Nurse employment in primary care – UK and New Zealand

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ABSTRACT

'There's more than one way to skin a cat' is a strange old saying which could be applied to the employment of nurses in general practice. Changing practice nurse employment from GPs to Primary Health Organisations is a 'red herring' and may not achieve the main aim of the Primary Health Care Strategy – a reduction in health inequalities, in the way that some nurse leaders have suggested. Lessons from the UK suggest that nurses organising themselves into peer groups, remuneration of general practices for the attainment of positive patient health outcomes and a statutory duty of clinical governance contributed to the development of practice nurses' roles and expansion of numbers of nurse practitioners in general practice. Nurses have become partners with GPs in general practice in the UK, a much preferable alternative for some than employment by a Primary Health Organisation.

Keywords

Nurse employment, primary care, clinical governance

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A recent editorial in the *British Journal of General Practice* by two New Zealand authors questioned the validity of the UK's Quality and Outcomes Framework (QOF) and asked of general practitioners (GPs) *'What have you done to yourselves?'* The editorial suggested that the QOF deprofessionalises the GP and follows a *'medicine-by-numbers, pay for performance'* path.[1]

The QOF evolved from the statutory duty of clinical governance placed on all NHS organisations in 1999 and the authors correctly suggested practices were making changes to implement evidence-based practice prior to the introduction of the QOF – for many general practices this was as a direct result of the implementation of clinical governance by Primary Care Groups (the forerunners to Primary Care Trusts).

The QOF dataset uses variables grouped into several domains; clinical, organisational, patient experience, additional services and access and general practices are awarded achievement points. The management of 11 chronic diseases with 76 indicators falls into the clinical domain while additional services offered include child health and maternity services.

Most of the chronic disease management work is conducted by practice nurses (PNs). Midwives and community practitioners (health visitors) work in partnership with GPs to provide child health and maternity services. Comparative data for the QOF has illustrated that differences in achievement of performance indicators between affluent and deprived areas are closing, with subsequent reduction in inequality of access and provision of evidence-based care.

Well-organised primary care compensates for substantial social disadvantage.[2] This point is pertinent to New Zealand as the inequality in mortality between Maori and non-Maori is worse than that between non-Hispanic Whites and non-Hispanic African Americans in the USA.[3] The New Zealand authors of the editorial were probably not aware of the major role that nurses play in primary care in the UK, particularly in achieving the QOF. It is common practice for patients with long-term conditions to be managed solely by

nurses. GPs continue to provide complex, consultative medical care. The same arrangement is not routine in New Zealand.

Nurse leaders in New Zealand have recommended that wherever possible GP employment of nurses should cease in favour of a salaried model of employment by a PHO or District Health Board (DHB), to enable nurses to develop their roles in primary health care and thus achieve the objectives of the Primary Health Care Strategy (PHCS).[4,5] However, a number of authors have noted the facilitation of development and innovation by small general practice team environments[6] and that the employment of nurses by GPs did not restrict innovation and development of practice nurses in the UK. Employment structures may be a 'red herring' in terms of increasing the autonomy of practice nurses to deliver nurse-led care in general practice.

During April 2007, Wendy Fairhurst-Winstanley a nurse practitioner and nurse partner in a general practice in Wigan, UK delivered the keynote speech at the Goodfellow symposium and spent two weeks presenting as a practice nurse, nurse practitioner and nurse partner in a general practice, to a number of audiences in Auckland and Northland. There are similarities between the general practice (GP) primary care delivered systems of the UK and New Zealand. Four key themes were apparent in Wendy's presentations: government strategy, funding, leadership, and an evidence base. Applying the themes to New Zealand concentrates on the real issue which needs addressing to achieve the aim of the Primary Health Care Strategy (PHCS) – implementing clinical governance in primary care. Once clinical governance is addressed, the employment structure of practice nurses is of little significance.

Similarities in general practice between the UK and New Zealand

- GPs are self employed
- GPs employ PNs
- PNs are an ageing workforce in both countries
- Inequalities in health exist in both countries
- General practices provide primary care.

Differences in general practice between the UK and New Zealand

See Table 1.

UK Government Strategy and the evidence base for primary care nurse-led services

There have been a plethora of government white papers (statutory documents) concerning primary care and the development of primary health care nursing in the UK since the Labour government came to power in 1997. A clinically-led primary health care service was the aim of Tony Blair's new Labour Government in 1997, with doctors and nurses in the driving seat, given the mandate to work together in Primary Care Groups to develop primary care, reduce the local inequalities in health and commission selected services from secondary care. Titles of white papers which overtly refer to the development of primary health care nursing – i.e. *'Making a difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare'*[9] and *'Liberating the talents'*[10] – raised awareness of the government's intention to maximise the skills of community nurses working in both primary care and community health.

Two systematic reviews found...health outcomes of patients seeing nurse practitioners were equivalent to those seen by GPs

The stimulus for GPs to employ practice nurses and thus expand practice nursing commenced in 1990 with the GP contract, which paid doctors to provide chronic disease clinics and to meet population target rates for vaccinations and cervical screening.[11] Most of this health promotion work is organised and delivered by nurses and the introduction of these nurse-led services, throughout the 1990s, resulted in reduced inequalities in health and health care provision in England.[12] With regard to chronic disease management, positive outcomes have been found for nurse-led services in: secondary prevention of ischaemic heart disease,[13] asthma care,[14] chronic heart failure[15] and hypertension.[16] Generally nurses are efficient at giving advice about diet and lifestyle, however the advent of widespread nurse prescribing in 1999 allowed nurses who had undertaken academic preparation for this role, the rights to independently prescribe medications. Nurse practitioners' roles in general practice include the triage and treatment of patients arriving in general practice with acute conditions and the evidence for the effectiveness of nurses in these roles has been largely positive. Two systematic reviews[17] found very similar results: health outcomes of patients seeing nurse practitioners were equivalent to those seen by GPs, patient satisfaction was higher although this was thought to be partly due to the fact that nurse practitioners tended to have longer consultations. As a result nurse practitioner consultations were not cheaper and impact on GP workloads was variable. Most of the Randomised Controlled Trials included were carried out prior to 2000 and many nurse practitioners were then new to the post. It would be interesting to repeat some of these studies now.

UK funding of general practice

The General Medical Services (GMS) Global Sum Formula determines the payments made to practices for the delivery of essential and additional services; it is distributed in line with the weighted needs of patients to reflect practice workload and the relative costs of service delivery. The Primary Care Trust commissions the practice to provide services, there is

Table 1. Differences in general practice between the UK and New Zealand.

	New Zealand	United Kingdom
Membership of a Primary Health Organisation (PHO)	Voluntary.	Statutory and the vehicle through which funding is delivered to GPs.
Board Governance	There is no statutory requirement for nurses to be board members of PHOs.	In 1999, it was a statutory requirement that at least two primary health care nurses were board members of Primary Care Groups – the forerunner to Primary Care Trusts (PCTs).[7]
Enrolment	Prior to 2003, the public could consult with any GP and be enrolled in any practice (and enrolled with more than one GP). Since 2003 there can only be enrolment with one PHO, but patients can access more than one GP.	Since 1947 almost every UK resident is enrolled with one GP. At registration of birth a baby is given their NHS number and a letter to enrol with a general practice.
Nurse prescribing in primary health care	Limited number of independent nurse prescribers – five independent nurse prescribers at March 2006. Registration as a nurse practitioner with Nursing Council is a pre-requisite to prescribing.[8]	Widespread independent nurse prescribing began in 1999 in primary health care – extended/supplementary nurse prescribing accounts for 7181 nurse prescribers and 41 903 nurses and midwives are registered to prescribe. (2005–06) (personal communication, NMC, April 2007).
Chronic disease management	Not consistently provided in primary care.	Routinely provided in primary care and part of the contractual obligation with the PCT.
GP remuneration	GPs are funded by government at varying levels – dependent on ethnicity of enrollee and deprivation index of area. Fees collected from patients.	Totally funded by government. No patient fees. Potentially one-third of GP income provided through the Quality and Outcomes Framework (QOF).
Community nurses and GP alignment	District nurses, public health nurses, mental health nurses, Plunket nurses, Tamariki Ora, school nurses and midwives are not part of a common primary health care team. Midwives work independently and separately.	District nurses, health visitors, school nurses and community psychiatric nurses are employed by Primary Care Trusts (PCTs) and work aligned to GPs. Midwives are employed by hospital trusts or work independently but aligned to GPs.
Clinician remuneration	General Medical Services (GMS) can only be claimed by GPs.	General Medical Services contracts were awarded to practices in 2004. Nurse practitioners could be remunerated in the same way as GPs if they became partners in a practice.

a contractual obligation to achieve national targets. Practices can also bid to provide enhanced services for which they receive extra funding from the PCT. Up to one-third of practice funding is achieved by attaining the targets in the Quality and Outcomes Framework (QOF). Nurse practitioners and practice nurses have been key to addressing gaps of care and provide services which weren't provided in primary care before the reforms of the 1990s. The latest GP contract of 2004 focuses on the practice rather than the GP and thus allows for partner arrangements with nurses.

Leadership of primary health care nurses in the UK

Since 1 April 1999 all NHS bodies in England, Scotland and Wales (including general practices) have had a statutory duty of clinical governance placed upon them. Sir Liam Donaldson, the UK's Chief Medical Officer defined clinical governance as: *'A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.'*[18]

The introduction of clinical governance into the National Health Service (NHS) in 1998, during the primary care reforms, highlighted the educational and clinical leadership requirements of all health profession-

als. Every NHS employee is accountable to the Chief Executive (in the case of general practices, through the Primary Care Trust) to ensure the quality of the service they deliver is improving continuously. Nurses in general practice formed themselves into peer support groups which met regularly to discuss policy and education. The peer groups were extremely important initially in identifying educational needs drawing up protocols of care, and organising training and study days (often funded by drug companies). Initially these groups were run by nurses but now they are generally supported by Primary Care Trusts who employ a practice nurse facilitator to oversee clinical governance and report back to the PCT any issues relating to practice nursing.

As nurses in general practice were, and for the most part still are, employed by GPs, grassroots determination and peer support has been important in the implementation of clinical governance in what can be a rather isolated branch of nursing. Nurse teams in general practice have grown, many practices now have a nurse team leader, some of whom have been made business partners in the practice. Throughout the UK, community nurses are aligned with general practices. Alignment implies that the community nurse is regarded as part of the general practice team (though not employed by the practice), able to share general practice patient records, be part of team meetings and contribute to decision-making. Many community nurses are co-located within the general practice and have formed integrated nursing teams. Members of an integrated team agree their roles, dependent on competencies, for example, health visitors provide developmental screening of young children and childcare advice to parents, concurrent to the delivery of immunisations by the practice nurse. District nurses provide wound care management at clinics in the general practice. The collegiality of all primary health care nurses working from one environment aids in nurse development. Studies have illustrated that a collective voice on nursing issues contributes to development in the primary care environment.[19] The patient benefits from having access to an integrated nursing team, receiving care from the most appropriately skilled clinician.

Conclusion

It wasn't the employment of nurses which changed to facilitate practice nurse development in the UK. Practice nurses organised themselves into peer groups, general practices were remunerated for the attainment of patient health outcomes and a statutory duty of clinical governance at organisational and individual level was applied. Nurse-led clinics and integrated community and practice nurse teams are not part of the New Zealand primary health care culture. Focusing on the employment structures of practice nurses may be of little relevance in addressing the inequalities in health and achieving the goals of the PHCS in New Zealand. The barriers to full implementation of the PHCS need to be explored. Solutions would include innovative use of nursing skills and integrating primary care and community nursing teams.

Competing interests

Wendy Fairhurst received reimbursement for traveling expenses and had accommodation provided for speaking at the Goodfellow Symposium in May 2007. The other authors declare no competing interests.

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