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GPC

General Practitioners
Committee

Practice nursing

Discussion paper by the GPC's
practice nursing working group

BMA 

Introduction

The practice nurse is a vital member of the practice team and the range of skills needed and the tasks expected of nurses continues to increase. The post of practice nurse was originally created by GPs in order to help them deliver their GMS contractual obligations. The expansion of national screening and immunisation programmes, the switch of work from the secondary sector to primary care and recent government initiatives have all resulted in an enormous expansion of the practice nursing role. In 2001, there are 18,500 practice nurses in the UK and this constitutes the largest “branch” of “community nursing”.¹ Their tasks are various including treatment room sessions, chronic disease management, home visiting, new patient checks, over 75 checks, immunisations and other primary prevention and health promotion work. There is also additional work in the field of triage and demand management. Increasingly some nurses are working as nurse practitioners and clinical specialists undertaking diagnosis and treatment in appropriate situations. Some nurses are able to prescribe from the nurse formulary. Practice nurses are usually employed and paid by the GP partners in the practice. Although a variable proportion of the cost is directly reimbursed by the health authority or primary care trust, this usually does not exceed 70% and may be considerably less. The balance of salaries must be met by the employing GPs. Furthermore, the direct reimbursement of practice nurses’ pay comes from the same “pot” as that for other practice staff such as receptionists, secretaries and managers. In many areas this is now paid to practices as a single cash-limited capitation-based “staff budget”. The expansion of the practice nurse’s role is therefore causing serious financial difficulty for many practices.

Changing role

New pressures such as health improvement plans, national service frameworks, clinical governance, improved access and skill mix, inter-agency working and improving equity highlight the changing role of practice nurses. Other trends in the changing nature of the nursing task include:

- The NHS plan’s proposals for more nurse-delivered services, and a patient’s right to see a nurse as an alternative primary care provider, i.e. the nurse practitioner, clinical nurse specialist or a nurse consultant.
- The higher standards of practice activity which are now expected professionally and legally. Activity includes chaperoning, surgery room preparation, assisting with and performing a wide range of diagnostic and therapeutic procedures, operation of complex machinery and IT skills, triage, diagnosis and counselling.
- A new career framework for nurses to replace clinical grades is under development ² to provide “better career progression and fairer rewards for team-working, developing new skills and taking on extended roles”.
- An increase in immunisations both in children and young adults, for example, meningitis, and in the elderly, such as, influenza and pneumococcus.
- General practice continuing to assume work from the secondary sector:
 - i) drug treatment monitoring
 - ii) anticoagulant services
 - iii) post A&E follow-up
 - iv) post surgical admissions
 - v) local phlebotomy services and pre-outpatient department testing

¹ A toolkit for nurses working in general practice, East Kent health authority, March 2001

² Making a difference - Strengthening the nursing, midwifery and health visiting contribution to health and healthcare, Department of Health, July 1999.

- vi) pre-admission assessment and support
 - vii) anti psychotic medication, with the necessary care plan approach follow up required.
- The national service frameworks and similar guidelines for cardiovascular disease being predicated on a major input from primary care nursing in routine testing and supervision. The national service framework for the elderly has nursing implications and it is assumed that the imminent national service framework for diabetes will also need significant additional nursing input.

There is evidence that although practice nurses undertake a wide range of roles and responsibilities these vary considerably from practice to practice and the range of work continues to expand.³ The consequences of the above factors are bigger, more complex and highly trained practice nurse teams, requiring major expenditure. It is also evident that some highly skilled and highly graded (and therefore costly) practice nurses spend much of their time in activity which might be more appropriate to a lower grade or a health care assistant. In terms of the changing skill mix requirements, attention will also need to be given to a number of related areas such as the training and development of nursing staff and nursing assistants, providing mentors, appraisal, grading, professional indemnity, occupational health and clinical supervision.

Benefits to GPs and patients - the place of nursing in the primary health care team

Practice nurses help to free up doctors' time by taking on appropriate tasks in such areas as vaccination and immunisation, well woman screening, routine diabetic care, asthma care and so on. However, within each of the services there are variations in the skills of individual nurses that need to be addressed. Appropriate deployment of practice nurses allows team working, enabling doctors to spend more time with individual patients⁴ and thus improve the quality of the care being delivered by the whole team. This has an impact on hospital admission rates⁵ and can also reduce work-related stress.

Funding of nursing staff

All GPs are eligible at the discretion of their health authority/board, in practice determined by primary care organisations, to receive direct reimbursement of all or part of the expense of employing suitable practice staff. The balance of expenditure on staff has to be met initially at least, by the GPs, although this is subsequently reimbursed globally through the indirect expenses element of gross fees and allowances. Practices with high rates of investment in services and innovation and those in areas with high staff costs distrust the fairness of this method. There is a great deal of variation with 100% funding for some posts particularly in Scotland, whilst in other areas there may be no funding at all for new posts. Currently, most health authority reimbursement to practices for employing staff including nurses is around 60% - 70% for existing staff. The GP partners in the practice make up the shortfall. In the past this was often facilitated at a practice level by the extra item of service fees which the nurse might bring into the practice. Even where this was not possible, assigning traditional GP work to a nurse was commonly viewed as good value for money, as it would often enable the GPs to manage a larger list than when working unaided.

³ What do practice nurses do? A study of roles, responsibilities and patterns of work, The Centre for Innovation in primary care, September 2000.

⁴ Attitudes to medical care, the organisation of work and stress among general practitioners, Howie JGR et al, British Journal of General Practice 1992; 42: 181-195.

⁵ Caring for larger lists, Marsh GN, BMJ 1991; 303:1312-6.

Most practices have now reached their limit in terms of expansion of practice nursing without additional funding. Cash-strapped health authorities and primary care trusts cannot or will not allocate more money for direct reimbursement of staff and there are no more economies to be made within practices. Many have found it difficult even to meet national pay awards for nurses which in some areas have not been recognised in uplifts in staff budgets. Despite this, government initiatives such as national service frameworks and the NHS plan create demands for more practice nursing time.

The NHS plan stated there would be investment in new staff including 20,000 extra nurses.⁶ It is not clear how many of these new nurses are intended for practice and community nursing. This leads to a number of questions including:

Where will the necessary nurses come from?
How will they be trained?
Who will define the limits of their responsibilities?
How will they be paid? (see above)

Increasing anecdotal evidence suggests the emergence of difficulties in recruiting practice nurses - particularly significant in London and the South East. In some areas, practice nurses are attracted into working instead for walk-in centres or NHS Direct with higher grading (and therefore salaries) than GPs are able to afford with current funding.

Number of practice nurses required

The necessary number of practice nurses within a surgery would be one full time practice nurse per full time GP. This can be expressed, at current list sizes, as one whole time equivalent practice nurse per 1900 patients, but should fall to 1500 or less as and when list sizes fall. Nevertheless it is clear that there are differences in what nurses do across practices and that other less-skilled staff could undertake some tasks. Research carried out by a working group in East & West Sussex health authorities showed that it was inappropriate to recommend full time “G” grades for each partner but that there could be a mixture within a practice of health care assistants, “E” or “F” grades and a “G” grade lead. However, skill mix can be a problem for small practices and sometimes a higher level of skills is needed within such practices.

Training

Although practice nurses employ some generic skills learnt in their hospital training, even in their current role, their work is highly skilled and specialised and requires additional training. Most practice nurses acquire this over a period of time through a combination of in-house training and short specialised courses. Most of this training is currently funded by practices.

A small proportion of nurses employed in general practice are nurse practitioners. These are nurses with additional training (usually from attending an extended full-time course) who are equipped to diagnose and manage a far more diverse range of problems. The courses concentrate on autonomous practice in relation to examination and diagnosis of patients.

In envisaging a much wider role for nurses in primary care, government plans appear not to recognise the distinctions between “generic” nurses, practice nurses and nurse practitioners. Even if sufficient nurses can be recruited, a massive amount of training will be required to enable hospital-trained nurses to move

⁶ The NHS Plan, a plan for investment, a plan for reform, Department of Health, July 2000

into general practice and to enable existing practice nurses to take on an enhanced role. This training will need to be funded.

Responsibilities

Most practice nurses are currently employed by the practice and are clearly seen as key members of the practice team. The extent of their duties is agreed between the nurse and the GP partners who have a clear contractual duty only to delegate tasks to someone who is appropriately trained. Nurses have their individual responsibility to the UKCC but within the practice the ultimate responsibility for the practice's patients rests with the GP partners. In most practices, this results in good teamwork and the "seamless" care of patients.

With the envisaged expansion of the role of nurses in primary care there is an increasing likelihood (already seen in some cases) of primary care organisations rather than practices employing "practice nurses". The working group believes that this could be acceptable for some specialist nurses working across several practices. As a general process though it is not recommended, as it will produce unclear management and lines of responsibility and an increased risk for patients. It was also felt that it jeopardised the major aspect of team working which was a commitment to a particular group of patients, the practice list.

Although health visitors and district nurses are usually employed externally, their roles and responsibilities are clearly defined. It is however, noteworthy that a major feature of many personal medical services pilots is unification of the nursing team under management by the practice.

Pay

The current problems regarding payment of practice nurses are described above under "funding of nursing staff". The health department in England is in the process of drafting a letter to primary care groups and trusts and health authorities to ensure that the role of the practice nurse is appropriately recognised in their reimbursement arrangements. It asks them and their practices to make provision for the proper and fair reward of practice nurses as soon as possible. As far as is practicable, practice nurses should not lose out on the level of pay uplift that they receive because they have elected to practice their profession in primary care. The health department has stated that to enable all GP practices to increase their practice nurses' pay in line with Review Body recommendations, GP practices should be appropriately reimbursed for the employment of practice staff by the HA/PCG/PCT. Therefore they should consult with their LMC to reach an agreement on a realistic level of GP reimbursement based on the NPRB's recommendations. In addition, GP practices should be encouraged to review their nurses' pay in line with the NPRB annual recommendations and to undertake a review annually thereafter. Although this may be seen as a small step forward it places no obligation on health authorities and primary care trusts, and does not identify any additional funding.

Proposals

In order to ensure patients have the quality healthcare which the government envisages, the GPC should consider negotiating for practice nursing staff pay and training to be funded at 100% reimbursement. Such reimbursement already successfully exists in parts of Scotland and does not appear to lead to any

lack of control by practices. Full reimbursement would also help to provide equity not only between practices providing general medical services but those providing personal medical services too.

Furthermore, to deliver a real patient-focussed healthcare service within general practice and allow practices to meet patient access targets, GPC should specify that skill mix is vital for primary care teams and there should be one full time nurse per full time GP (one per 1900 patients, and decreasing number of patients as list sizes fall). The nursing team could consist of a mixture of health care assistants, staff grade nurses as well as those with specialist skills. However, this has implications not only for resourcing and funding as mentioned above but also for premises. There is also another issue of practice nurses themselves being overloaded and needing the opportunity to delegate certain tasks to health care assistants or primary care health technicians who have the appropriate competencies.

Consideration should also be given to a separate and dedicated budget for practice nursing staff separate from other practice staff. This funding should be sufficient to cover all aspects of appropriate training and nurses' absences whilst they are away training.

Other recommendations

- That health authorities and primary care organisations identify a nursing budget per practice and provide 100% reimbursement for core nursing services with discretion on an individual practice basis for a further reimbursement to be agreed locally, for any additional nursing staff.
- That practices and nurses be encouraged to access specialist nurse courses and diploma courses to manage chronic diseases through more publicity and available resources.
- That health care assistant training such as the NVQ in health at level 2 & 3 has a more primary care emphasis.
- That practices be encouraged to draw up protocols to cover clinical supervision and training and development of practice nurses.
- That training opportunities be developed for receptionists who wish to move to a more clinical role.
- That adequate funding for employment and training of practice nurses and all other practice staff must be an essential feature of any new contract.

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