

*King's* Fund

# Nurse-led Primary Care

Learning from  
PMS pilots

Richard Lewis

Foreword by the  
Chief Nursing Officer

King's Fund  
11–13 Cavendish Square  
London W1G 0AN

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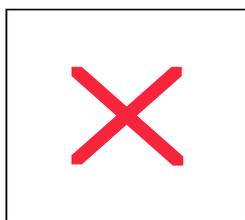
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## **Foreword**

The development of personal medical services (PMS) pilots in primary care has been an opportunity to do things differently. The pilots have provided a new way of working and new opportunities for GPs to pursue a different career path, as well as meeting different, locally relevant objectives.

All the PMS pilots have also provided opportunities for nurses to work in new ways. Whether working in a team with salaried GPs, or providing specialist services for vulnerable populations, nurses have been an essential element of the whole PMS picture. But there is a small group of nurses who have contributed to PMS pilots in a very particular way. These are nurses who have personally led the new services, taking on the professional and managerial burden of creating the pilot's objectives, building the multi-professional team, managing the expenditure, and ensuring that the ultimate beneficiaries of this radical and sometimes challenging change are patients and service users.

This report explores the experiences of nine of these pioneer nurses. Against a background of the development of PMS and the evolution of nursing roles in primary care, the report analyses data collected through two focus groups of nurse leads. The nature and characteristics of nurse-led pilots are described and the nurses explore their value systems, their model of care, and their relationships with other professionals and with hospital services.

It is never easy to be first, and it is not easy to expose your anxieties, frustrations and less-than-ideal experiences to the scrutiny of others. But there is a great deal to be learned from this thoughtful, realistic and ultimately optimistic appraisal of the early years of these nurse-led pilots.

I am grateful to them for their courage, their honesty and their leadership. I hope that this report encourages all of us to be more supportive and responsive to the leaders and pioneers amongst us. I also hope that it encourages many more nurses to grasp

opportunities that are offered to 'do things differently' to improve services for patients.

*Sarah Mullally  
Chief Nursing Officer  
London, March 2001*

## **Executive summary**

In 1998, the Secretary of State approved nine PMS pilots to offer 'nurse-led' primary care. These pilots were designed to maximise the use of nursing skills and to allow nurses to exercise leadership within the primary health care team. This report describes the experiences of the nine nurse leads as they have developed their pilots.

Government policy has emphasised the need to examine the mix of skills within the NHS, in particular to break down existing demarcations between medical and nursing roles. The Chief Nursing Officer has identified ten key roles that all nurses with appropriate skills might undertake. In primary care, the role and number of nurses has increased substantially during the 1990s. Much attention has been placed on the role of the nurse practitioner. There is a growing body of research evidence which suggests that these nurses can offer care that is similar in quality and cost to that of doctors in a number of settings. Nurse-led PMS pilots have begun to put into practice a new model of care that is consistent with the Government's objectives for the NHS.

### ***The pilots***

Nine nurse-led sites 'went live' in the first wave of PMS pilots. Five pilots were managed by community NHS trusts, two pilots were managed by existing GP practices and two pilots were managed by nurses acting as independent contractors. In the latter two practices, nurses acted as the employers of other team members, including GPs.

Pilots shared a number of priorities, including: serving vulnerable populations (such as refugees or homeless people); providing patient-focused care; breaking down professional boundaries; improving access to services; community development and/or patient empowerment; and developing partnerships with other agencies and community groups. The nine pilots are serving very different numbers of patients. In some pilots, the list of registered patients is very small. In general, nurse-led pilots

have relatively large primary health care teams when compared to the average for general practice.

### ***What is nurse-led care?***

Nurse leads define 'nurse-led' care as the combination of extended nursing roles and a culture that promotes equality between different professions and the empowerment of patients. Because of the emphasis on vulnerable populations, nurse leads perceive that local 'traditional' general practices are directing particular patients to the pilots rather than providing services themselves.

### ***Pushing back the professional boundaries***

Nurse leads were concerned that the number of nurse practitioners in primary care (including NHS Direct) was growing without sufficient attention nationally on establishing agreed competencies, standards or training. At local level, clinical governance processes had not led to any quality assurance in relation to the work of the nine pilots.

Within their own pilots, nurse leads have mostly been successful in establishing a new model for interprofessional working. However, in one pilot significant disagreements over the respective roles of nurses and doctors had caused two successive nurse leads to leave the team. Nurse leads had experienced some hostility to their pilots from other local doctors. Nurse leads perceived that this hostility was greatest if they attempted to offer services to a mainstream population, rather than to disadvantaged groups.

Nurse leads have generally been successful in negotiating the right to access diagnostic services directly and to make and receive referrals from the hospital sector. However, this has mostly relied on informal arrangements and few nurse leads have agreements with all hospital specialties. Some consultants still insist on communicating only with the pilot doctor.

## ***Pilot implementation***

Nurse leads have been presented with a number of obstacles in implementing their pilots. Nurses are not eligible to sign benefits or death certificates, or to officially register patients (this must be formally done by a GP). In addition, the ability of nurses to prescribe is (currently) highly restricted.

Nurse leads employed by community NHS trusts identified a lack of autonomy and, in some cases, support in developing their pilots. NHS trusts have proved bureaucratic and not sufficiently responsive to the day-to-day needs of a primary care team. However, independent contractor nurse leads, while autonomous, have suffered from isolation. The existence of 'local champions' has been important in the success of the pilots.

## ***Conclusions***

More than two years into their pilots, the nine nurse leads have achieved a great deal and are putting into place the Government's radical vision for health care. There are a number of lessons to be learnt:

- 'Nurse-led' care is not simply a description of the role of nurses but describes also a culture of professional equality and patient-focused services.
- This new model of care has created some local controversy and, in particular, hostility from doctors. Nurse leadership is but a further change heralded by PMS pilots that have, more generally, raised the hackles of a section of 'traditional' general practice. Nevertheless, the pilots have managed to negotiate a new doctor–nurse relationship within primary care and with hospital colleagues.
- Nurse-led pilots have tended to serve vulnerable populations, often poorly served by general practice. They have proved popular with these patients, although this raises interesting ethical issues. Traditional general practices are perceived now to direct patients to the nurse-led pilots, raising the spectre of a two-tier service –

with the disadvantaged receiving their care from nurses and the mainstream population from doctors.

- Current NHS and welfare regulation are not sufficiently sensitive to the new role of nurses and need review (in the case of nurse prescribing, changes are imminent). Community NHS trust-managed schemes are likely to transfer to primary care trusts (PCTs) when these have been established. It is far from clear whether this will resolve the problems of bureaucracy that beset community trust pilots. Nor is it clear whether medically dominated PCTs will support the nurse-led model.
- A new infrastructure is required to support new nursing roles. In particular, more clarity is required over the competencies, training and quality assurance of nurse practitioner services. Nurse leads perceived that they had received little in the way of support from their professional bodies.

The nurse-led pilots have begun to implement the Government's strategy for nursing. Emerging research suggests that this model of care is popular with patients (although evidence on the cost-effectiveness of nurse-led pilots is not available). However, it is not clear whether there are sufficient nurses available and willing to follow the example set by the nine nurse leads.

## 1. Introduction

This report considers two key aspects of Government health policy: the introduction of personal medical services (PMS) pilots as a means to increase the responsiveness and effectiveness of primary care; and the renegotiation of the respective roles of professionals within the primary health care team, specifically enhancing the contribution to care made by nurses. These two policy streams have come together in the advent of ‘nurse-led’ PMS pilots – a small, but important, group of primary health care teams that are led by nurses, and that have the development of nursing roles as a key objective.

In announcing a first wave of PMS pilots, Frank Dobson, then Secretary of State for Health, specifically encouraged nurses to use them as an opportunity to develop a new kind of primary care: a primary care that maximised the nursing contribution as well as the leadership qualities of nurses themselves. Subsequently, nine nurse-led pilots were approved to begin operation on 1 April 1998. These nine initiatives provide the focus for this report: what sort of primary care have they developed; what has been their experience of ‘nurse leadership’ so far; and what might we learn about the implementation of the Government’s policy to extend nursing roles?

### ***Personal medical services pilots***

PMS pilots, introduced following the 1997 NHS (Primary Care) Act, marked an important departure in the policies of successive governments towards primary care. Primary care has been (and largely still is) focused on the work of GPs. Prior to the Act, all GP principals held individual contracts with the Secretary of State for Health, were independent contractors and were responsible for the direct employment of practice staff, including practice nurses and a range of other practice-based professionals. The relationship between GPs and the NHS was largely governed through collective bargaining between the General Practice Committee (formerly the General Medical Services Committee) of the British Medical Association and the

Department of Health. The result was a national general medical services (GMS) contract. Local involvement in, and discretion over, the activities of GPs was limited.

PMS pilots introduced some significant changes to the *status quo*:

- Contracts (and budgets) were drawn up and negotiated locally between the health authority (or, later, the primary care trust) and the primary care provider.
- New types of provider were able to contract to provide primary medical services. These included community NHS trusts, independent nurses and, exceptionally, limited companies.
- New opportunities for the salaried employment of GPs were created, offering an alternative to the independent contractor model.

While the first wave of pilots was modest in size, with 83 pilots going ‘live’ in April 1998, numbers soon grew rapidly.<sup>1</sup> By the third wave in 2001, the Government estimated that 20 per cent of GPs would be covered by PMS contracts.

PMS pilots are significant for primary care nursing. They are already introducing new roles and responsibilities for nurses,<sup>2</sup> and significant developmental resources are being made to encourage the employment of a new cadre of ‘nurse practitioners’. In particular, pilots that are currently managed by NHS trusts and that may, in the future, transfer to PCTs, are introducing new power structures within primary health care teams. Through the salaried employment of the whole team, the employer–employee dimension that has so long characterised the GP–nurse relationship is removed. Exceptionally, independent contractor nurses are employing the other members of the team. These new organisational forms open up new possibilities for interprofessional relations.

### ***The challenge for nursing***

In March 2000, the Government announced a significant increase in the resources available to the NHS. These resources were not simply a ‘one-off’ bonanza, but were part of a five-year plan that would increase spending, in real terms, by 35 per cent. However, this Government largesse came with strings attached. If the Government

was going to heed the continuing cries for more money that emanated from within the NHS, it would expect wholesale changes in the way in which the NHS was to operate in return.<sup>3</sup>

At the time of his announcement, Tony Blair set the NHS five key challenges that formed a new 'deal' between government and the health service. One challenge was to 'strip out unnecessary demarcations, introduce more flexible training and working practices, and ensure that doctors do not use time dealing with patients who could be treated safely by other health care staff'. Health Secretary Alan Milburn, in his address to the Annual Congress of the Royal College of Nursing, stressed that nurses were at the centre of the Government's plans for modernisation and promised 'a health service which liberates nurses not limits them'. Nurses were, he suggested, the new leaders of change, and nursing values were at one with the values that he wanted to underpin the NHS: care, compassion, professionalism and dedication.<sup>4</sup>

The Secretary of State identified ten nurse roles that should, in the future, become widespread throughout the NHS (later described as the Chief Nursing Officer's 'ten key roles for nurses' – see Box 1.1). These roles built on the experience and achievements of leaders in the field; if opportunities to fulfil these roles were available to some then they should be available to all appropriately skilled nurses. Nurses of the future look set to move into territory hitherto firmly occupied by doctors.

This theme of shuffling the professional pack was one that was embellished in the *NHS Plan*. This set out a challenging agenda for the NHS. The post-Plan NHS was to be responsive, convenient and tailored to individual needs. Access to primary and intermediate care services was particularly highlighted. Nurses were to act as linchpins of this new NHS. According to the Government, 'pressure on GP services will be eased as nurses and other community staff ... take on more tasks.'<sup>5</sup> Instant access to primary care advice via NHS Direct, rapid access within the GP surgery, the encouragement of GPs to develop sub-specialisms all rely on nurses carrying out extended roles. A similar agenda is unfolding for hospital and community nursing, with more than 1000 nurse consultants promised, together with the re-invention of the hospital matron.

### **Box 1.1: Chief Nursing Officer's ten key roles for nurses**

1. Order diagnostic investigations (e.g. pathology tests and x-rays).
2. Make and receive referrals direct (e.g. to a therapist or pain consultant).
3. Admit and discharge patients for specified conditions and within agreed protocols.
4. Manage patient caseloads (e.g. for diabetes and rheumatology).
5. Run clinics (e.g. ophthalmology or dermatology).
6. Prescribe medicines and treatment.
7. Carry out a wide range of resuscitation procedures, including defibrillation.
8. Perform minor surgery and out-patient procedures.
9. Triage patients using the latest IT to the most appropriate health professional.
10. Take a lead in the way local health services are organised and in the way they are run.

### ***The evolving role of the primary care nurse***

The 1990s saw a rapid increase in the employment of practice nursing. Between 1989 and 1999, the number of whole time equivalent practice nurses in England more than doubled from 4632 to 10,689.<sup>6</sup> Practice nurses were seen as an increasingly essential component of the primary health care team, not least because the re-structured GMS GP contract included financial incentives that encouraged the provision of a wide range of services that were particularly suited to nurses.

A key debate within primary care has concerned the appropriate skill-mix in relation to medical and nursing roles. Increasingly, governments have seen substitution between nurses and doctors as a policy response to the apparent shortage of GPs. Much of this attention has focused on the role of the 'nurse practitioner'. This is a slippery term; nurse practitioner status is not formally recognised by the United Kingdom Central Council (UKCC), the body that currently regulates the nursing profession. However, the Royal College of Nursing has provided a role definition that covers the work of nurse practitioners within a primary care setting. In its view, the nurse practitioner is:

*An advanced level clinical nurse who through extra education and training is able to practice autonomously, making clinical decisions*

*and instigating treatment decisions based on those decisions, and is fully accountable for her own practice.*<sup>7</sup>

The ability of nurse practitioners to substitute effectively for doctors in a wide range of settings is now well demonstrated both in the United States and in the UK. Randomised controlled trials have provided ample evidence to suggest that care by nurse practitioners is similar in quality and cost to that provided by doctors. In addition, patient satisfaction with nurse practitioner care is comparable, if not higher, than that resulting from care provided by a doctor.<sup>8,9,10,11</sup> A Department of Health-sponsored evaluation also suggested that nurse practitioners were able to provide services that are acceptable to patients and (where data were available) at similar or lower cost than that of doctors.<sup>12</sup>

The ability of nurses to prescribe a limited range of products has been tentatively introduced.<sup>13</sup> However, a fundamental review of non-medical prescribing has been undertaken and proposals are currently under consultation.<sup>14</sup> It is proposed that, following suitable training, independent prescribing rights are held by those nurses holding a specialist practitioner qualification recognised on the UKCC professional register or a clinically based qualification, such as a nurse practitioner degree.<sup>15</sup>

Yet finding an appropriate new equilibrium between medical and nursing roles has not been without its difficulties and tensions. Certainly, both doctors and nurses acknowledge that the boundaries between them are blurring. For doctors, this has been something to fear. For nurses, there is frustration in the perceived subservience of their role in relation to that of doctors. Very often, medical colleagues also act as primary care nurses' employers, emphasising the unequal relationship that exists.<sup>16</sup> Interprofessional collaboration may require equal status and power if it is to be effective.<sup>17</sup> As two commentators have caricatured interprofessional relations:

*Nurses, more assertive, educated, and competent than ever before, resent what they see as continuing put downs by a profession holding all the cards. Doctors, puzzled and unaccustomed to being challenged, are themselves resentful at the apparent undervaluing of*

*their competence, knowledge, and skills by nurses, the public, and policymakers. Everyone is confused.*<sup>18</sup>

So, are doctors and nurses simply two tribes with different world-views, using the patient as their battleground? A study of medical and nursing cultures suggested that, in fact, there are no distinguishable differences between the 'core values' that underpin both professions. However, their different cultures and histories lead to alternative interpretations as to how these values might be pursued in practice. Tensions are also evident *within* the nursing profession as changes in skill-mix shift roles between different branches of primary care nursing. One consequence of changing skill-mix and care substitution is a decline in professional identities. This may be necessary if entrenched behaviours are to change. Nevertheless, a strong professional identity is associated with good teamwork and morale, and a loss of identity may result in reduced quality of care.<sup>19</sup>

Nurse-led PMS pilots appear to invert the common, medically dominated culture of primary care and to radically restructure professional identity. One PMS pilot nurse lead has suggested that formal professional titles act as a barrier to teamwork and that nurse-led pilots should introduce 'democratically organised teams with decision-making based on consensus'. As a consequence, greater emphasis should be placed on the particular skills and expertise of each individual team member.<sup>20</sup> Has this blurring of professional identities led to reduced morale? An evaluation of this pilot suggests the opposite. Despite initial scepticism and even anger, staff within this practice soon expressed great enthusiasm.<sup>21</sup>

PMS pilots already appear to be in the vanguard of change in relation to skill-mix, whether or not they are formally nurse led. Nurse roles are evolving rapidly in practice-based pilots and new nurse roles are being developed, such as triage and nurse-led chronic disease management.<sup>22,23</sup>

How have patients adapted to these changes in practice? An evaluation of patient perceptions of nurse-led care suggests that they have found the new model acceptable. Indeed, many patients expressed a preference to see the nurse rather than the doctor.

Patients valued the nurse-led service because it offered continuity and stability, was accessible and personalised, and because the nurse took an interest in people's material and domestic situations. Interestingly, in this evaluation these were the same attributes that patients associated with the previous, much-valued GP care that they had received prior to the pilot's inception.<sup>24</sup> This poses a question – is successful nurse-led care simply the same as 'good' primary medical care?

### ***Evaluation methods***

This evaluation focuses on the views and perceptions of the pilot nurse leads themselves. Therefore, the nine nurses (and in some cases their immediate managers, where they have been heavily involved in establishing the pilots) have provided the data upon which this report is based. Clearly, others who have been involved in the pilots (whether as commissioners, neighbouring practices or as patients) may have a very different view of events. These other perspectives are important but have not been the subject of this research.

The main form of data collection has been through two focus groups (held in June and December 2000). Seven of the nine sites attended the first focus group and four sites were represented at the second. The focus groups were intended to allow the participants to explore their experiences and to distil lessons that might be important for other nurses following in their footsteps and, indeed, for the wider NHS in considering the role of nurses within primary care.

Prior to the first focus group, all sites were sent a questionnaire. This was designed to collect basic information about each pilot, as well as the qualitative views of the nurse leads about the perceived success of the pilots in meeting their objectives and any lessons learnt through implementation. Questionnaires were completed by all pilots. Subsequently, the questionnaire was extended to collect data systematically about the relationship with the acute hospital sector (a topic that emerged as significant during the first focus group and which is discussed in this report).

This evaluation of nurse-led pilots has also drawn upon the larger scale evaluation of first wave PMS pilots being carried out by the King's Fund (in association with the

National Primary Care Research and Development Centre). This evaluation has used a range of qualitative and quantitative methods, and incorporated two of the nine nurse-led sites.<sup>25</sup>

## **Conclusion**

Nurse-led PMS pilots are the latest thrust of an evolving policy to enhance the contribution that nurses make to primary care. No doubt, different protagonists have different motivations for this. Government may see nurse-led care as a means to avoid a GP recruitment crisis; nurses may see it as an opportunity to establish autonomous practice. It has been noted that, unlike doctors, nurses find their professional futures shaped predominantly by external factors, whether these be doctors as employers, the economics of care or changes to the health system generally.<sup>26</sup> Nurse-led PMS pilots appear to offer nurses an opportunity to shape their professional development themselves.

However, notwithstanding the advances already made by PMS pilots, nurse-led pilots face obstacles that reflect the medically dominated history of NHS administration. These include severe limitations on nurses' ability to prescribe autonomously, their inability to register patients directly and restrictions on their powers of certification, for example in the case of death or mental health section.<sup>27</sup> This degree of restriction on autonomous practice contrasts with the United States, where nurse practitioners practice without any requirement for physician supervision or collaboration in 50 per cent of states. In addition, nurse practitioners in all states are directly reimbursed for services under Medicaid (the government health programme for the poor).<sup>28</sup>

The Government's proposals for enhanced roles for nursing are supported by a raft of evidence about the effectiveness of nursing care in different settings. Yet how, and whether, these roles can be effectively translated into the mainstream of primary care is a rather different question. In this respect, much of the Government's thinking appears to be relatively untested. As they reach the end of their third year of operation, this report seeks to describe and examine the experiences of the first nine nurse-led pilots. These nurses are the trail-blazers for the new cadre of nurses upon which the NHS Plan relies.

## 2. The nine nurse-led pilots

Brief details of the nine nurse-led PMS pilot sites are presented in Table 2.1.

### ***Pilot characteristics***

Eight of the nine pilots were newly established practices, providing services where none had before been provided. In one case, the nurse-led pilot was awarded a vacant list following the death of the incumbent GP. Six of the nine pilots were designed to provide services to specifically targeted populations (although, not necessarily exclusively to these populations) or to increase access to primary care for the general population in ‘under-doctored’ areas. The most common population groups targeted were those of homeless people (five pilots) and refugees and asylum seekers (two pilots).

While the ‘official’ start date of first wave PMS pilots was intended to be 1 April 1998, only two pilots were operational at that time. Several pilots experienced considerable delays as they prepared themselves to provide services. This was due to the need to recruit team members or to secure premises. The majority of pilots were operational within six months of the intended start date. One pilot became operational in December 1999, more than a year and a half after the intended starting date.

### ***Contracts, organisation and management***

The nine pilots adopted one of three organisational and contractual approaches. The most common arrangement was for the pilot to be managed by a community NHS trust that held a contract with the local health authority (five pilots). Two pilots were managed by existing general practices that established branch surgeries or quasi-independent organisations. In one case, the contract holder was a PMS practice and, in the other, a GMS practice. Finally, two pilots were provided by independently contracted nurses who contracted on their own behalf with their local health authority and directly employed practice staff.

Four of the nine pilots contracted to provide PMS 'Plus' services (i.e. services that are beyond those provided as standard within a general practice). In three of these pilots, the 'Plus' element comprised community nursing services; in the other, child development and midwifery services.

### ***Pilot objectives***

Pilots were established with a wide range of individual objectives. However, a number of themes emerged across pilots. These included:

- serving vulnerable populations (five pilots)
- providing 'patient-focused' or 'user-friendly' services (four pilots)
- developing the clinical skills of team members and/or breaking down professional boundaries (four pilots)
- improving patient access to primary care (four pilots)
- community development and/or patient empowerment (four pilots)
- developing partnerships with other agencies, voluntary or community groups (two pilots).

### ***List size and team composition***

By December 2000 (two years and eight months after their intended start dates), the nine pilots displayed a wide range in the number of registered patients. List sizes ranged from 500 to 2600 patients, with a mean average of 1311 patients. Some of the pilots with particularly low list sizes were serving well-defined populations with particularly high needs (for example, pilots serving exclusively homeless populations). In other cases, pilots had experienced a rapid on-take of patients since their establishment and were serving populations of 2000 or more.

The composition of the clinical teams also varies widely among pilots. There is no clear pattern between list size and size of the clinical team. For example, the Appleton Primary Care Pilot and the Valley Park Surgery are both serving 1000 patients but have significantly different clinical teams. In some cases, the ratio of clinicians to patients might be considered quite high compared to 'traditional' general practice. An

‘average’ GP principal is likely to have a registered list of 1845 patients (or 1965 per whole time equivalent GP). Each principal will, on average, work with 0.4 of a ‘whole time equivalent’ practice nurse.<sup>29</sup> Nurse-led PMS pilots tend to have a significantly ‘richer’ primary health care team, both in terms of the doctor–nurse ratio and the total clinical resource. However, it should be noted that the population served by the nine nurse-led pilots may be significantly different to the average, and many are associated with significant deprivation and high health needs.

### **Box 2.1**

A day in the life of Teresa Kearney, Nurse Practitioner  
PMS nurse-led pilot for travellers and homeless families  
Acorns Surgery, Grays, Essex

‘Manning the surgery begins at 10 a.m., which is comparatively late but, for us, appropriate given our client group. This enables me to sort out post, answer telephone queries or to be able to fit in a meeting before surgery commences. There is currently a great deal of interest in the PMS model and I handle a good few enquiries by telephone from PCTs, mostly those that are about to go live (for PMS) on 1 April 2001.

Surgery, however, inevitably overruns, finishing between 1–2 hours behind schedule. This is largely due to patients presenting with multiple and complex needs. The fact that the patient population is transient motivates both myself and my GP colleague to cover as much as possible in one consultation. This would be anathema to most primary care providers, with patient consultation times allocated to them at 5 to 7 minute intervals.

For us, a consultation may last 50 minutes, especially if an interpreter is present. When surgery eventually finishes, it’s back to sorting out other presenting problems or queries that have arisen from various quarters, for example the trust or the PCG.

Lunch is usually eaten on the move or I miss it altogether; today it is while I travel to the local acute hospital. There I run a TB clinic in conjunction with one of the consultant chest physicians. This is a bi-monthly arrangement. I thought that it could improve the primary–secondary interface and at the same time raise the profile of the practice among secondary care colleagues. Another plus was the desire to provide continuity of care, as some patients would be referred to the acute hospital for screening. This has worked quite well, and those of my patients who do attend the clinic are both pleased and surprised to see a familiar face.

After this, I am off to a teenage strategy meeting. The last job of the day is to telephone the surgery to collect my messages and then I can look forward to home and the family.’