

PRACTICE NURSES

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This Information Sheet will be of interest to current and prospective practice nurses, those working alongside practice nurses and those involved in the implementation of recent changes in primary care such as the new contract and *Agenda for Change* initiative. It examines the current and future role of the practice nurse.

I. INTRODUCTION

The advent of the new contract between general practices and PCTs will see the role and standing of the practice nurse change. Further developments such as extended prescribing, the provision of out of hours care and the *Agenda for Change* initiative, amount to a unique opportunity for practice nurses to increase their status in the healthcare professions. Nurses will be able to become partners in a practice, and will also have the opportunity to provide out of hours services previously supplied exclusively by GPs.

II. SKILL MIX IN PRIMARY CARE

A. DEFINITIONS

The development of *skill mix* is an integral feature of NHS reform and has affected many healthcare professions, but particularly nursing in the context of the primary health care team.¹ Skill mix may be defined in individual, organisational and/or sectorial terms and involves the:

- mix of disciplinary groups involved in the delivery of a service;
- mix of skills within a given disciplinary group;
- and/or the mix of skills possessed by an individual.

There are two conceptually different ways in which changes in skill mix are perceived to alter primary health care provision. These are:

Delegation/Substitution

Task(s) formerly performed by one type or grade of professional are transferred to a different type or grade of professional. Skill mix change in British primary care is largely focused on the transfer of tasks from highly qualified, expensive professionals to less highly qualified, less expensive professionals. Examples include task delegation from GPs to senior nurses and from senior nurses to junior nurses or nurse assistants. The intention is to reduce costs and improve service efficiency.

Diversification

The range of services provided within primary care is enhanced through recruitment of new types of professionals or through the acquisition of new skills by existing professionals. Examples include the addition of practice counsellors and the introduction of clinics for minor operation

in general practice. The intention is to fill previously unmet health needs and/or replace services previously provided within hospitals or other settings. In practice, skill mix changes may involve both aspects. For example, many GPs have delegated the routine care of patients with asthma to practice nurses. Many of these nurses have undertaken specialist training in asthma care and offer a wider range of services than was previously available. This skill mix change therefore exhibits elements of both delegation and diversification.

Number of Practice Nurses, Great Britain, 2003

Country	Number of Practice Nurses
England	21,667
Wales	1,286
Scotland	2,006

Sources:

Department of Health, *England & Wales General and Personal Medical Services Statistics, 30/09/03*²;
NHS Scotland, Information Services, *Workforce Statistics*.

B. NHS WORKLOAD PLAN FOR SKILL MIX

NHS policy changes have encouraged a shift from hospital based to community based care and have increased the volume and range of services demanded of primary health care professionals. Anticipated changes in the GP workforce, consequent on a recent decline in recruitment to the speciality and a shift towards part time, have also caused the Government to consider fundamental service reorganisation, with practice nurse skill mix high on this agenda.

In July 2003 the Workforce Development Confederation published a paper - *Measuring and Quantifying Skill Mix*³ - outlining the 2002 Government Spending Review (SR) assumptions on skill mix, and discussing the evidence base for those assumptions. Taken from that document the table below shows the maximum estimated potential for substitution from GPs to nurses. To facilitate the skill mix shifts shown in the table, by 2007 the NHS would expect to see a 17% increase in the ratio of practice nurses to GPs from 60 per 100, to 70 per 100.

Scenarios/Substitutions	Column A*	Column B**	Column C***
	POTENTIAL: Max % of workload transferable	PHASING: Max % of workload transferable by 2007/8	Transformation Rate
From GP to Primary Care Nurse or Equivalent.	15%	10%	1.5

*Column A shows the estimated maximum percentage of work that could be transferred between staff groups in the medium term

**Column B shows the realistic maximum skill mix shifts that could occur by 2007/8.

***Column C shows the transformation rate – the relative pace that the less senior staff could carry out the work transferred from the more senior staff. For example practise nurses would take 1.5 times longer to do the work than GPs.

C. EVIDENCE BASE FOR SKILL MIX

Early studies on skill mix concentrated on the transformational difficulties relating to greater delegation in the practice and the blurring of traditional role boundaries, and concluded that the efficacy of skill mix was predicated upon structural team arrangements and cultural change. They discussed how skill mixing was characterised by roles reflecting historical precedent and conflicts of power, and surmised that effective teamworking in this capacity required the devolution of power across the primary health care team.

A literature review of skill mix between nurses and doctors in 2000⁴ concluded that, in order to deliver the vision of a primary care led NHS, meet the health care needs of users, address the inevitable anxieties of GPs and bring forth the professional aspirations of nurses and other health care professionals, more equitable and less hierarchical models of multi-professional teamworking in primary care would be most successful. A 1997 study⁵ found that the changing roles and identities of nurses and GPs had created a culture of uncertainty about professional identity, new

roles, and the evolution of patients from passive recipients to active consumers. It discussed how such uncertainty can inspire innovation, but more often provoked demoralization and loss of autonomy.

Another study in 1996⁶ relating to delegation and the issues arising thereof, which examined tasks suitable for delegation and the acceptability to other members of the PCHT and to patients, identified that delegation of at least some tasks was both feasible and acceptable, but that cultural change was required. In a follow-up study⁷ the authors found that delegation and teamworking was a common way of delivering care although this varied in extent and that there was great potential in transferring more work away from GPs towards other clinical workers. It concluded that this flexibility could improve the quality of patient care and satisfaction.

There has been little in the way of a comprehensive assessment of the benefits of skill-mix in general practice. An article in the BJGP in 1999⁸ noted that for the previous decade there had been large increases in the number of nurses working in general practice, but that this had been largely unplanned and not based on effectiveness studies. There is some localised and anecdotal evidence that using practice nurses to triage all appointments can result in longer consultation times. A 2004 article⁹ examined a practice which uses nurses to triage same day appointments. People with colds, minor illnesses, coughs, dressings and contraception needs were seen by the nurse without referral to a GP. This left the GP to deal with the more complex appointments, and allowed the practice to offer patients 15 minute appointments. Another article¹⁰ found that establishing a first-contact team of two practice nurses and a GP has enabled a general practice to offer same day access for any patient who wants it. The team provides morning and afternoon sessions five days a week, seeing an average of 45 patients a session. Most conditions seen by the team are self-limiting. The service has freed up GPs to spend more time with patients who had booked an appointment, allowing them to give each patient a minimum of ten minutes.

A recent literature review¹¹ focused on patient satisfaction with skill mix in primary care. A number of characteristics that influence the type of services that patients want were discovered. Older people and those from ethnic minorities want a traditional, GP-led service, whereas access is important to younger people and those in full-time work. Those from lower socio-economic groups value nurses, but have found the increasingly complex organization of services a problem. There are different levels of knowledge and expectations about health services, and information on the skills of professionals, what they do and the links between them needs to be available. Patients liked nurses as they were good communicators, formed good therapeutic relationships, gave information on illnesses and spent more time with patients. Continuity of care is key, but has been presented as old fashioned and reorganizations may have reduced continuity. Skill mix could be viewed as forming a barrier between doctor and patient, but GPs can help build awareness and confidence in patients about the roles and contribution of the team. The competence of health professionals is vital and patients considered nurses competent, although had some concerns about nurses and pharmacists taking on some new roles. Despite being satisfied with nurses, some patients still wanted to see a doctor next time or felt that a doctor should be available.

Another recent article¹² examines the available evidence for cost-effectiveness of skill-mix. The paper outlines the economic issues surrounding doctor/nurse skill mix and the problems of obtaining correct solutions from the perspective of efficiency. It emphasises the importance of an understanding of basic economic principles and offers a pragmatic economic framework to facilitate decisions in this area. It states that historically the development of doctor/nurse skill mix has occurred ahead of evidence of effectiveness, and there remains little evidence of cost effectiveness at a time when skill mix changes are being introduced in an effort to increase health service efficiency. It concludes that although there is a developing literature to suggest that, in some areas, substituting nurses for doctors gives equal or better health outcomes, the economic debate remains characterised by rhetoric.

III. BECOMING A PRACTICE NURSE

It is possible to take either a diploma or degree course to qualify as a nurse. Education is provided by universities, with placements in local hospital and community settings. The minimum educational qualifications for entry to nursing and midwifery programmes are set by the Nursing & Midwifery Council (NMC). These are statutory requirements which must be met by all entrants to the Diploma and Degree programmes regardless of age and experience. The first year is a Common Foundation Programme, with an introduction to the basic principles of nursing, and candidates can then specialise in adult, children, mental health or learning disability nursing. Full time diploma courses last three years, while degree courses last three or four years. The Council of

the Royal College of Nurses (RCN) voted in April 2004 to make nursing an all-graduate profession at the point of registration.

Becoming a Nurse – RCN Website

<http://www.rcn.org.uk/resources/becomenurse.php>

Starting a Career in Nursing and Midwifery – NHS Careers Website

http://www.nhscareers.nhs.uk//nhs-knowledge_base/data/1146.html

IV. AGENDA FOR CHANGE

The *Agenda for Change* (AfC) is the new NHS pay and career structure negotiated between UK health departments, the NHS Confederation and health service unions. Negotiations on the proposals began in 1999 when the health departments of England, Northern Ireland, Scotland and Wales published a document called *Agenda for Change*¹³. This document highlighted the need for changes to pay, career structure and conditions of employment within the NHS.

The unique position of GPs, who effectively operate as independent contractors, has meant that under current legislation the Department of Health cannot enforce a terms-and-conditions package on GPs, and because practice nurses are employed directly by GPs, any benefits or salary improvements secured through the AfC initiative cannot be automatically extended to the practice nurse. There is a wide ranging debate in the nursing profession, and particularly amongst practice nurses, on whether it is preferable to be paid by a GP or PCT, and also whether practice nurses should be able to choose to be paid by one or the other.

The RCN has expressed the view that practice nurses and nurse practitioners employed by GPs should be paid at AfC rates of pay, when the scheme is rolled out across the UK in October 2004. The RCN is working with the Department of Health, employer groups, the RCGP, the BMA and other unions to ensure that GPs are aware of the benefits it believes AfC brings to the practice and patient care. The RCN has also pledged to develop guidance for those employers and practice nurses in implementing AfC. The RCN published *Practice Nurses and Nurse Practitioners Recommended Pay, Terms and Conditions 2003 – 2004*¹⁴, aimed at practice nurses, nurse practitioners and their employers. It provides recommendations for RCN practice nurse members' pay for 2003/04 and what should be included in their contracts as well as outlining RCN policy on practice nurses and the new AfC pay system. The Practice Nurse Association has produced a briefing paper entitled *Practice Nurses for Agenda for Change*¹⁵ which detailed the results of the RCN vote on this initiatives and the position of practice nurses.

"While they may be employed by independent contractors, invariably they work closely with NHS staff to ensure that targets are met. In other words, practice nurses are an integral part of the NHS family."

Source: *Agenda for Change and Nurses employed outside the NHS*¹⁶, RCN

Agenda for Change – RCN Website

<http://www.rcn.org.uk/agendaforchange/>

Agenda for Change – Department of Health Website

<http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/AgendaForChange/fs/en>

Agenda for Change: where you fit in – Nursing Standard Website

<http://www.nursing->

[standard.co.uk/resources/res_levelthree/agendaforchange/agendaforchange04poster.pdf](http://www.nursing-standard.co.uk/resources/res_levelthree/agendaforchange/agendaforchange04poster.pdf)

V. ROLE OF A PRACTICE NURSE IN A GP SURGERY

In highly generalised terms, the role of the practice nurse involves: giving injections; taking blood; examining and changing wound dressings subsequent to hospital discharge; and supervising patient tests. Practice nurses work with women to give information and advice about contraception, sexual health, and pregnancy, also advising patients on travel vaccinations and health promotion issues.

The section below provides a more detailed breakdown of the work of the practice nurse and the different levels of nurses working in a practice. The descriptions are largely taken from the *NHS Job Evaluation Handbook*¹⁷ which assimilates NHS jobs into a consolidated system ensuring equal pay for work of equal value, by creating comparative elements within job profiles.

A. NURSE WORKING IN A PRACTICE (PRACTICE NURSE)

In outline, this level of practice nurse:

- Delivers nursing care.
- Runs clinics.
- Provides health promotion advice.
- Carries out immunisations and smear tests.
- Inducts new staff.
- Has knowledge of chronic disease management, general health care, family planning and well woman care.

Skills include communicating information to and reassuring patients, as well as planning home visits. The practice nurse will give injections and other surgical interventions; assess and manage the care needs of patients; implement clinical policies and readjust protocols to meet need. They will also make judgments on changes to drug treatments and may refer patients to hospital.

This level of nurse works largely independently and their work is managed rather than supervised. They are able to demonstrate their duties to less experienced employees and supervise students, and can undertake surveys or audits. They may occasionally participate in research and development, clinical trials or equipment testing.

Full job profile including recommendations relating to pay bands – Department of Health Website
<http://www.dh.gov.uk/assetRoot/04/03/48/77/04034877.pdf>

B. SPECIALIST PRACTICE NURSE

In outline, the specialist practice nurse:

- Delivers nursing care, including running specialist clinics.
- Educates patients.
- Carries out immunisations and smear tests.
- Inducts new staff.

A nurse working at this level carries out the same duties as a practice nurse, but will also have specialist clinical knowledge. The qualification required would be a degree plus post registration (ENB) or equivalent. These nurses require skills to assess and interpret specialist clinical conditions, and have the ability to plan home visits, run clinics, organise their own work, give injections and perform other surgical interventions. They assess and manage care needs for patients, while implementing clinical policies and readjusting protocols when necessary.

Specialist practice nurses are accountable for their own professional actions and are capable of initiating action within broad clinical policies. Such a nurse would be able to demonstrate their own duties and supervise students; undertake research in their own specialism; carry out complex audits; and become involved in clinical trials.

Full job profile including recommendations relating to pay bands – Department of Health Website
<http://www.dh.gov.uk/assetRoot/04/03/48/77/04034877.pdf>

C. HIGHLY SPECIALISED NURSE (NURSE PRACTITIONER)

In outline, this specialist nurse practitioner:

- Assesses patients.

- Plans and implements care.
- Provides specialist advice and maintains records.
- Is a lead specialist in a defined area of nursing care, also providing specialist education and training to other staff and students, and undertaking research and lead clinical audits in her own specialist area.

A nurse working at this level will have professional knowledge acquired through a degree plus state registration, supplemented by diploma level specialist training, experience, short courses and CPD. The nurse is able to communicate very sensitive condition-related information to patients and their relatives, and provide empathy and reassurance. They are also capable of assessing and interpreting specialist acute needs and taking the appropriate action; and have the ability to plan specialist nursing service provision including education and training and cover. They can develop specialist protocols; assess, develop and implement specialist nursing care programmes; and give advice to patients and relatives.

Nurse practitioners are accountable for their own professional actions, not directly supervised and are lead specialists for a defined area. They provide specialist training and education, undertake research and lead clinical audit in their own area of work.

Full job profile including recommendations relating to pay bands – RCN Website
<http://www.rcn.org.uk/agendaforchange/payconditions/jobprofile/downloads/Band7/Job-Profile-Highly-Specialist-Nurse1.pdf>

D. HEALTH CARE ASSISTANTS

Health care assistants, also known as nursing assistants, auxiliary nurses or clinical support workers, support other health care professionals with the day-to-day tasks of patient care. The role of the Health Care Assistant (HCA) in general practice has developed significantly in recent years and they are now an accepted part of the primary care health team. HCAs work within community settings under the guidance of a qualified nurse, providing support to more specialised healthcare staff. For more information see the resource box below:

RCGP Fact Sheet on Health Care Assistants
<http://www.rcgp.org.uk/information/publications/information/PDFFact/01AUG04.pdf>

V. THE NEW CONTRACT AND THE PRACTICE NURSE

Under the new GMS contract practice nurses will have the chance to extend their roles in areas such as chronic disease management, first contact care and preventative care. The contract will also promote better access to continuing professional development (CPD), clinical supervision, appraisal and better employment conditions. Nurses will be eligible for improved maternity and paternity leave and access to childcare, on a par with nurses employed directly by PCTs. Nurses will also be able to become practice partners with greater involvement in decision-making. PCT lead nurses will have a vital role to play in implementing the contract, monitoring and reviewing contracts, ensuring clinical governance systems are in place for new roles, and supporting nurses in joint working across the PCT and practices.

"As a practice-based contract, there is recognition that primary care is best delivered by a team of professionals working together towards common goals. At the same time, modernisation of pay and terms and conditions, as outlined in AfC, means that nurses can be rewarded for the greater contribution they will make to patient care."

Chief Nursing Officer Bulletin July/August 2003
http://www.publications.doh.gov.uk/cno/bulletindetail_july.htm

A. KEY POINTS ARISING FROM THE NEW GMS CONTRACT

Aside from providing a radical alteration to the primary care landscape and changing the relationship between the GP and the PCT, the new GMS contract has opened up a wide range of opportunities for practice nurses, and nurses in primary care as a whole. The new contract will lead to a more prominent role for health professionals in the strategic planning and commissioning process.

- The new GMS contract will be a practice-based contract – frontline nurses can extend their interests from the clinical to the business aspects involved in a practice and take on a more strategic role within primary care, should they so wish.
- Practice nurses can become partners in the practice.
- They can form a limited company (provided at least one GP is a signatory on the contract).
- Nurses could become sub or specialist providers of services such as sexual health, minor surgery, vaccinations and immunisations, since practices will be able to opt out of providing additional and out-of-hours services.
- The team-based emphasis of the contract will facilitate better use of the skill-mix within the practice and help the nursing team to provide more integrated patient care.
- PCT lead nurses will need to ensure that all frontline nurses have access to appropriate training, professional advice and CPD.
- PCT lead nurses will also have a key role to play in analysing and interpreting clinical data so that the Quality and Outcomes Framework can be implemented.
- The new contract will promote opportunities for better networking.

B. THE PRACTICE AS EMPLOYER

The National Primary and Care Trust Development Programme (NatPaCT) has produced guidance aimed at those employing practice nurses. *New Primary Care Contracts – what they mean for employers of nurses in general practice*¹⁸, includes a reminder that this was a practice contract *not* a GP contract, and outlines what would be expected of a practice as an employer of practice nurses:

- Reviewing employment practices and improving conditions for nurses to help recruitment.
- Understanding the professional accountability of nurses to enable them to perform safely.
- Ensuring access to education and training so that the nurse is competent.
- Working with each nurse to review performance, identify learning needs, provide access to clinical supervision and carry out appraisal.
- Ensuring nurses are rewarded for their responsibilities appropriately using the principles of AfC and the Skills & Knowledge Framework.
- Using the PCT lead nurse for advice and information on safe employment practice and developing new roles.
- Involving nurses in discussions about the contract and in monitoring reviews with the PCT.
- Working with other practices and the PCT to redesign nursing roles and identify the competencies needed to ensure patient safety.
- Including feedback on nursing services in patient surveys.
- Helping nurses to gain experience in leading services and in meeting the requirements of commissioners to prepare them for extended roles.

C. PROFESSIONAL RESPONSIBILITIES OF PRACTICE NURSES

A further NatPaCT factsheet - *New Primary Care Contracts – what they mean for nurses working with general practice*¹⁹ - advises nurses in a practice to:

- Know their skills (and any gaps in their skills) and have a personal development plan.
- Make links across the PCT with other nurses in general practice and community nurses.
- Ensure they have a job description that reflects their current role.
- Think about their career aims.
- Talk to the PCT GMS lead or the lead nurse if they are interested in becoming a partner or delivering out of hours services.

A research programme based at De Montfort University - *Extending the Role of the Practice Nurse*²⁰ - is working with a number of general practices within Leicestershire and Nottinghamshire. As the practice nurse begins to provide treatment to patients currently provided exclusively by GPs, the study aims to ascertain the training needs of practice nurses and design an appropriate educational intervention to allow this transition to occur.

VI. EXTENDED PRESCRIBING

In May 2001, ministers announced their intention to extend independent nurse prescribing to enable more nurses to prescribe a wider range of medicines for a broader range of medical conditions. In March 2002, the Department of Health published *Extending Independent Nurse Prescribing within the NHS in England: a guide for implementation*, subsequently updated in February 2004²¹. This covers many issues including good practice, training and indemnity.

In November 2003, Health Secretary John Reid announced the addition of a further ten new medical conditions and more than thirty additional medicines to the list, which extended formulary nurse prescribers could prescribe. This list is constantly being examined for revisions by the Department of Health and checking the relevant section of the Department of Health website for developments is the best way to keep up to date.

Nurse Prescribing – Department of Health

<http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustryServices/Prescriptions/NursingPrescribing/fs/en>

VII. NURSES WITH A SPECIAL INTEREST

The NHS Plan sets out clear targets for improving access to and the convenience of primary care services, by reducing waiting times in primary care and extending the range of services available in primary and secondary care settings. Recruiting a Practitioner with a Special Interest (PwSI) is one of a range of options available to PCTs to help achieve these aims. Running in parallel to the development of the GP with a Special Interest (GpWSI) is the advent of the Nurse with a Special Interest (NwSI) initiative. Both posts see the health professional supplement their important generalist role by delivering a high quality, improved access service to meet the needs of a single PCT or group of PCTs. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services. They do not offer a full consultant service and do not impact on access to consultants by local GPs. There are already numerous NWSIs employed by PCTs in different areas of clinical care including diabetes.²²

"The services we offer are very patient-centred. Our clinics are local, easy to access and give patients the confidence of knowing they can see someone they know who has time to spend with them. We don't diagnose. Our role is to troubleshoot, advise, support and educate."

Alexis Hodgkins, Nurse with a Special Interest in Diabetes

Implementation of posts for staff with special interests is service driven. PCTs can identify an area for service development for which a NwSI might be appropriate. The development of GP premises, the creation of one-stop shops and Diagnosis and Treatment Centres, plus the use of private investment to enhance GP practices in LIFT sites, will all provide even greater capacity and more appropriate premises for outpatient appointments in primary care.

PCTs are supported in the implementation of PwSI services by a team from NatPaCT which can provide bespoke local support, helping PCTs develop demand management skills in expanding their primary care services. The team work closely with the National Primary Care Development Team and all other areas of the NHS Modernisation Agency. In 2002, the Department of Health published *Liberating the Talents: helping PCTs and nurses deliver the NHS Plan*²³ as a guide to local primary care organisations. The document outlines examples of good practice and sources of assistance. The document *Developing Key Roles for Nurses and Midwives: a guide for managers*²⁴ provides a full description of professional and legal aspects of expanding the role of the nurse. It contains numerous case studies and aims to help general practice get the best out of nurse's skills and expertise.

Practitioners with Specialist Interests – NatPaCT Website

<http://www.natpact.nhs.uk/cms/165.php>

Practitioners with Specialist Interests – Department of Health Website

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/PrimaryCare/GPsWithSpecialInterests/fs/en>

VIII. REGULATION

The Nursing and Midwifery Council (NMC) is an organisation established to protect the public by ensuring that nurses, midwives and health visitors provide high standards of care to their patients and clients. Its functions include:

- Maintaining a register of qualified nurses, midwives and health visitors.
- Setting standards for education, practice and conduct.
- Providing advice for nurses, midwives and health visitors.
- Considers allegations of misconduct or unfitness to practise due to ill health.

The Fitness to Practise Directorate processes complaints about misconduct or ill health made against nurses, midwives and health visitors. The NMC publishes a Professional Code of Conduct²⁵, the latest edition of which incorporates guidance on enlarging the scope of a nurse's practice, previously published separately as the *Scope of Professional Practice*²⁶. The extended range of services and responsibilities that a practice nurse could potentially take on has implications in terms of indemnity and underlines the need for a clear declaration of what is specifically expected from the practice nurse in his/her contract. This ensures the practice is aware of any additional risk that a practice nurse would be taking on. The Code also places a specific requirement on the nurse to:

acknowledge the limits of your professional competence and only undertake practice and accept responsibilities for those activities in which you are competent. If an aspect of practice is beyond your level of competence ... you must obtain help and supervision from a competent practitioner until you and your employer consider that you have acquired the requisite knowledge and skill.

This effectively means a nurse cannot be obliged by an employer (in this case the practice) to undertake new or additional tasks they do not consider themselves to be competent to perform without breaching the Code of Professional Conduct. Practice nurses are personally accountable for their actions, above their accountability to their employer. Professional accountability cannot be delegated or suspended by the nurse or their employer.

Most nurses, midwives (and some Health Care Assistants) have professional indemnity insurance through their membership of a professional organisation or trade union such as the RCN or the Royal College of Midwives, which will generally cover the cost of legal representation and support, and third party damages, up to a pre-set limit.

IX. PRACTICES NURSES IN THE REST OF GB

A. ROLE OF THE PRACTICE NURSE IN SCOTLAND

The Health Department at the Scottish Executive is currently undertaking a consultation on developing a *Framework for Nursing in General Practice*. According to the Scottish Executive, the purpose of the framework will be to:

- Support the development of nursing services and roles within general practice.
- Ensure the safety of practice nursing services by identifying the competence required by nursing staff at all levels.
- Support changes in skill mix where appropriate, including nurses taking responsibility for current medical duties, development of enhanced nursing roles and the appropriate use of skills within the nursing team.
- Support the local implementation of AfC principles by practices.
- Enable practices to ensure that their practice nursing workforce is fit for its new purpose.
- Support and promote professional education, including where appropriate multi-professional education.

- Support effective links with the academic sector by ensuring that competencies underpin future education provision.
- Support good employment practice in primary care.

Framework for Nursing in General Practice – NHS Scotland Website
<http://www.show.scot.nhs.uk/sehd/practicenursing/index.htm>

B. PRACTICE NURSES IN WALES

In July 1999 the Welsh Assembly published *Realising the Potential: A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales*²⁷, which aimed to set out a framework to enabling these professions to maximise their contribution to healthcare in Wales. The South East Wales Nurses Audit Group has also published *Practice Nurse Perspective: the Future Regarding the New GP Contract*²⁸

Realising the Potential – Welsh Assembly Website
http://www.wales.gov.uk/subihealth/content/keypubs/realisingthepotential/sfcontents_e.htm
Agenda for Change in Wales – RCN Website
<http://www.rcn.org.uk/agendaforchange/countries/wales/>

CONCLUSION

There is a clear commitment on the part of Government to shift what have traditionally been seen as secondary care services into the primary care setting. This will have major implications for the primary care health team in terms of the services they will be expected to offer. Nurses will be critical to the success of these reforms and will enjoy extended roles in prescribing and partnership responsibilities, further clinical specialisation, and opportunities as providers of out of hours care.

"I want to encourage a new generation of entrepreneurial nurses....In my vision nurses are winning contracts to provide services under the new enhanced GMS service provision, they are running practices - let's have more nurses employing more doctors. Nurses are commissioned to run integrated care services for diabetes or heart failure patients. Nurses and midwives need to be supported to take risks safely, be less rule bound, less hierarchical. Encourage them to be confident and to know that their skills are what patients need and that they have an equal place at the top table and the bedside."

John Reid, Speech to Chief Nursing Officer conference, Brighton, November 2003²⁹

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23 Portland Place
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Tel 020 7637 7181
Fax: 020 7436 2924
<http://www.nmc-uk.org/nmc/main/home.html>

Scottish Practice Nurses
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25 Queen Street,
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www.spna.org.uk

These Information Sheets can be obtained through the Information Services Section of the RCGP, or viewed on the RCGP's Web site:
http://www.rcgp.org.uk/rcgp/information/publications/information/infosheets_index.asp

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FURTHER ELECTRONIC RESOURCES

NHS Prodigy Guidance for Nurses
<http://www.prodigy.nhs.uk/Nurse/>
Nurse Practitioner UK
<http://www.nursepractitioner.org.uk/index.htm>
Nurse Practitioner/Advanced Practice Nurse Network (INPAPN)
<http://www.aanp.org/INP%20APN%20Network/INPAPNNHome.asp>
Nurse Prescriber UK
<http://www.nurse-prescriber.co.uk/>
Community Practitioners' and Health Visitors' Association
<http://www.msfcphva.org/practicenursing/pnhome.html>
Nursing UK
http://www.nursingnetuk.com/courses_index.php?fs9001=2423b195eba53c13748af6ac62155f7e