currently being generated under the traditional public-only model.

Making nursing and midwifery independently contractible providers under PCRS would also enable the development of a national nursing costing model. By attaching tariffs and outcome metrics to defined episodes of care, finance and performance systems could, for the first time, demonstrate the comparative cost and value of nurse-led versus traditional models across chronic disease, frailty, maternal and child health, and palliative care. This shift is essential to ensuring that future investment decisions are grounded in demonstrable value rather than historic allocations. National CNMO oversight of entitlements and tariffs would further eliminate regional variation in ANP/AMP diagnostic access, radiology, and referral rights, embedding independent practice within a single, nationally consistent governance framework. Table 9 summarises the current measurable impact of ANPs and AMPs within the public practice model and highlights the scale of value that a nationally commissioned independent practice model could unlock.

Table 9: Current Impact of ANPs and AMPs (Public Practice Model)

Domain	Evidence of Measurable Impact	Key Sources
Hospital Avoidance	25–35% reduction in avoidable admissions; 161 ICU admissions avoided; 90% EDITH patients managed in nursing homes	HSE ECC & ICPOP (2023); Critical Care Outreach Evaluation; EDITH Evaluation
Access & Waiting Times	90–100% timely reviews; PET reduced by up to 2h 43m; 3.9 patients removed weekly from waiting lists	DoH (2021, 2022); Sleep Service Pilot; IAANMP 2025 submissions
Quality & Clinical Outcomes	74% reduction in falls; improved therapeutic monitoring and diagnostic accuracy; improved healing rates (66%→90%)	CRISP Evaluation; IBD Biologic Clinic; Lipid Protocol; Skin Tear QI
Patient Experience	~90–95% positive experience across multiple pathways; 100% satisfaction in several ANP-led services	DoH (2022); O'Carroll et al. (2021); IAANMP Evaluations
Equity & Integrated Care	Expanded reach into rural, home, LTCF and marginalised groups; improved continuity	DoH (2023); WHO (2021); Huntington's Disease Outreach
Economic Impact	€5.10 social value per €1 invested; lower cost-per-	ArrowHealth SROI (2023); OECD (2022); WHO (2021)

	episode (20–30% below physician-led care)	
Workforce Capability	322 staff trained; external healthcare use reduced by 30%; internal capacity ↑ 85%	ID Services ANP Report; ERB (2022); APNA (2022)

The results in Table 9 illustrate that advanced practitioners are already contributing substantial clinical and operational benefits despite structural barriers that limit full-scope practice. These outcomes reinforce the central findings of the Expert Review Body (2022), which emphasises the need for modernised governance, expanded contractual pathways, strengthened clinical assurance, and advanced educational structures. Table 10 maps the proposed governance and practice reforms to the specific ERB recommendations they address, demonstrating the coherence and national policy alignment of the proposed model.

Table 10: Alignment with ERB Recommendations

Governance Domains with Assigned ERB Recommendations	
1. Regulation	**Statutory oversight by NMBI; professional accountability under Nurses and Midwives Act 2011** **Relevant ERB Recommendations:**
	Rec 1 – Strengthen professional autonomy and regulatory clarity. **Rec 7** – Ensure nursing and midwifery representation in system-level regulation and governance. **Rec 18** – Ensure alignment of regulatory and educational standards for advanced roles.
2. Contractual Authority	**HSE powers under Health Act 1970 Sections 58–59–67 for independent provider agreements** **Relevant ERB Recommendations:**
	Rec 8 – Enable nurses and midwives to practise to full scope, including new models of care. **Rec 9** – Establish enhanced roles and contractual mechanisms to expand service delivery. **Rec 10** – Ensure national frameworks support consistency and mobility across services.
3. Policy Alignment	**Programme for Government 2025+, HSE NSP 2025, Sláintecare Implementation Strategy 2021–2023** **Relevant ERB Recommendations:**
	Rec 7 – Nursing and midwifery leadership must be represented in strategic policy decisions. **Rec 9** – Expand advanced and autonomous practice aligned to national reform.

	Rec 14 – Embed nursing and midwifery in integrated care, community models, and Sláintecare priorities.
4. Financial Accountability	**Transparent PCRS reimbursement, outcome-based monitoring, and system-level evaluation** **Relevant ERB Recommendations:**
	Rec 11 – Reform funding and resourcing models to support new ways of working. **Rec 12** – Ensure equitable access to resources across regions and services. **Rec 19** – Implement evaluation and outcome measurement for advanced roles.
5. Quality, Mentorship & Advanced Practice Oversight	**Peer-led audit; ANP/AMP clinical governance; supervision and sign-off for new specialist candidates; continuous professional development** **Relevant ERB Recommendations**
	Rec 15 – Strengthen clinical governance and advanced-practice assurance. **Rec 18** – Enhance advanced practice structures, mentorship, and progression pathways. **Rec 19** – Implement robust audit, evaluation, and peer-led governance systems.
6. Indemnity	**Affordable professional insurance for routine care; enhanced indemnity mechanisms for complex advanced-practice roles, potentially supported by a Memorandum of Understanding with the State Claims Agency (SCA)** **Relevant ERB Recommendations:**
	Rec 9 – Remove barriers to full-scope and autonomous practice, including legal and operational impediments. **Rec 11** – Ensure enabling resourcing arrangements for expanded and advanced practice. **Rec 15** – Strengthen clinical governance, risk management, and safety systems for advanced roles.

By embedding independent practice, advanced education pathways, and strengthened governance within a unified framework, the model aligns precisely with the direction set by the Expert Review Body. A full crosswalk of the 2022 ERB recommendations to the IAANMP Independent Practice Framework is provided in Appendix 4.

Advanced Practitioners play a pivotal leadership role in modelling safe autonomous practice and mentoring colleagues; however, all practitioners can operate independently within their competence. A unified governance framework enables consistent standards of assessment, documentation, escalation, and quality improvement across generalist, specialist, and advanced roles.

9.8 Workforce Attraction, Retention and Global Alignment

Independent practice directly aligns with the expectations of a modern nursing and midwifery workforce, autonomy, flexibility, digital integration, and meaningful career progression. It retains mid-career practitioners who are otherwise lost to rigid structures while attracting younger clinicians who expect adaptive, community-focused roles. This strengthens workforce stability and preserves institutional expertise. Independent practice also aligns with the expectations of a global, mobile workforce; without modernised contractual and governance frameworks, Ireland risks losing skilled clinicians to jurisdictions where autonomy, portability, and flexible practice models are standard.

Critically, independent contracting also addresses the attrition that typically occurs at mid-career or in the early-retirement years. Many nurses and midwives leave the system not because they wish to exit practice, but because rigid organisational structures, limited advancement pathways, and inflexible rostering make continued participation untenable. Independent practice presents a viable alternative to permanent withdrawal, allowing highly experienced practitioners to remain active in specialist fields such as chronic disease management, women's health, and palliative care, with greater control over workload, scheduling, and scope.

This model also aligns directly with global policy directions. The WHO Global Strategic Directions for Nursing and Midwifery (2021–2025), alongside UN, ICM, and ICN guidance, call for empowered, innovative, and flexible workforce structures capable of advancing universal access and the Sustainable Development Goals. Independent practice operationalises these priorities by combining professional empowerment with population-level impact, enabling nurses and midwives to lead service innovation while addressing unmet community need. This model gives concrete effect to the WHO Global Strategic Directions for Nursing and Midwifery (2021–2025), which call for empowered, flexible, and innovatively contracted workforces to advance universal health coverage.

Embedding independent pathways within the HSE's contracting and reimbursement architecture would strengthen the national workforce in several ways: it would reduce dependence on agency staffing and short-term locums; cultivate a culture of professional ownership and accountability; accelerate digital adoption and service innovation, particularly among younger practitioners; and foster intergenerational mentorship, as independent and public-sector clinicians collaborate across new models of care.

By adopting this approach, Ireland positions itself as a global exemplar of nurse- and midwife-led workforce reform, uniting professional fulfilment with system sustainability, and directly improving population health outcomes. The projected system-level benefits of an independent practice framework are outlined in Table 11, demonstrating how expanded autonomy, diagnostic authority, and streamlined pathways would accelerate access, strengthen equity, reduce hospital dependency, and enhance overall efficiency across the health service.

Table 11: Projected Impact Under an Independent Practice Framework

Domain	Projected System-Level Benefit	Rationale
Faster Access & Diagnostics	Same-day/next-day assessment with direct ordering of investigations	No GP or consultant gatekeeping; reduced waiting times
Greater Hospital Avoidance	Significant increase beyond current 25–35% reductions	Earlier decision-making due to unrestricted diagnostics
Reduced Waiting Lists	High-volume removal of low–moderate complexity cases	ANPs/AMPs able to manage full episodes independently
Improved Outcomes	Earlier intervention → reduced disease progression	Diagnostic delays eliminated
Stronger Equity	First-contact care in rural/underserved areas	ANP-led community hubs equipped for full assessment
Higher Efficiency	Reduced duplication; fewer clinical touchpoints; lower cost-per-episode	Streamlined pathways and autonomous decision-making
Enhanced Workforce Stability	Higher retention, recruitment and satisfaction	Role clarity, autonomy and elimination of operational barriers
Standardised National Governance	Elimination of regional variation	CNMO-led oversight of access entitlements

Independent contracting provides a strategic alternative to high-cost agency staffing, improving continuity and accountability while reducing a major area of health expenditure growth.

Together, these findings establish a clear and urgent case for reform. The next section outlines the national implementation framework required to activate independent nursing and midwifery practice safely, consistently, and at scale.

10. Nursing, Midwifery and Advanced Practice Key Performance Indicators (KPIs)

The Health Service Executive (HSE) monitors nursing and midwifery performance through a defined suite of indicators that span workforce stability, quality and safety, professional governance, community activity, and advanced-practice performance. Workforce metrics incorporate vacancy and turnover rates, sick-leave patterns, skill-mix ratios, and recruitment timelines, while quality and safety indicators include pressure injuries, falls, medication safety, healthcare-associated infections, and compliance with early-warning score systems and national documentation standards (HSE, 2024).

Midwifery services report additional performance measures under the National Women and Infants Health Programme, including normal birth, caesarean section and induction rates, breastfeeding initiation and exclusivity, and postnatal contact timelines (HSE, 2023). Advanced Nurse Practitioners (ANPs) and Advanced Midwife Practitioners (AMPs) operate under a national reporting framework that captures clinical activity, admission-avoidance episodes, emergency department (ED) diversion, reductions in length of stay and 30-day readmissions, prescribing governance, audit outcomes, education activity, and leadership contributions (ONMSD, 2022). Community nursing metrics further assess access and capacity through home-visit responsiveness, chronic disease reviews, frailty assessments, reablement outcomes, integrated care-plan implementation, and early supported discharge activity (DoH, 2021). However, much of the activity delivered by ANPs, AMPs, and community nurses remains absorbed into wider hospital or programme reporting structures, meaning the system cannot clearly see or quantify the specific contribution of nursing and midwifery to hospital avoidance, chronic disease management, or flow improvement.

Despite the maturity of advanced-practice roles, their impact is still under-represented in national datasets. Because ANP/AMP activity is coded under medical or service-level outputs, the unique system-level contribution of nursing and midwifery remains largely invisible, particularly in areas such as admission avoidance, early intervention, stabilisation of chronic illness, and community continuity. This lack of disaggregated data obscures their contribution to hospital avoidance, flow improvement, community stabilisation, and chronic disease management, and limits the system's ability to evaluate return on investment, identify best practice, or scale high-impact ANP/AMP models. A dedicated KPI set, with mandatory reporting at RHA and national levels, is therefore required to surface the true impact of advanced practice and to inform future workforce planning, Sláintecare implementation, and resource allocation.

This gap becomes even more significant as Ireland moves toward independent nursing and midwifery practice. At present, there is no KPI framework capable of capturing activity, quality, or outcomes delivered by independent providers, despite the clear need to measure hospital avoidance, chronic disease control, and community capacity under a PCRS-funded model.

Although these indicators provide visibility on workforce and service performance, reporting across Regional Health Areas (RHAs) remains inconsistent, and there is currently no unified KPI framework that captures the specific contribution of independent nurses and midwives operating under Sections 58–59 of the Health Act 1970. With Sláintecare prioritising care at the lowest level of complexity and shifting activity from acute to community settings, a dedicated metrics suite is required to assess the system-level impact of independent nursing and midwifery practice on hospital flow, chronic disease management, care integration, and population health outcomes.

All independent nursing and midwifery providers would remain fully bound by the Nurses and Midwives Act 2011, NMBI standards, and HSE governance requirements, ensuring that independent practice enhances, not dilutes, public confidence in quality and safety.

Importantly, independently delivered nursing and midwifery practice already exists in Ireland, some of it informally due to the absence of a national framework, and others, such as ArrowHealth, operating within robust governance structures and demonstrating measurable system impact. This confirms both feasibility and urgency for a formal national KPI framework. Scaling hospital avoidance and community capacity requires leveraging the full workforce. Generalist, specialist, and advanced practitioners can each deliver components of independent care, escalating appropriately and working as an agile continuum. This model multiplies system impact by distributing capability rather than concentrating it in a small subset of roles.

10.1 Proposed KPI Domains for Independent Nursing and Midwifery Practice

To assess the contribution of independent nursing and midwifery practitioners to the HSE's priority challenges, particularly hospital avoidance, chronic disease management, community capacity, service integration, quality, and equity, a structured and nationally consistent KPI framework is required. The domains below provide a Sláintecare-aligned approach to measuring impact, ensuring that independent practice is evaluated on outcomes that matter most to patients, practitioners, and the health system. Table 12 outlines the proposed KPI domains and associated outcomes that would demonstrate the effectiveness, safety, and value of an independent practice model.

Table 12: The HSE Challenges and Proposed Outcomes to be measured	
HSE Challenges	**Proposed Outcomes**
Admission Avoidance and Acute Flow	Indicators measuring acute demand reduction and improved patient flow: Hospital admissions avoided ED attendances avoided or diverted Reduction in Patient Experience Time (PET) in ED Reduction in 30-day readmissions for nursing-sensitive conditions Earlier intervention resulting in reduced length of stay
Chronic Disease Management and Population Health	Metrics assessing long-term condition management and preventive care: Completion rate of chronic disease reviews Community-managed exacerbations (COPD, heart failure, diabetes, frailty) Medication optimisation and deprescribing outcomes Uptake of preventive health measures (vaccinations, screenings, health checks)
Integrated Care and Community Capacity	Measures capturing continuity, integration, and timely access to care at home: Early supported discharge episodes Virtual ward or remote-monitoring engagements Response time to first community visit Care delivered at home within defined timeframes Continuity-of-care indicators (same-provider contacts)
Quality and Safety	Indicators reflecting adherence to professional standards and governance: Clinical audit compliance Adverse event and near-miss reporting Prescribing audit outcomes (where relevant) Implementation fidelity to evidence-based protocols and pathways
Patient Experience and Equity	Measures demonstrating accessibility, person-centredness, and fairness: Patient satisfaction scores and net promoter result Outcomes for rural, underserved, or high-deprivation populations Timeliness and responsiveness of care
Workforce, Education and Professional Leadership	Metrics evaluating the contribution of independent practice to workforce sustainability: Number of ANP/AMP candidates supervised and signed off Contribution to workforce retention and stability Leadership roles within community and multidisciplinary teams Delivery of education, mentorship, and professional development

With the KPI framework defined, Section 11 outlines how commissioning and reimbursement structures can operationalise independent nursing and midwifery practice at national scale. With the statutory authority established, policy alignment confirmed, and a clear implementation pathway defined, the next step is to articulate the national commissioning and reimbursement model that will operationalise independent nursing and midwifery practice at scale.

11. Operationalising Independent Practice

Ireland already possesses the legislative basis required to activate independent nursing and midwifery practice. Implementing ERB Recommendation 28 does not require new law; it simply requires administrative activation of existing statutory powers under Sections 58 and 59 of the Health Act 1970. Once applied, these provisions would allow nurses and midwives to become contractible providers under the Primary Care Reimbursement Service (PCRS), mirroring arrangements already in place for GPs, dentists, pharmacists, and optometrists. Activating Sections 58 and 59 for nursing and midwifery is therefore as much a transparency reform as it is a workforce reform. It allows the State to move from viewing nursing as an undifferentiated overhead to treating it as a clearly specified, accountable, and auditable set of services, with associated costs and outcomes visible in national datasets. This reform is designed for phased, tightly governed implementation beginning with defined populations, ensuring safe scaling, strong evaluation, and national consistency

This activation directly advances:

- **ERB Recommendation 28**, enabling independent practice models;
- **ERB Recommendations 1, 7–10, 13, 18–19, 31**, addressing autonomy, leadership, advanced practice, education, and integrated care;
- **Sláintecare's principle** of care at the lowest level of complexity, closest to home;
- **Programme for Government 2025+ commitments** on expanding community nursing and midwifery; and
- **WHO Global Strategic Directions (2021–2025)**, which emphasise empowerment, innovation, and workforce retention.

11.1 Policy Clarification

A joint circular from the Department of Health (DoH)**,** Health Service Executive (HSE)**,** and Department of Public Expenditure, NDP Delivery and Reform (DPER) is required to confirm formally that Sections 58 and 59 of the Health Act 1970 apply to registered nurses and midwives as eligible independent providers under the PCRS. This single step activates existing statutory authority, ensures policy clarity for contracting, and anchors independent practice within the State's established reimbursement framework.

11.2 Framework Development

The HSE should establish a National Independent Nursing and Midwifery Provider Framework, defining the operational standards for safe, efficient and accountable service delivery. The framework should set out:

1. Service categories**,** including wound care, chronic disease monitoring, frailty and reablement, maternal–child health, palliative and post-discharge care.
2. Fee and tariff schedules**,** aligned with existing PCRS structures.
3. Diagnostic and referral access**,** embedded within integrated community networks.
4. Quality, data and reporting requirements, consistent with HSE digital and interoperability standards.
5. Credentialing and governance mechanisms**,** aligned with NMBI professional regulation and peer-review processes.

This framework should draw on international exemplars such as the NHS Community Provider Contracts (UK)**,** Nurse Fee-for-Service models (USA)**,** and the Australian Medicare Nurse Practitioner Programme (APNA, 2022)**.**

11.3 Pilot Implementation

Importantly, independent nursing and midwifery practice is not a hypothetical future model, it is already happening in Ireland. Some practitioners operate semi-covertly due to the absence of formal structures, while others, such as ArrowHealth, deliver care within robust governance frameworks that demonstrate measurable impact. These existing models confirm both the feasibility and the urgency of establishing a regulated national framework.

A small number of Sláintecare-aligned demonstration pilots should be launched across priority clinical areas where independent nursing and midwifery practice will have immediate impact, chronic disease, frailty, palliative care, and preventive health. These should include a mixture of nurses and midwives from graduate to advanced level who would prefer to work in this new model.

Each pilot should assess:

1. Access and equity outcomes**,** especially for underserved populations;
2. Hospital-avoidance effects and impact on delayed discharges**;**
3. Workforce flexibility, retention and career progression**;**
4. Patient experience, continuity and personalisation of care**.**

Pilots should incorporate virtual interdisciplinary teams (IDT) meetings, digital referrals, and shared care pathways linking primary, community and acute services. These will demonstrate how independent practice integrates safely and efficiently within existing health-service structures.

11.4 Evaluation and Scaling

Evaluation should be led by the Health Research Board (HRB) using a mixed-methods approach that combines:

- quantitative outcomes (cost, activity, quality, safety),
- qualitative insights (patient and practitioner experience), and
- system-level metrics aligned with Sláintecare KPIs.

Findings should be publicly available through Sláintecare dashboards and consolidated into a National Implementation Toolkit to support replication and scaling across all RHAs. This evaluation architecture satisfies ERB Recommendation 28 and supports the DoH Statement of Research Priorities 2023–2025**.**

11.5 Governance and Oversight

Independent providers must operate within a clear and robust governance framework. This includes:

1. Regulatory assurance under the Nurses and Midwives Act 2011 and full compliance with NMBI standards.
2. Clinical governance aligned to the practitioner's scope, supported by structured interdisciplinary engagement with GPs and medical consultants where required.
3. Formal clinical supervision and mentorship, enabling nurses and midwives to oversee and sign off new specialists and candidates, reflecting a peer-led professional governance model rather than a medically subordinated one.
4. Contractual accountability under the Health Act 1970 and the HSE Provider Framework.
5. Outcome-based reporting to the HSE and DoH, ensuring safety, equity, quality and financial integrity.

This staged activation process turns existing statutory authority into operational capability. It provides the policy clarity, contractual structure, governance assurance, and evidence-led evaluation needed to embed independent practice safely and sustainably. In doing so, it gives full practical effect to ERB Recommendation 28**,** positioning nursing and midwifery as central drivers of integrated, community-based care consistent with Sláintecare, the Programme for Government, and international workforce reform. All independent nursing and midwifery providers would remain fully bound by the Nurses and Midwives Act 2011, NMBI standards, HSE governance requirements, and public-service entitlements, ensuring that the reform strengthens, rather than disrupts, public confidence in safety, quality, and accountability. The immediate actions required to activate Recommendation 28 within this framework are set out in Section 11.6 below.

11.6 Recommendation: Immediate Activation Steps

To implement ERB Recommendation 28 and enable independent nursing and midwifery practice within existing legislation, the following actions are recommended for immediate approval:

1. Issue a joint DoH–HSE–DPER circular confirming the applicability of Health Act 1970 Sections 58–59 to registered nurses and midwives as eligible PCRS providers.
2. Mandate the HSE to develop a National Independent Nursing and Midwifery Provider Framework, including tariffs, diagnostic access, governance and data requirements.
3. Launch Sláintecare-aligned demonstration pilots across chronic disease, frailty, palliative and preventive care to test generalist and advanced-practice models.
4. Commission the Health Research Board to lead national evaluation, with publication through Sláintecare dashboards and integration into a national Implementation Toolkit.
5. Establish a unified governance structure**,** ensuring regulatory assurance, peer-led oversight, contractual accountability and outcome reporting for all independent providers.

Approval of these actions will operationalise the statutory intent of the Health Act 1970, fulfil Recommendation 28 of the Expert Review Body (2022), and provide a scalable, evidence-led model for integrated, community-based care in Ireland.

Having set out the statutory basis, operational requirements, and governance structures necessary to introduce independent nursing and midwifery practice, the next step is to translate these principles into concrete policy actions. Section 12 summarises the specific administrative decisions now required from the Department of Health, the HSE, and DPER to activate existing legislative powers and initiate a managed, evidence-led national rollout. These actions form the essential bridge between intent and implementation.

12. Policy Activation Request

12.1 Operational Reform

To convert statutory authority into operational reform, Ireland now requires a coordinated set of administrative decisions that activate independent practice and embed advanced roles within a unified governance and funding framework. These actions will be implemented through a phased, tightly governed rollout beginning with defined cohorts and priority pathways, ensuring national consistency, safety, and strong evaluative oversight. The table below summarises the seven priority actions needed from the Department of Health, HSE, and DPER to advance ERB Recommendation 28, fulfil Sláintecare commitments, and address workforce and access challenges at national scale.

Independent nursing and midwifery practice is already occurring in Ireland, some informally due to the absence of formal structures, and some, such as ArrowHealth, within robust

governance, digital reporting, and audit frameworks. These existing models demonstrate that independent practice is both feasible and safe, while highlighting the urgency of establishing a regulated, nationally consistent system that can deliver this capability at scale. Table 13 sets out the core policy actions required to operationalise independent practice nationally, providing clarity on intent, leadership responsibility, and expected outputs**.**

Table 13: Policy Intent and Recommended Actions

Recommendation	Purpose / Intent	Lead Resp	Key Outputs
1. **Develop a National Nursing and Midwifery Costing and Outcomes Model**	Attribute activity, outcomes, and cost-effectiveness directly to nursing-led episodes of care across acute and community settings.	HSE Finance; DPER; ONMSD; DoH Analytics.	National tariff structure; outcome indicators; integration with HIPE, PCRS and Sláintecare dashboards; annual reporting on nursing-generated value.
2. **Issue a Joint DoH–HSE–DPER Circular**	Activate Sections 58 and 59 of the Health Act 1970 to make nurses and midwives eligible for direct PCRS contracting; no new legislation required.	DoH, HSE, DPER	Circular confirming eligibility; administrative activation of statutory authority.
3. **Develop a National Independent Nursing and Midwifery Provider Framework**	Define service categories, tariffs, diagnostic and referral entitlements, credentialing, governance, and data standards for independent practice.	HSE (lead), ONMSD, NMBI	National provider framework; tariff schedules; credentialing and peer-review standards; Sláintecare-aligned data and quality metrics.
4. **Introduce Clinical Academic Contracts**	Establish consultant-style contracts for senior nurses and midwives integrating clinical practice, research, and education.	HSE, DoH, Universities	Clinical Academic Contract; funded academic–clinical posts; implementation of ERB Recommendations 18–19.
5. **Establish a Chief Nursing and Midwifery Officer Position**	Provide professional parity with the Chief Clinical Officer and strengthen operational governance.	HSE, DoH	Appointment of CNMO; enhanced system leadership; implementation of ERB Recommendations 7–9.

6. **Implement 2026 Regional Pilots under Sláintecare**	Test independent-practice models across RHAs using defined PCRS tariffs for chronic disease, frailty, palliative and preventive care.	HSE, RHAs	Pilot sites operational in 2026; evaluation of access, ED avoidance, early discharge, satisfaction, and SROI; virtual MDT pathways in place.
7. **Evaluate, Scale, and Report Nationally**	Conduct a mixed-methods evaluation of access, safety, cost-effectiveness, and workforce sustainability to guide national rollout.	HRB (lead), DoH, HSE, DPER	National evaluation; reporting to Government and ERB Implementation Group; scaling plan for 2027–2028.
8. 8. Establish a National Professional Indemnity Mechanism for Independent Practitioners	Ensure safe, affordable, and consistent indemnity coverage for independent nursing and midwifery practice, aligned with scope, service complexity, and regulatory requirements.	State Claims Agency (SCA), DoH, HSE, NMBI	National indemnity framework; risk-stratified coverage model; updated indemnity guidance for independent practitioners all grades; Memorandum of Understanding for high-risk, consultant-level advanced practice (e.g., procedural ANP/AMP roles).

Making nursing activity visible, costed, and attributable will allow Ireland to measure the return on investment of preventive, chronic-disease, urgent-care, and home-care interventions. This enables value-based commissioning, strengthens fiscal accountability, and ensures national funding decisions reflect the true productivity and impact of nursing and midwifery. Administrative activation should make explicit that independent practice applies across the three-tier continuum, generalist, specialist, and advanced, not solely to advanced practitioners. This ensures equitable opportunity, efficient workforce utilisation, and local flexibility in service design.

All independent nursing and midwifery activity will remain fully governed under the Nurses and Midwives Act 2011, NMBI professional standards, HSE oversight structures, and

established public-service entitlements, ensuring that the reform strengthens public trust and enhances, not fragments, the safety, quality, and accountability of care.

12.2 Indemnity Reform to Enable Independent Nursing and Midwifery Practice

As Ireland activates independent nursing and midwifery contracting under the PCRS, a modernised indemnity system becomes essential to ensuring public safety, practitioner protection, and State assurance. International experience, from the United Kingdom, Canada, Australia, and New Zealand, demonstrates that autonomous practice at scale can only be delivered within a clear, consistent, and risk-appropriate indemnity framework. Such a framework must apply to all grades of nurses and midwives**,** aligned to their defined scope of practice and the complexity of the care they provide.

Currently, indemnity arrangements in Ireland vary considerably by employer, setting, and practitioner role. This fragmentation creates uncertainty and inhibits the safe expansion of independent practice, particularly for nurses and midwives working in community, primary care, long-term care, maternal and child health, chronic disease management, mental health, intellectual disability, and private or self-employed roles. As the system moves toward contracting generalist, specialist, and advanced practitioners, indemnity provision must become transparent, nationally consistent, and proportionate to clinical risk**.**

A national indemnity framework should therefore be built upon five core principles:

• Risk-stratified coverage aligned to scope of practice:
Indemnity must reflect the clinical risk and complexity of the generalist, specialist, and advanced tiers—not the contractual status of the practitioner. This mirrors international best practice and ensures safe, fair, and proportionate coverage.

• Parity across public, voluntary, and independent practice:
Practitioners delivering the same type of care should have access to equivalent protection. Parity supports mobility across settings, reduces administrative barriers, and enhances public confidence.

• State-supported indemnity for high-risk advanced practice:
Certain advanced roles, such as those involving diagnostics, prescribing, or procedural interventions, may require enhanced protection. A State-backed indemnity arrangement, delivered through the State Claims Agency, would align Ireland with NHS Resolution and Canadian NP models and support consultant-level advanced practice.

• Full integration with contracting and credentialing:
Indemnity requirements must be embedded within the national provider framework, PCRS contracting standards, credentialing and peer-review processes, clinical governance structures, and national quality and data reporting systems. This ensures consistency across all RHAs.

• Affordable and accessible coverage for all practitioners:
Indemnity must not be a barrier to participation. Group schemes, blended indemnity models, or State-supported mechanisms may be required to ensure equitable access for generalist and specialist practitioners.

To operationalise indemnity reform, Ireland should:

1. **Establish a National Indemnity Framework for Independent Practice**
   Lead: SCA, DoH, HSE, NMBI
   – Delivering a national structure with risk-based tiers.
2. **Develop Risk-Stratified Indemnity Packages**
   – Ensuring proportional coverage for generalist, specialist, and advanced practice.
3. **Create a State-Backed Indemnity Option for High-Risk ANP/AMP Roles**
   – Mirroring international consultant-level protection models.
4. **Guarantee Indemnity Parity Across Public, Private, and Independent Practice**
   – Eliminating inequities that restrict mobility or participation.
5. **Embed Indemnity Standards into All Independent Practice Contracts and Provider Frameworks**
   – Ensuring safe and consistent implementation across RHAs.

Together, these reforms will provide the foundation necessary for safe, scalable, and nationally consistent independent nursing and midwifery practice.

13. Anticipated Outcomes

Activating independent nursing and midwifery practice will generate measurable system, workforce, and population-level gains, directly supporting Ireland's shift toward integrated, community-led care. These outcomes will be realised through a phased, tightly governed national rollout, ensuring safety, consistency, and strong evaluation at every stage of implementation.

1. **Accelerated Sláintecare Delivery**
   Community-based, nurse- and midwife-led services will reduce hospital dependency, shorten inpatient stays, and create genuine care continuity across acute, primary, and home settings.
2. **Improved Access and Equity**
   Expanded acute, home-based, and preventive services, delivered by both public and independent practitioners, will enhance reach into rural, marginalised, and underserved populations.
3. **Greater Efficiency and Value for Money**
   Avoidable admissions, re-presentations, and delayed discharges will fall, building on evidence from Enhanced Community Care (ECC), ICPOP, and ArrowHealth evaluations demonstrating significant hospital-avoidance and bed-day reductions.

Importantly, many of these benefits are already being demonstrated within existing Irish models, such as Enhanced Community Care, ANP-led hubs, and ArrowHealth, confirming that independent practice builds on proven, safe, and effective pathways rather than introducing untested concepts.

4. **Strengthened Workforce Sustainability**
   New contractual pathways and independent practice options will enhance retention by supporting autonomy, innovation, career diversity, and flexible working for nurses and midwives across all stages of practice.
5. **Modernised PCRS Infrastructure**
   Recognising nurses and midwives as contractible providers within the Primary Care Reimbursement Service will diversify community capacity, ensure parity within multidisciplinary teams, and support outcome-based funding models.
6. **Enhanced National Leadership and Governance**
   Establishing a Chief Nursing and Midwifery Officer at HSE operational level, alongside consultant-style academic contracts, will embed professional expertise, shared governance, and system accountability at every tier of decision-making.
7. **Expanded DNP and Professional Doctorate Pathways**
   A national practice-doctorate structure will support advanced clinical expertise, innovation, and service redesign, enabling expert practitioners to remain close to patient care while driving national transformation.

All independent nursing and midwifery activity will remain governed under the Nurses and Midwives Act 2011, NMBI professional standards, HSE oversight structures, and outcome-based reporting, ensuring that public confidence, safety, and accountability are enhanced throughout the reform.

Collectively, these outcomes fulfil the direction set by the Expert Review Body (2022), the Department of Health's *Statement of Research Priorities* (2023–2025), and the HSE National Service Plan 2025 commitment to value-based, integrated, community-centred reform. These gains also provide the structural and economic rationale required to move from pilot achievements to sustained national commissioning.

Finally, independent practice will enable transparent costing of nursing and midwifery care, allowing the State to quantify return on investment, reduce waste, and redirect resources from low-yield hospital activity to high-impact community-based services led by nurses and midwives.

14. Conclusion

Ireland stands at a decisive point in its health-system reform. The NMBI State of the Register 2025 confirms a record 86,948 registrants, with 79,194 practising clinicians, the largest, most geographically distributed, and most highly educated nursing and midwifery workforce in the State's history. The rapid expansion of advanced practice and prescriptive authority

demonstrates a profession ready not only to support transformation, but to lead it. In other words, Ireland is not reform-deficient, it is activation-deficient. The system already relies on nurses and midwives to deliver core population health functions; independent practice simply gives structural expression to this reality.

Yet the current system continues to constrain nurses and midwives within institution-bound roles defined for a different era. Their clinical contribution remains largely invisible within national costing systems, absorbed into global hospital and community budgets as staffing overhead rather than recognised as discrete, outcome-generating activity. As a result, the State cannot accurately quantify the full impact of nursing on hospital-avoidance, waiting-list reductions, chronic-disease control, or patient-reported outcomes, despite clear evidence from ANP-led services, CSTs, ICPOP, ECC, and independent models such as ArrowHealth.

Independent nursing and midwifery practice is therefore not only a workforce reform; it is a visibility, value, and accountability reform. By enabling independently contracted, activity-based services under the Primary Care Reimbursement Service (PCRS), supported by national credentialing, diagnostic entitlements, and digital integration, Ireland can for the first time attach clear costs, outcomes, and system value to nursing- and midwife-led episodes of care. This shift transforms nursing from an undifferentiated cost centre into a measurable, auditable, high-impact service line, strengthening transparency, planning, funding, and population-health outcomes.

The actions set out in this report, activation of Sections 58 and 59 of the Health Act 1970, a national independent provider framework, consultant-style Clinical Academic contracts, establishment of a Chief Nursing and Midwifery Officer role, Sláintecare-aligned pilots, and HRB-led evaluation, do not require new legislation. They represent the operational activation of statutory powers and policy directions that already exist. Implementing them through a phased, tightly governed national rollout will ensure safety, consistency, and strong evaluation, delivering measurable gains between 2026 and 2028.

Ireland has already invested heavily in its nursing and midwifery workforce. The evidence generated by AN/MPs, CN/MSs, generalist specialist nurses, and clinical-nursing-in-the-home models shows what the workforce can achieve even under current constraints. The next step is simply to remove those structural barriers and recognise nursing and midwifery as core engines of accessible, equitable, integrated care.

Independent practice aligns directly with the WHO Global Strategic Directions for Nursing and Midwifery (2021–2025) and positions Ireland as an early adopter of internationally endorsed reforms centred on autonomy, innovation, and community-based service delivery. It provides the mechanism through which the State can operationalise Sláintecare's central promise: care delivered at the lowest appropriate level of complexity, as close to home as possible, by the professionals best equipped to provide it.

Independent nursing and midwifery practice is not a reform for one part of the workforce; it is the framework through which every nurse and midwife in Ireland can contribute to a modern, resilient, equitable health system. It is the future of Irish healthcare, and the policy mechanism that makes Sláintecare deliverable. This reform is not limited to advanced practice; it activates a full continuum, from generalist to specialist to advanced practitioner, ensuring that every nurse and midwife, across all divisions and settings, can contribute autonomously to national health-system goals. It is also the structural platform through which Ireland will achieve a modern, digitally enabled, community-centred health service capable of meeting the demands of 2030 and beyond.

In short, Ireland cannot modernise its health system while nursing remains invisible in economic and policy terms. By enabling independently contracted, outcome-measured nursing and midwifery services, the State unlocks the full potential of its 86,948 registered professionals and delivers a high-value, community-centred model of care capable of meeting the needs of current and future generations.

Independent practice is therefore the enabling mechanism through which Ireland can transform a world-class nursing and midwifery workforce into a world-class health system, one that is transparent, community-centred, and capable of delivering measurable population-level impact.

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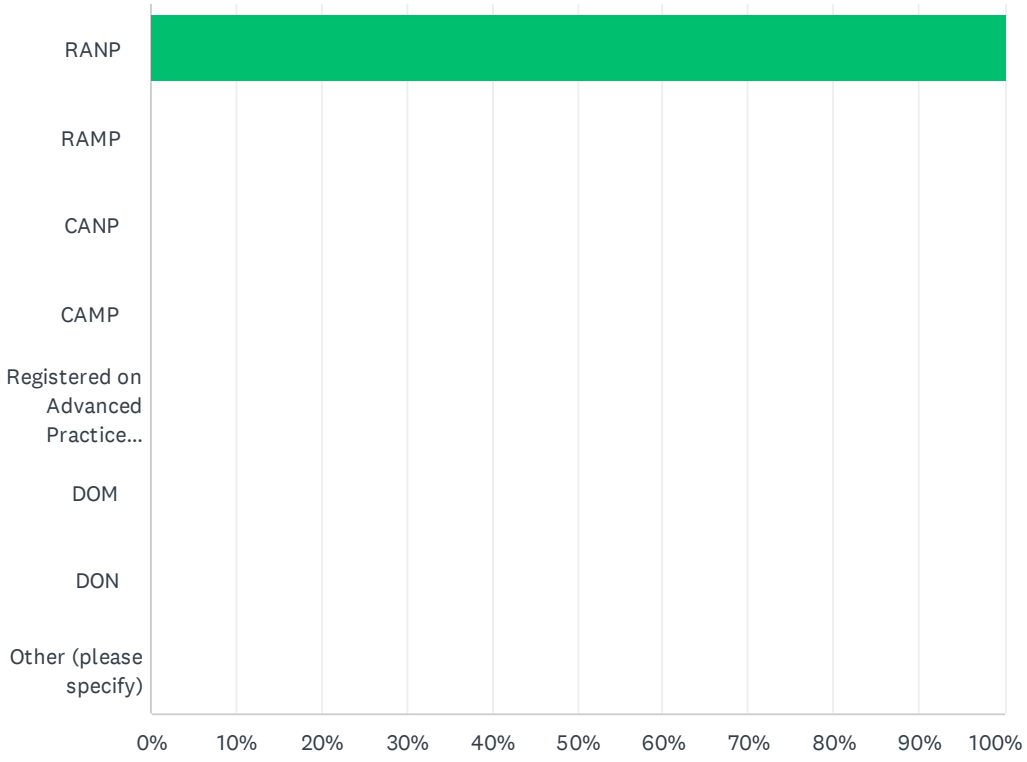
16. Appendices

Appendix 1: Survey

Q1 What is your job title?

Answered: 5 Skipped: 0

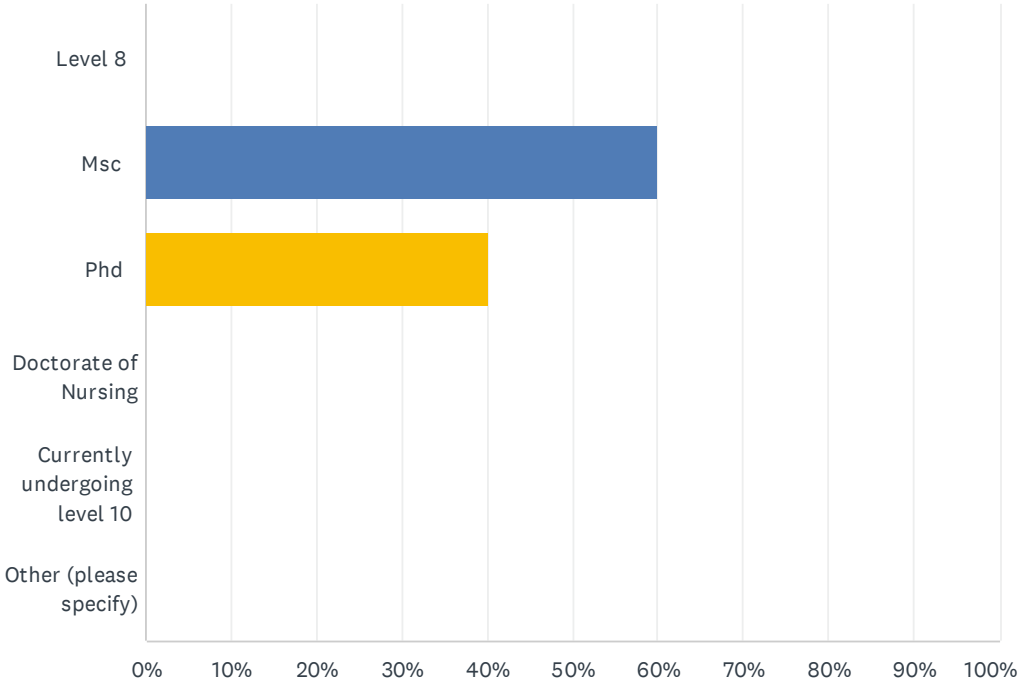


ANSWER CHOICES	RESPONSES	
RANP	100.00%	5
RAMP	0.00%	0
CANP	0.00%	0
CAMP	0.00%	0
Registered on Advanced Practice Division with NMBI but not in post	0.00%	0
DOM	0.00%	0
DON	0.00%	0
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q2 What is the highest level of education you have achieved?

Answered: 5 Skipped: 0

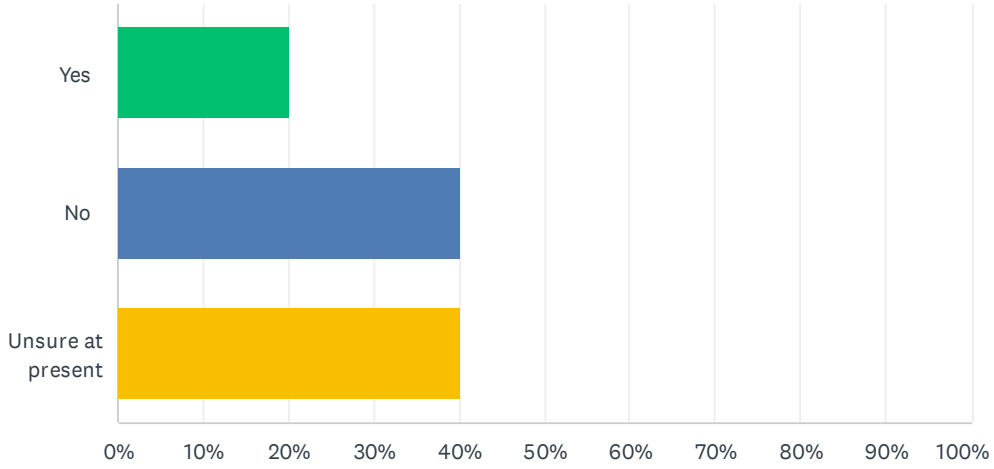


ANSWER CHOICES	RESPONSES	
Level 8	0.00%	0
Msc	60.00%	3
Phd	40.00%	2
Doctorate of Nursing	0.00%	0
Currently undergoing level 10	0.00%	0
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q3 Do you intend to complete QQI 10 level education?

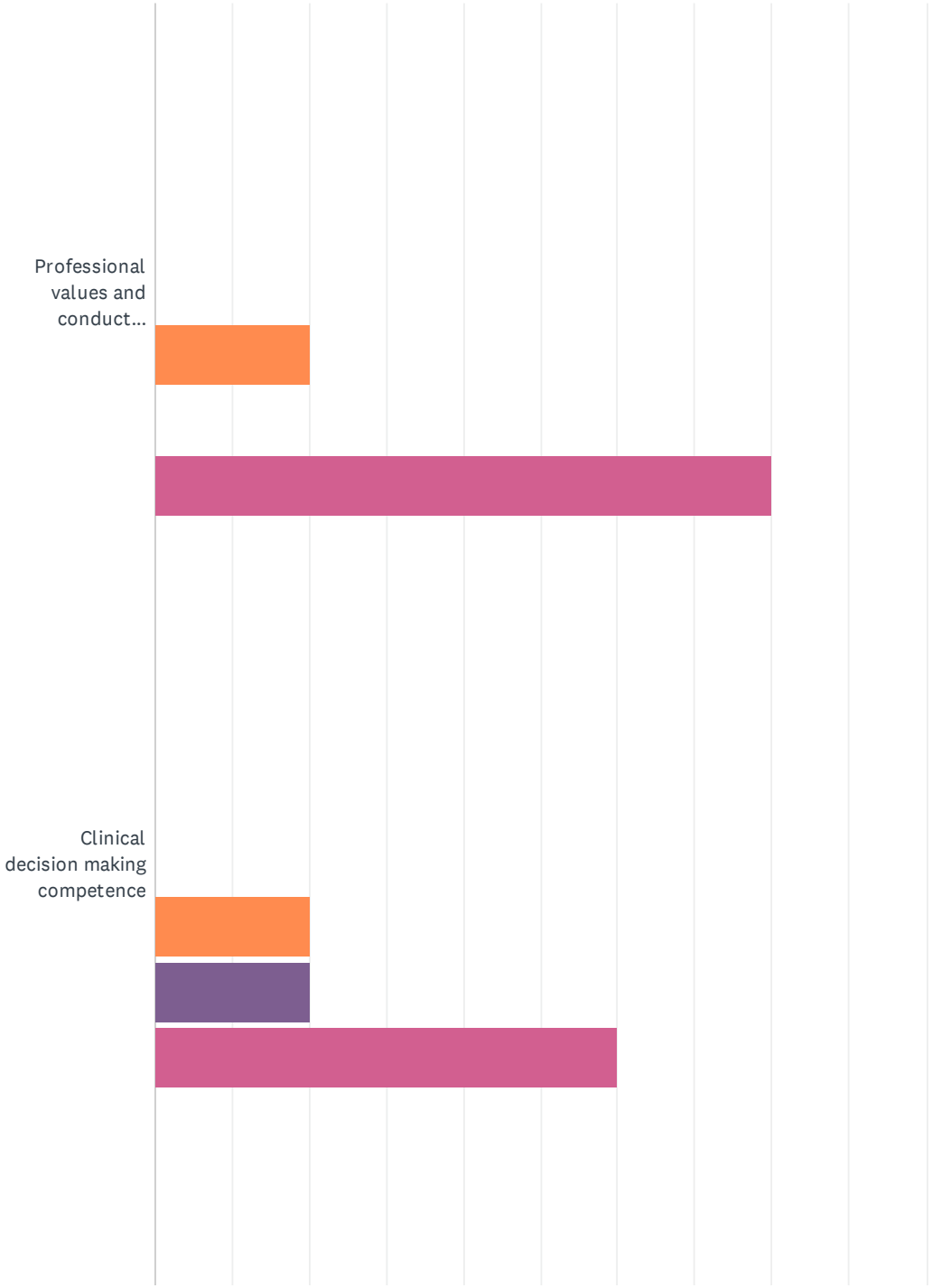
Answered: 5 Skipped: 0



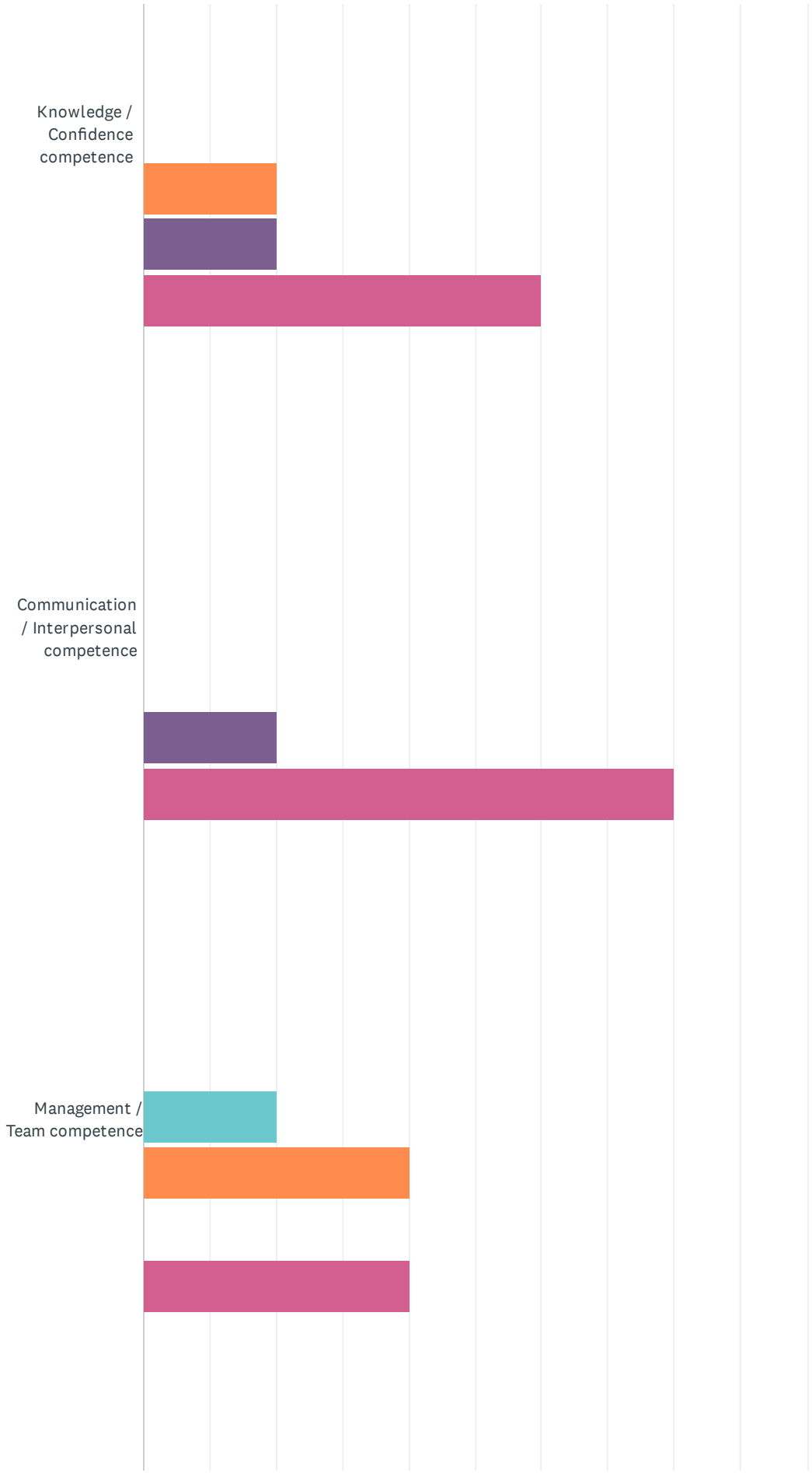
ANSWER CHOICES	RESPONSES	
Yes	20.00%	1
No	40.00%	2
Unsure at present	40.00%	2
TOTAL		5

Q4 On a scale from 1 (never heard of) to 7 (extremely familiar), please rate how much the 6 domains are part of your clinical practice as an advanced practitioner. The more you do on your role, the higher you would rate it. The less you do, the lower you would rate it. If this domain is not part of your day to day role, select 1 (never heard of). Space at the end to add comments to explain rating

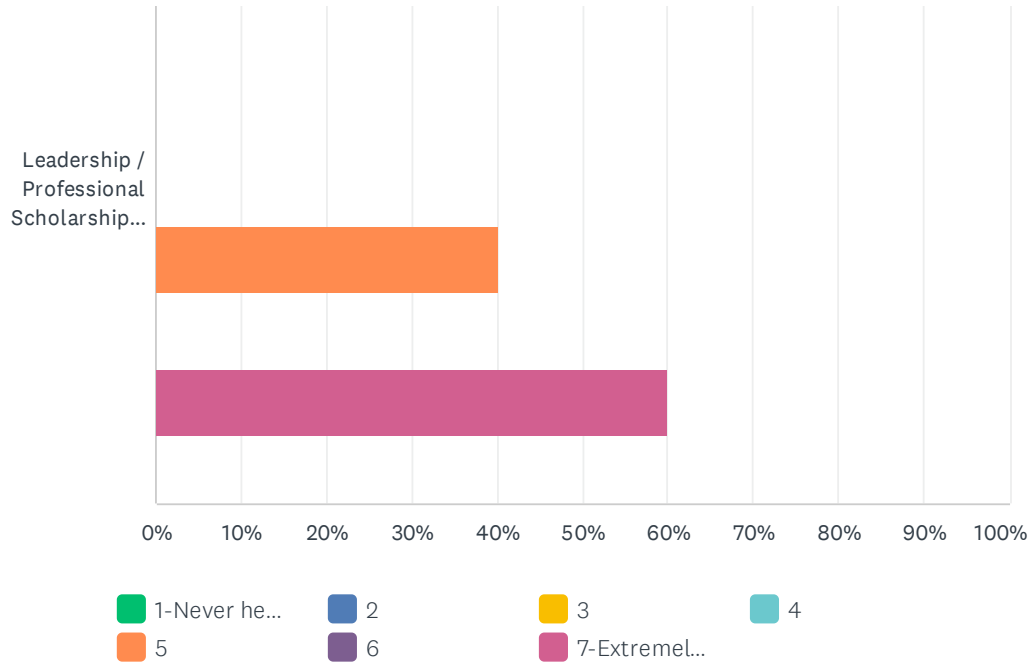
Answered: 5 Skipped: 0



Educational pathways for Advanced Practitioners and Senior Leadership roles



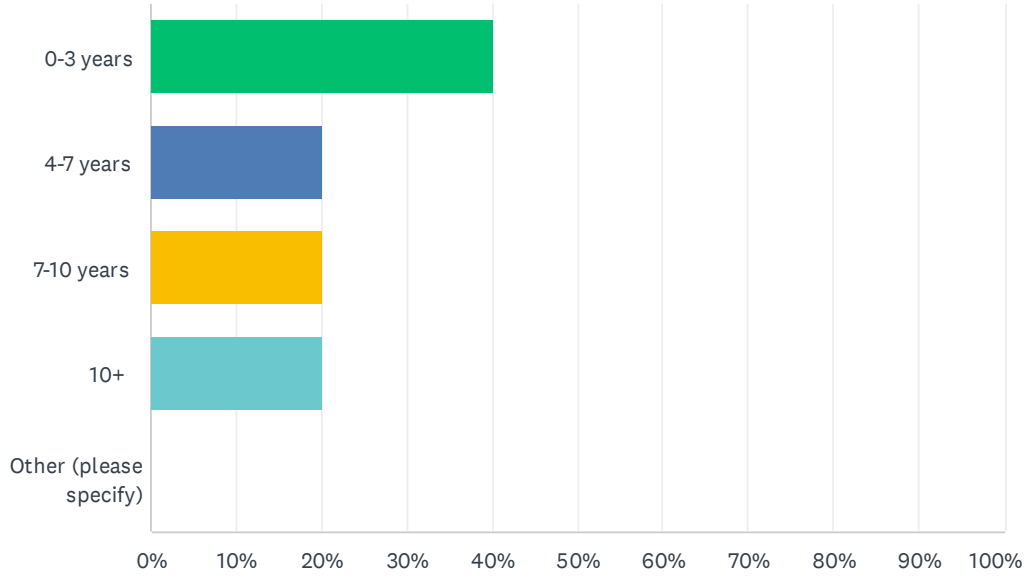
Educational pathways for Advanced Practitioners and Senior Leadership roles



	1-NEVER HEARD OF	2	3	4	5	6	7-EXTREMELY FAMILIAR	TOTAL
Professional values and conduct competence	0.00% 0	0.00% 0	0.00% 0	0.00% 0	20.00% 1	0.00% 0	80.00% 4	5
Clinical decision making competence	0.00% 0	0.00% 0	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5
Knowledge / Confidence competence	0.00% 0	0.00% 0	0.00% 0	0.00% 0	20.00% 1	20.00% 1	60.00% 3	5
Communication / Interpersonal competence	0.00% 0	0.00% 0	0.00% 0	0.00% 0	0.00% 0	20.00% 1	80.00% 4	5
Management / Team competence	0.00% 0	0.00% 0	0.00% 0	20.00% 1	40.00% 2	0.00% 0	40.00% 2	5
Leadership / Professional Scholarship competence	0.00% 0	0.00% 0	0.00% 0	0.00% 0	40.00% 2	0.00% 0	60.00% 3	5

Q5 How long are you working in an advanced practice role ?

Answered: 5 Skipped: 0

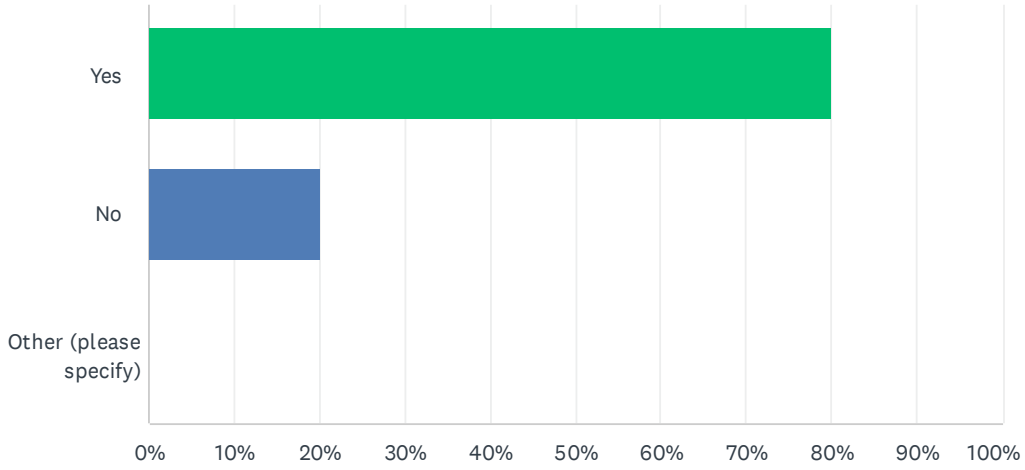


ANSWER CHOICES	RESPONSES	
0-3 years	40.00%	2
4-7 years	20.00%	1
7-10 years	20.00%	1
10+	20.00%	1
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q6 Do you feel you are qualified in a leadership role to help progress nursing professionals from graduate to advanced level ?

Answered: 5 Skipped: 0

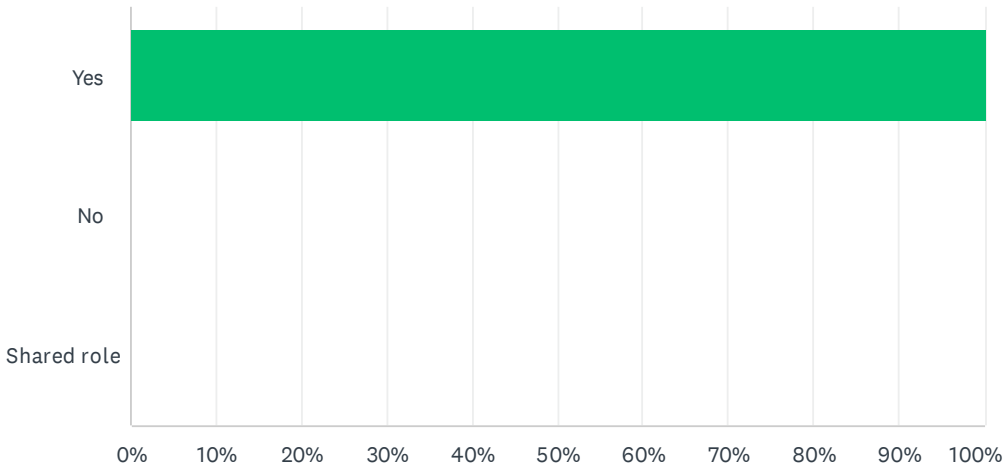


ANSWER CHOICES	RESPONSES	
Yes	80.00%	4
No	20.00%	1
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q7 Do you work as an ANMP patient facing?

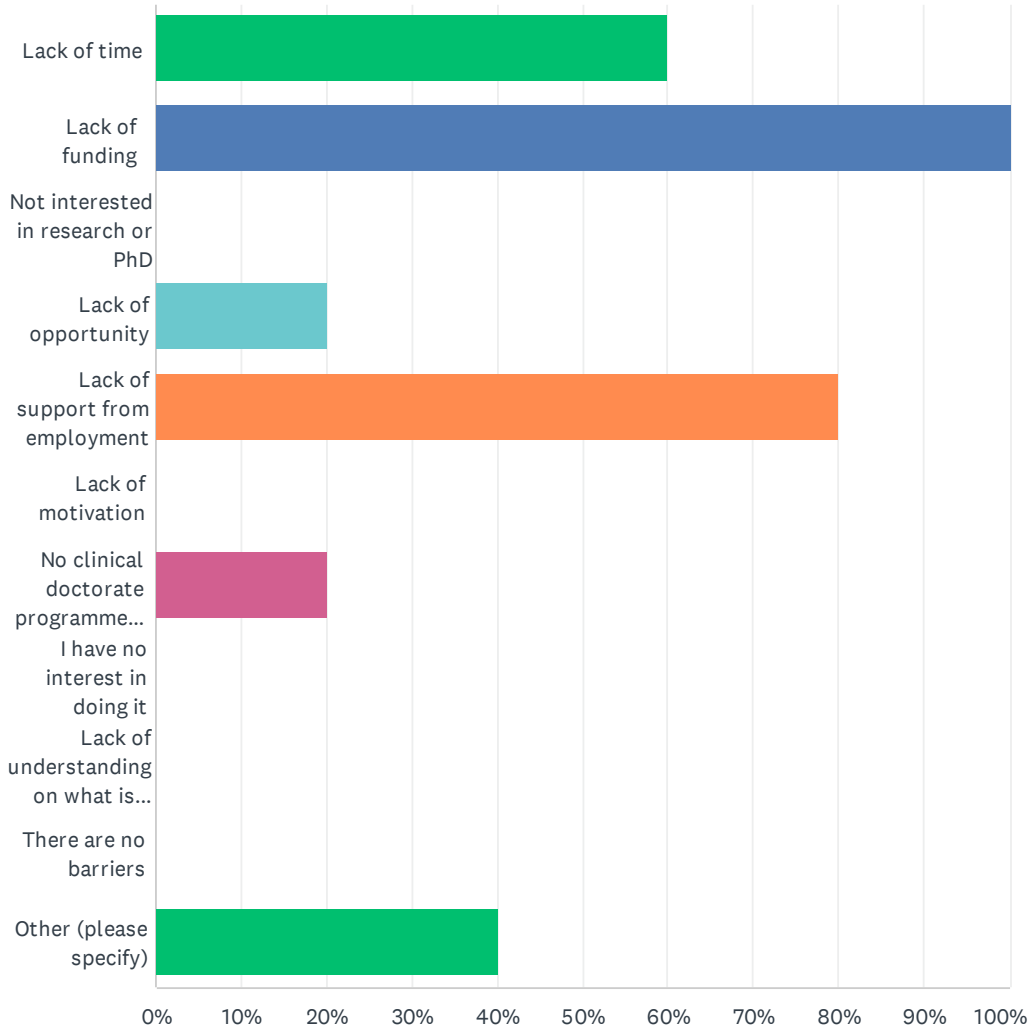
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	5
No	0.00%	0
Shared role	0.00%	0
TOTAL		5

Q8 What do you feel are the barriers to completing a QQI level 10 doctorate?

Answered: 5 Skipped: 0

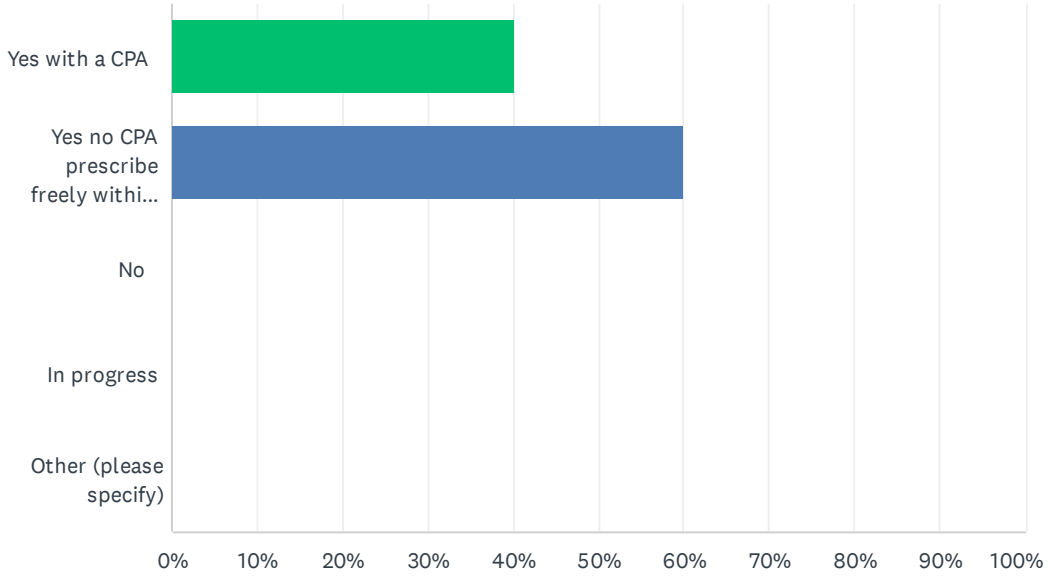


ANSWER CHOICES	RESPONSES	
Lack of time	60.00%	3
Lack of funding	100.00%	5
Not interested in research or PhD	0.00%	0
Lack of opportunity	20.00%	1
Lack of support from employment	80.00%	4
Lack of motivation	0.00%	0
No clinical doctorate programme available	20.00%	1
I have no interest in doing it	0.00%	0
Lack of understanding on what is entails	0.00%	0
There are no barriers	0.00%	0
Other (please specify)	40.00%	2
Total Respondents: 5		

#	OTHER (PLEASE SPECIFY)	DATE
1	I have just completed my PhD. I got no funding or support from employment. A colleague who had funding got a secondment and back fill. These are the two biggest challenges. Also funding to support publishing and article processing fees.	11/11/2025 10:09 AM
2	Need more information on the option.	11/6/2025 10:51 AM

Q9 Do you have prescriptive authority for medications?

Answered: 5 Skipped: 0

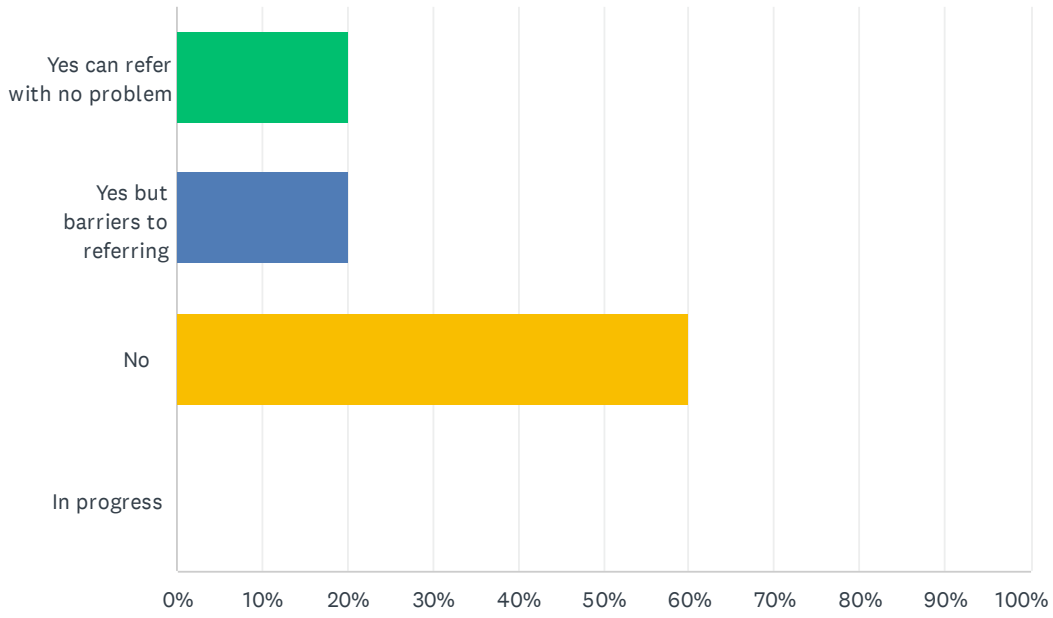


ANSWER CHOICES	RESPONSES	
Yes with a CPA	40.00%	2
Yes no CPA prescribe freely within my scope	60.00%	3
No	0.00%	0
In progress	0.00%	0
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q10 Do you have radiology referring authority?

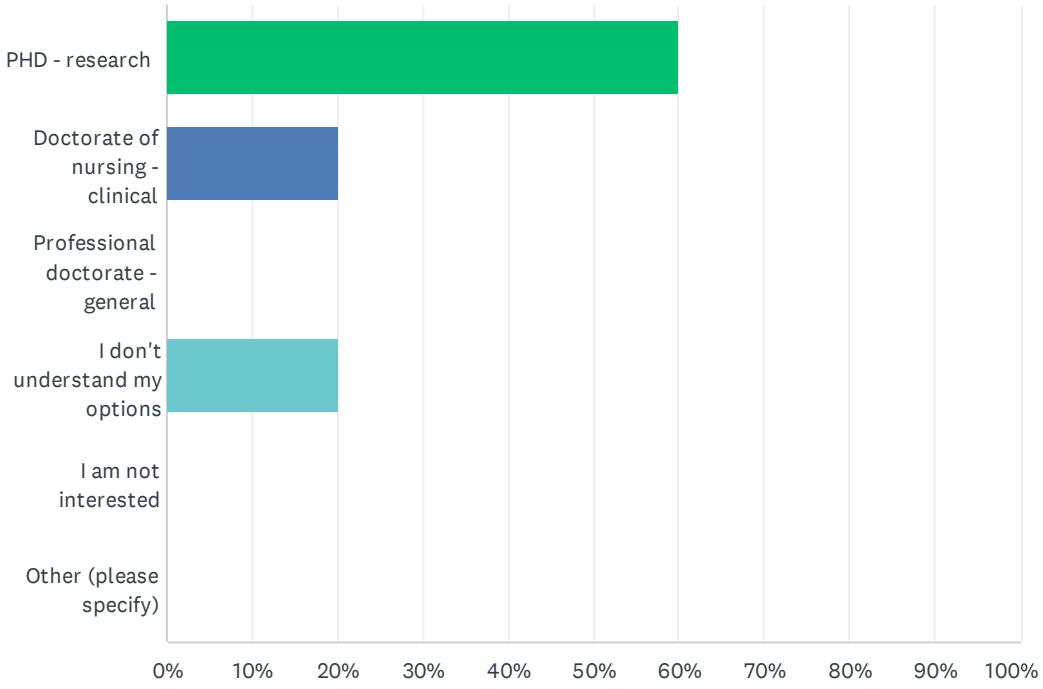
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes can refer with no problem	20.00%	1
Yes but barriers to referring	20.00%	1
No	60.00%	3
In progress	0.00%	0
TOTAL		5

Q11 If you had an option to complete QQI level 10 education which pathway would you prefer?

Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
PHD - research	60.00%	3
Doctorate of nursing - clinical	20.00%	1
Professional doctorate - general	0.00%	0
I don't understand my options	20.00%	1
I am not interested	0.00%	0
Other (please specify)	0.00%	0
TOTAL		5

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Appendix 2: IAANMP Repository Publications

Please see link to the evidence of the impact of RANMPs in practice –

https://iaanmp.com/iaanmp-members-publications-and-research-2020-2025/

Appendix 3: List of evidence demonstrating impact of ANPs and AMPs in Practice

IAANMP Impact Domain	System-Level Findings	Evidence Examples	KPIs for Measurement
1. Access & Timeliness	ANPs/AMPs significantly reduce waiting times, achieving 90–100% timely reviews. Extend specialist access into homes, LTCFs, and marginalised settings.	• Sleep Service Pilot: 90% urgent cases reviewed in 4–6 weeks. • EDITH: timely assessment in nursing homes. • Huntington's Disease ANP: clinics delivered in homes, LTCFs, homeless hostels.	• % seen within recommended timeframe • Waiting list reduction (%) • No. outreach/home/LTCF reviews • Travel avoided (km/patient)
2. Reduced Acute Care Burden	Prevent unnecessary ED and ICU admissions through early escalation and community-based intervention.	• Critical Care Outreach: 161 ICU admissions avoided (€1.09M savings). • EDITH 2: 90% managed in nursing homes. • CRISP: 74% reduction in falls; reduced carer stress.	• ED attendances avoided • ICU/acute admissions avoided • Cost avoidance (€) • Falls reduction (%)
3. Clinical Outcomes & Disease Optimisation	ANPs improve therapeutic monitoring, diagnostic accuracy, and adherence to international guidelines; digital tools enable early escalation.	• IBD Biologic Clinic: improved monitoring & compliance. • Lipid Algorithm: monitoring ↑ from 20% → 39%. • Fracture Liaison diagnostic pathway. • SMARTCP: daily symptom tracking & PIR.	• Guideline-aligned care (%) • Therapeutic monitoring compliance (%) • Escalation alerts triggered • Review frequency improvements
4. Equity & Integrated Care	Remove structural barriers to access; create integrated pathways; improve access for high-risk groups.	• IBD Pregnancy Clinic. • Huntington's Outreach (hostels, LTCFs, homes). • Respiratory GP Reach-In avoiding ED referrals.	• No. integrated pathways • % care delivered outside hospitals • Access rates for marginalised groups • Equity indicators
5. Quality, Safety & System Efficiency	Standardise assessment & prescribing; improve safety; digital tools reduce duplication & enhance communication.	• Falls Prevention: FRIDs in 96%; 60% de-prescribed. • Digital discharge templates reducing GP queries. • Skin tear healing ↑	• Adverse events avoided • Medication optimisation (%) • Documentation quality metrics

		66% → 90%; infection ↓ 60% → 20%.	• Healing/infection rates
6. Innovation & Digital Integration	Lead digital transformation—remote monitoring, automated templates, QR-linked education.	• SMARTCP app (escalation alerts + patient-initiated review). • QR-linked tracheostomy/CVC resources. • Digital injury-unit documentation.	• Digital activation rates • Escalation triggers • Reduction in in-person reviews • Patient usability scores
7. Workforce Capability Development	Upskill the wider workforce; expand internal capacity; reduce reliance on external services.	• ID services: 322 staff trained. • 30% reduction in external healthcare usage. • 85% increase in service capacity.	• Staff trained (no.) • Competence improvement • External referral reduction (%) • Capacity expansion (%)
8. Patient Experience	High satisfaction, improved understanding, better self-management; ANP reviews perceived as thorough and accessible.	• Sleep Clinic: 100% satisfaction. • IBD Passport: 93% strong satisfaction. • Obesity clinic: improved wellbeing & CVD profiles.	• Satisfaction (%) • Health literacy improvement • Self-management adherence • Complaints reduction (%)
1. Access & Timeliness	ANPs/AMPs significantly reduce waiting times, achieving 90–100% timely reviews. Extend specialist access into homes, LTCFs, and marginalised settings.	• Sleep Service Pilot: 90% urgent cases reviewed in 4–6 weeks. • EDITH: timely assessment in nursing homes. • Huntington's Disease ANP: clinics delivered in homes, LTCFs, homeless hostels.	• % seen within recommended timeframe • Waiting list reduction (%) • No. outreach/home/LTCF reviews • Travel avoided (km/patient)
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3. Clinical Outcomes & Disease Optimisation	ANPs improve therapeutic monitoring, diagnostic accuracy, and adherence to	• IBD Biologic Clinic: improved monitoring & compliance. • Lipid Algorithm: monitoring ↑ from 20%	• Guideline-aligned care (%) • Therapeutic monitoring compliance (%)

	international guidelines; digital tools enable early escalation.	→ 39%. • Fracture Liaison diagnostic pathway. • SMARTCP: daily symptom tracking & PIR.	• Escalation alerts triggered • Review frequency improvements

Appendix 4: ERB (2022) Recommendations Crosswalk to IAANMP Independent Practice Framework

This appendix provides a full crosswalk between the Expert Review Body (ERB) Recommendations (2022) and the Independent Nursing & Midwifery Practice Framework proposed in this report. It demonstrates how each ERB requirement is operationalised, advanced, or structurally supported by the IAANMP model.
Section A: Rec 1, 7-9, 13, 18-19, 28 & 31

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Rec 7-9	Ensure strong, visible nursing & midwifery leadership in national and regional governance.	Proposes CNMO at HSE Executive level; recommends RHA Directors of Nursing & Midwifery; aligns with Sláintecare governance.
Rec 18-19	Strengthen education, research, mentorship, and evaluation of advanced practice.	Establishes national DNP/DMP pathways; funded fellowships; research integration; advanced practice KPIs; peer-led governance.
Rec 31	Enable nurses to work at top-of-licence across integrated systems	Removes barriers to diagnostics, referral, prescribing; supports autonomous case management; aligns ANP entitlements with independent contracting.

SECTION B: WORKFORCE, RETENTION & WELLBEING (Recs 2–6)

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Rec 16	Reform undergraduate curriculum to reflect community, digital and integrated care.	Independent practice model reinforces need for digital, community-based training embedded in undergraduate programmes.
Rec 17	Develop transition-to-practice programmes for new graduates.	Creates supervised pathways from early-career roles into advanced or independent positions with structured mentorship.
Rec 16	Reform undergraduate curriculum to reflect community, digital and integrated care.	Independent practice model reinforces need for digital, community-based training embedded in undergraduate programmes.
Rec 17	Develop transition-to-practice programmes for new graduates.	Creates supervised pathways from early-career roles into advanced or

		independent positions with structured mentorship.

SECTION C: EDUCATION & TRANSITION (Recs 16–17)

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Rec 16	Reform undergraduate curriculum to reflect community, digital and integrated care.	Independent practice model reinforces need for digital, community-based training embedded in undergraduate programmes.
Rec 17	Develop transition-to-practice programmes for new graduates.	Creates supervised pathways from early-career roles into advanced or independent positions with structured mentorship.

SECTION D: DIGITAL HEALTH & DATA INTEGRATION (Recs 20–27)

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Recs 20–22	Implement electronic records, digital documentation, and unified systems.	Independent providers use interoperable systems aligned with national digital standards.
Recs 23–25	Integrate activity into predictive analytics, dashboards, and national datasets.	PCRS-linked activity flows into national planning tools, strengthening nursing visibility in analytics.
Recs 26–27	Ensure digital upskilling across nursing and midwifery.	Independent practice requires telehealth, data literacy, and digital monitoring competencies; reinforced via DNP/DMP pathways.

SECTION E: LEADERSHIP, GOVERNANCE & GRADING (Recs 32–37)

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Recs 32–34	Modernise governance for CNM3, ADON, DON roles.	Assigns CNMO governance; aligns leadership roles with RHA structures; supports integrated care governance.
Recs 35–37	Standardise grading, remove outdated hospital banding.	Independent contracting provides competency-based progression, replacing legacy banding logic.

SECTION F: PAY, CONTRACTUAL & SCALE REFORMS (Recs 38 & 47)

ERB Recommendation	Requirement / Intent	How This Report Addresses It
Rec 38	Address pay anomalies post-Enhanced Nurse/Midwife Contract.	Independent practice provides fair, output-linked remuneration alongside national pay reforms.
Rec 47	Standardise entry/exit rules for merged PHN/CNM2/CMM2 scales.	Provides alternative progression pathways for clinicians affected by scale inconsistencies.

SECTION G: THE CENTRAL RECOMMENDATION: Rec 28 (Fully Integrated)

Rec 28 Evaluate, develop and implement independent nursing and midwifery practice models. This report is the implementation pathway for Rec 28, activating PCRS contracting, defining governance, outlining pilots, embedding evaluation, and integrating independent practice into the national health system.