PRACTICE NURSING: A TIME OF CHANGE

A study of nursing in general practice

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I declare that the work reported in this thesis was composed and conducted by myself. None of the contents have been used in support of another degree or professional qualification.
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The view is offered within this thesis that nursing is essentially a practice-based discipline and therefore any theory of nursing must reflect what happens in practice. By analysing research material from a study of practice employed and attached nurses, the ways in which these nurses work was explored within the context of the primary health care team. Both delegated and more autonomous roles were examined, and the implications of these and their relationship with holistic care were described in view of the continued expansion of the role.

The objectives were: a) to examine the process of care and to identify any changes in workload, or differences in working patterns, of practice employed and attached nurses as a result of the introduction of the New GP Contract in April 1990; b) to measure patient satisfaction with nurse consultations and ascertain their views on the changing role of community nurses; and c) to determine the opinions and attitudes of practice nurses, community nurses and general practitioners, to future developments and educational opportunities for primary care nursing.

This was a before and after study of two sets of 15 half days of practice nurse workload, one year apart. Thirty four nurses participated in 1990 with a total of 6675 consultations; 33 nurses in 1991 with a total of 6050 consultations. The largest proportion of patients seen by both groups of nurses during both periods of recording was by general practitioner referral. Practice employed nurses initiated
more of their own appointments in the second year and saw fewer general practitioner referrals. This trend was reversed for attached nurses. By the second recording period both attached and practice employed nurses had experienced a reduction in the time spent on routine treatment room work and an increase in clinic activity. Practice employed nurses reported a higher level of therapeutic listening than the attached nurses both years.

In response to questionnaire surveys patients reported being very satisfied with consultations with practice nurses and, given the choice, said they would make an appointment to see the nurse again. They were in favour of practice nurses prescribing medicines and dressings for some conditions without having to see a doctor.

This study of practice nurses identified that there does not appear to be a single model of practice nursing, rather it is developing from being traditional and task-based, to being more expanded and innovative. Traditional and more innovative ways of working were linked to managerial and organisational factors and, to a certain extent, to feelings of membership within the primary health care team. Issues of medical control in relation to the number and nature of interruptions had implications for the management of nurse-patient consultations.

General practice, like any management system, constantly experiences change, but this is particularly evident at the present time. Practice nurses, as well as other members of the primary health care team, may feel inadequately prepared for the pace of these changes. General practitioners reported that they were willing to give practice employed nurses time off to attend courses and contribute to the costs. This however, was not the experience of the nurses themselves, many of
whom had to attend in their own time and costs were mainly self-financed or met from other sources. It appeared therefore, that general practitioners had a controlling influence over access to continuing education and training of practice employed nurses.

Practice nurse education should be reinforced with greater investment in courses for experienced practice nurses to become practice nurse trainers. General practitioner trainers bring their wealth of experience to vocational trainees in general practice. The experienced nurse should be able to offer the same expertise to new colleagues. Inter-professional training for all members of the primary health care team should be encouraged.

The changes in primary and community care services have made experimentation with expanded nursing roles more urgent. Essentially, the continuing professional development of practice nursing requires an understanding of the knowledge embedded in practice and a strong evidence base to justify accountability and the requirements for safe, autonomous practice. Practice nurses are a key resource, and education and training for the development of their role should be a priority in the new National Health Service.
PREFACE

Historical Background to the Development of the Thesis

In 1968 I was employed as a practice nurse in Mackenzie House, the general medical practice which is part of, but operates independently of, the Department of General Practice, Edinburgh University. The practice looks after approximately 5,500 patients who are drawn from the surrounding area, and I worked there in the capacity of practice nurse for fifteen years. During the early years of my employment there were comparatively few practice nurses, and the role was essentially one to be developed by the individual.

There is a significant history attached to the development of the Department of General Practice. In 1776 the building was founded as the Royal Dispensary and charitable treatment was provided within the premises. By the early 1940s, however, it was anticipated that demand for such services would diminish when patients could obtain treatment free of charge under the terms of the new National Health Service Act (1946).

At the onset of the health service, the vision for the establishment of a medical practice under the auspices of Edinburgh University was that of Richard Scott, a senior lecturer in public health and social medicine, later to become the first professor of general practice in the world. On 1st. July 1948 the medical practice opened its doors, working from the existing premises. The University supplied the
personnel, which consisted of Richard Scott as medical practitioner, one assistant medical practitioner, a medical social worker, a nurse, a dentist, and secretarial support. The practice itself was the site of one of the early approaches to teamwork and, in one of his descriptions of the work of the practice, Scott (1950) refers to the nurse in a way that we might describe a nurse practitioner today:

...the nurse, while having a special contribution to make, uses a skill that is essentially the same, except in degree, as that of the doctor.

(Scott 1950, p.6)

At the present time, in addition to its contribution to medical student teaching, the Department of General Practice also maintains teaching links with the Department of Nursing Studies and other departments within the University. Over the years, the Department has built up a strong research base in primary care.

**Developing the Research Questions**

In 1983, I joined the research team within the Department and the facility of working in a research and teaching environment encouraged me to focus my questions about nursing in general practice. Howie (1989) said that the first essential criterion of asking a good question is that it is important enough to be worth answering, and I decided that over the years I had developed some questions that deserved an answer. Furthermore, Hockey (1991) said that the purpose of research in nursing is to increase the sum of what is known about the professional activity of nurses.

Having considerable experience as a practice employed nurse, I was aware that other practice employed nurse colleagues, and nurses attached to treatment rooms by the Health Board, appeared to undertake a variety of different tasks and procedures. Some nurses were working in a very task-oriented way, and others
were more innovative and involved in an extended and expanded role. I became interested in trying to find out the level of delegation nurses encountered in general practice, and how autonomous they were in their working practices.

A significant proportion of the work of the practice nurse to date has involved referral of patients from the general practitioner, usually involving some form of diagnostic test or treatment procedure. This results in regular interruptions to the nurse-patient consultation and can be quite disruptive. The number and nature of these interruptions was a feature I wished to include in my study. In 1990, the advent of the New General Practitioner Contract (DoH 1989a) seemed a suitable opportunity to investigate some of these issues as well as looking at any changes that might take place as a result of its introduction.

The Research Proposal

In December 1989 a research proposal was submitted to the Health Services Research Committee (HSRC) of the Scottish Home and Health Department. The proposal was successful, with two caveats. Firstly, the Committee rejected one of the methods of the research. This was to categorise and measure the time that nurses take to carry out the different nursing activities in general practice. In particular, to examine the time spent on giving advice and health education, and on therapeutic listening and counselling. In order to undertake this, it was proposed that the researcher would sit in with the nurses on a sample of consultations, and record the times that different activities start and finish. A specifically tailored spreadsheet model would allow data to be entered directly onto a lap-top computer. The Committee were concerned about the consistency of interpretation of the interactions and therefore about the validation of results from
this phase. In addition, the Committee felt that this aim was not directly addressing change in that it was looking at how the nurses worked rather than the role they were fulfilling.

Secondly, the Committee considered that patients' views about the changing role of community nurses should be included. Originally the intention was only to assess patients' views of the changing role of practice nurses, but the specification was amended accordingly. The title of 'Practice Nurse Study' was adopted because it was considered to be a generic description of nurses working in the treatment rooms of general practice regardless of their employment status.

It is hoped that the thesis which evolved from this piece of research will make a contribution to the understanding of the development of practice nursing within primary care.
Although I have declared that the content of this thesis is my own work, I cannot in all honesty deny the contribution of others in the many and various ways that they have either helped, or allowed me the freedom to pursue this exercise. Undertaking a task of this complexity and rigour has proved to be both a challenge and an enlightenment as many before me will bear witness to in the various fields of academic endeavour.

I find that the number of people I have to thank and who have supported me throughout the time it took to complete this thesis quite daunting. Unfortunately, I do not have the space here to thank them all individually, but I hope that I have done so throughout the time that I have worked with them. If you are not mentioned by name in these acknowledgements and you have contributed in any way, you are not forgotten and I hope you will accept my grateful thanks.

There are obviously a number of people I would like to acknowledge in particular. I would like to thank Dr. Dorothy Whyte, Senior Lecturer in the Department of Nursing Studies, for her supervision. This encompassed guidance, encouragement and support, as well as tea and sympathy! Her ability to clarify the different theories of nursing greatly enhanced my understanding and provided many hours of interesting discussion. Her knowledge of relevant literature sources was always generously bestowed. Mike Porter, Senior Lecturer in the Department of General Practice was not only one of my supervisors, but also a colleague, with whom I
have worked for many years. His interest in, and enthusiasm for, the expanded role of nurses in general practice provided the catalyst that stimulated me to undertake the study on which this thesis is based. I thank him for his commitment to my subject-matter, his attention to detail and infinite knowledge about primary care, in the completion of this work.

The study on which this thesis is based was supported by funding from the Health Services Research Council, Scottish Home and Health Department. The thesis could not have proceeded without the support of my Head of Department, Professor John Howie, who allowed me the time and space to undertake the study. Dr. Sally Wyke, Director of Research, guided my progress and was a continual source of encouragement. I am also grateful to other colleagues in the Department of General Practice for their support and friendship, particularly that of fellow Ph.D. students Guro Huby, Jane Hopton and Margaret Maxwell. I also acknowledge the help and computer support of Colin Pryde (Computing Support Manager) who helped me to use the appropriate computer packages to present my data. My particular thanks go to David Heaney, a fellow researcher, who supported the burden of other shared research work in progress and which accordingly, allowed me to pursue this thesis. For this sacrifice, my gratitude. The layout and presentation of this thesis was the work of my dear friend and colleague, Maeve Power, to whom I can only say 'thank you'.

I would also like to thank the nurses and other health professionals who participated in the study, and the patients who took the time to complete questionnaires.
Finally, I face the almost impossible task of thanking my family for their tolerance and loving support. My daughter, Carrie, has taken a lively interest in the progress of this thesis and has asked some stimulating and thought provoking questions about its content, which I have been obliged to address. My husband, Ian, has always been a source of encouragement, and his enduring patience with this undertaking and his firm advocacy in my ability, have greatly influenced the completion of this thesis.
Chapter One

SETTING THE SCENE: AN INTRODUCTION TO A STUDY OF PRACTICE NURSES

'Where shall I begin, please your Majesty?' he asked. 'Begin at the beginning,' the King said, gravely, 'and go on till you come to the end; then stop.'

Alice in Wonderland, Chapter 11. (Lewis Carroll)

This chapter endeavours to set the scene for what is to follow, and it is hoped that the story which unfolds goes some way toward clarifying and informing the work of nurses in this flourishing area of health care.

In the past few decades, and particularly in the last five years, there has been a rapid increase in the number of practice nurses working as members of the primary health care team. The aims of this thesis were to examine the issues surrounding the evolution and development of practice nursing, and to explore the nature of the role and how it is changing. The nature of innovation and change however are such that, being a continuum, any pursuit of them is constrained by their unpredictability and reflexivity. In addition, as the practice nurse does not work in isolation, the development of the role is examined in the context of the primary health care team.

In the second chapter a review of the literature on practice nursing includes an account of the origins and development of practice nursing from the beginning of
the twentieth century. Practice nurses can be employed by either a general practitioner or by a Health Board (in Scotland) or a Health Authority (in England and Wales), and the nature of the employment of the nurse is discussed in terms of the introduction of attachment schemes and health centre practice. Over the years, various Acts of Parliament and other significant events relevant to community nursing and primary care have taken place, and a number of these will be discussed in the content of the chapter. The introduction of the New GP Contract in 1990 (DoH 1989a) resulted in the largest number of nurses to be employed in general practice to date, and the reasons for this will be examined. The work of the nurse in general practice and the expansion of the practice nurse role is considered in the context of a growing literature on the subject.

The third chapter, although exploring the relationship between theory, practice and research in relation to practice nursing, also encompasses nursing as a whole. The development of nursing knowledge and the transition from the more traditional practice-based methods of training and education when nurses were part of the workforce, to the present theoretically based teaching methods where nurses have the status of students, is discussed. The place of models and theories as applied to practice nursing are considered, as are the themes of reflection, perceptive awareness and listening, among others.

In chapter four, the Practice Nurse Study is introduced. An explanation of the aims, design and methods of conducting the study are given, and a short supplement to the Methods is included. This supplement concerns fieldwork, and attempts to put into context some of the discussion that follows, by recounting informal interactions with the nurses who participated in the study.
Chapter five presents the results and an interpretation of the data contained in the practice nurse workload part of the Practice Nurse Study. The workload of practice employed and attached nurses is compared and contrasted before, and twelve months after, the introduction of the New GP Contract. A discussion of the findings from the fieldwork data are included.

In chapter six the workload and working patterns of practice nurses are complemented by the perceptions of patients in the participating practices. These are obtained from the results and a discussion of the findings from two questionnaires. The first attempted to measure patient satisfaction with consultations with practice nurses, and the second to assess patients' views of the changing role of community nurses. Patient opinion is then compared and contrasted with the findings from the workload part of the study.

Chapter seven contains an account of practice nurses', community nurses' and general practitioners' views about the introduction of the New GP Contract and how it affected them, as well as their perceptions of future developments in primary care nursing. These views were obtained as a result of a questionnaire administered to all practice nurses, health visitors, district nurses and general practitioners in participating practices in the study. The questionnaire included practice nurses who did not participate in the workload part of the study.

In chapter eight an attempt is made to draw together all the themes that have permeated this thesis, and to examine the future role of practice nursing within primary care. Primary Care: The Future (DoH 1996a; 1996b) emphasises the importance of team working, education, training and research for all health care professionals. It also suggests that nurses in primary care, among others, have
scope to take on wider roles. As the public become more proactive about their health, the place for nurse-led services becomes more of a possibility, particularly when accompanied with the ability to prescribe. Christine Hancock describes the new primary care specialist nurse as ‘Supernurse’ (Hancock 1996). What must not be lost in all this excitement about the future of primary care nursing however, is the importance of the basic element of nursing, one of ‘caring’. This, and other issues are considered in the final chapter.
Chapter Two

THE DEVELOPMENT OF PRACTICE NURSING: A LITERATURE REVIEW

Her duties were varied. She would assist Dr. Grant in the surgery - helping with dressings and even doing dispensing from stock bottles. She lived in the practice house with the Grant family and her bedroom window overlooked the front door so that when the bell rang she could take any messages. Evidently she used to vet these night calls and if she could deal with them she went to see them herself.

W Brown's personal communication about Nurse Mary Hannah Robson (in Stilwell 1995, p. 129-130). This is the first confirmed record of an employed practice nurse. In 1913 she joined a Dr. Grant’s practice in Easington Colliery in North East England.

Introduction

In this review of the literature on practice nursing the intention is to examine the development of the role in the context of some of the events that have taken place from the time of the first descriptions of practice nurses early this century up to the present time, and to examine relevant research undertaken. Some of these events, and the studies surrounding them, involve nurses attached to the treatment rooms of general practice and others relate to the work of practice employed nurses. No examination of the practice nurse role would be complete however, without consideration of such issues as autonomy and accountability, and this subject matter, in turn, would not be complete without reference to education and training.
Practice nursing cannot therefore, be considered in isolation, but rather in the context of the primary health care team and of nursing as a whole. During the time that this thesis has been written, comprehensive changes have taken place within primary care with a concomitant effect on the employment of practice nurses and the role that they play within the team. The on-going changes are designed to improve and expand the services offered to patients, and practice nurses are very much at the forefront of the provision of some of these services. For all of these reasons, the literature review within this chapter has been revisited from time to time to provide updated information on some of the changes that have taken place.

Towards a Definition of Practice Nursing

The term 'practice nurse' can apply to a nurse employed either directly by a general medical practitioner or employed by a Health Board (Scotland) or a Health Authority (in England and Wales), and attached to a general medical practice. The work of the practice nurse is still relatively undefined, and other terms such as 'treatment room nurse' add to the confusion about the nature of the role and the professional qualifications held by these nurses. Nurses employed by general practitioners are usually called 'practice nurses', and attached nurses are also referred to as either 'practice nurses' or more commonly as 'treatment room nurses'.

Originally, attached nurses working in the treatment rooms of general practice held a district nursing qualification and worked in close association with a practice, visiting patients at home, doing some sessions in the treatment room attending to more mobile patients, and seeing patients referred to them by the
general practitioner while working in the surgery. In addition to this group of nurses there are, at the present time, attached nurses who have not always completed district nurse training, but are registered nurses employed by the Health Board or Health Authority solely to work in the treatment rooms of general practice. Occasionally, practice employed and attached nurses work alongside each other in the surgery or health centre.

Nurses working in the treatment rooms of general practice hold a wide range of professional qualifications, from second level enrolled nurses at one end of the scale to first level nurses with degrees, midwifery, district nursing and health visiting qualifications at the other. At present, there are no formal entry qualifications to work as a nurse in general practice because a post-basic community nursing qualification to practice in this area of health care is not required. Variation in role ranges from the performance of limited, delegated tasks to what is variously described as an 'extended' or 'expanded' role, with a high degree of autonomy (Reedy 1972; Bowling 1981; Tudor Hart 1985; Greenfield et al. 1987; Bowling 1988a; Fowler et al. 1988; Cater and Hawthorn 1988; Sheppard 1992; Robinson et al. 1993; Atkin et al. 1993; Ross et al. 1994).

For the purpose of this thesis, and to avoid confusion, nurses in both employment categories working in the treatment rooms of general practice will be referred to generically as practice nurses. When referring exclusively to nurses employed by general practitioners, or to nurses employed by the Health Board as attached nurses, this will be specifically stated. In addition, as a matter of convention, the personal pronoun 'she' will be used when referring to practice nurses.
A number of definitions and descriptions of practice nursing exist. In the revision of the Statement of Fees and Allowances for general practitioners that followed the introduction of the New GP Contract there contained for the first time a definition of the practice nurse:

* A practice nurse should hold an appropriate qualification which is registered or recorded on the effective part of the Professional Register maintained by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC). This will normally be Registered General Nurse. Where activities are undertaken for which a specific qualification is required, for instance health visiting, midwifery or district nursing, the person will be expected to hold the appropriate qualification of Registered Health Visitor, Registered Midwife or a recordable qualification in District Nursing. In addition, the Registered Midwife must be a practising midwife as defined in the UKCC Midwives Rules. Where the practice nurse holds the qualification of Enrolled Nurse (General) only, and is registered on Parts 2 or 7 of the UKCC Professional register, then he or she may only undertake a limited range of duties, having due regard to the skills of enrolled nurses contained within the nurse training rules of the UKCC.

(DoH 1990a, par. 52.23)

From another perspective, the Royal College of Nursing (RCN) in its Standards of Care for Practice Nursing (RCN 1991) publication described the ‘philosophy’ of practice nursing as applied to practice employed nurses. The emphasis on quality of care is supported by an, albeit rather vague, statement:

* The practice nurse works within general practice, improving the quality of primary health care in the setting of the health centre or surgery. She provides general nursing services with an emphasis on health promotion and preventive care. The practice nurse is accessible to the practice population, offering a variety of care within a flexible framework. Her direct employment by a general medical practitioner - not a health authority - results in a stable relationship in the practice team and the nurse can make the nursing needs of the patient known to her colleagues.

(RCN 1991, pp. 1-2)

It is interesting that there is an emphasis on the importance of the nurse being an employee of the general practitioner, and a judgement that this provides stability within the team. It is suggested that practice employed nurses are ideally placed to
provide the communication link between patients, general practitioners and other nursing colleagues. While there is some merit in this because they are practice-based, it does not address the importance of the relationship between general practitioners and community nurses, who require an established communication network to deal with day-to-day issues that may arise.

Further, within the publication, the term ‘general’ nursing services is rather unspecific and, it could be argued that flexibility of role and function may not always be an advantage if the nurse is an employee of the general practitioner. This argument was raised a decade ago by Hockey (1984), at the same time as the Report on the Training Needs of Practice Nurses (RCN 1984) expressed concern about the tenuous connection between practice employed nurses and the National Health Service. The RCN were anxious that this form of employment might limit access to the range of educational opportunities that were available to National Health Service employed nurses. Finally, with regards to the Standards of Care for Practice Nursing publication, the authors who formed the Working Group consisted of practice employed nurses and representatives of the RCN, and their observations obviously reflected their respective positions.

The Use of Terminology in Describing Roles

Throughout this review of the literature on practice nursing it appears that the levels of representation of several words, and the meanings that are ascribed to them, are quite different. This will be examined further, but attention is drawn here to several incidences of use that are of particular relevance.
The terms ‘extended’ and ‘expanded’ roles appear to be used interchangeably, and sometimes confusingly, by the authors of studies. In addition, the content of policy documents can add to the confusion (RCN 1979; UKCC 1992a; 1992b). The following extract is from the RCN publication on ‘The Extended Clinical Role of the Nurse’:

It is accepted that there are many reasons why the nurse might wish to extend her role; there is a need to identify which of these are valid in the interests of the patient, the service and the professions concerned, and in encouraging expansion where appropriate, to define the essential controls and related ethical and legal implications.

(RCN 1979, para. b.10)

Several authors have drawn attention to this dilemma in the use of terminology, including MacGuire (1980), Hunt and Wainwright, (1994), Wright (1995). They suggest that an extended role is one in which a nursing qualification is not necessarily a pre-requisite, and is one which involves tasks not included in normal training for registration. These tasks are essentially medical and are usually carried out by doctors, such as setting up intravenous infusions. Expanded roles on the other hand, are those that require a nursing qualification, but are concerned with nursing as a therapeutic activity in its own right.

Similarly, the term ‘traditional’ role is described in a number of sometimes separate, and sometimes overlapping, ways. On occasions it is associated with the performance of so-called, simple, nursing tasks involving physical attention, such as bathing or doing dressings, although the caring aspect of the role is mentioned in this context by some authors. It can also be confused with the extended role because of the emphasis on some of the more basic ‘technical’ tasks, such as venepuncture, but usually applies to work delegated by the doctor. Technical tasks

1 Emphasis added.
2 Emphasis added.
are also attributed to nurses working in a more expanded manner, but who have greater independence and autonomy in the way they work. Nurses working in this way are sometimes referred to as advanced practice nurses or nurse practitioners, and their work will be discussed later in this chapter.

The Origins of Practice Nursing

Reports of nurses working in general practice date from as early as 1911 (Baly 1973; RCN 1991), but prior to 1948 nurses were only occasionally employed by doctors and in a very fragmented way. Most general practitioners were in single handed practice and the nursing role was often secondary to that of receptionist. In fact, many of the early nurses in the general practice setting were doctors' wives (Kuenssberg 1991). Nurses who were employed by the doctor had to answer the telephone, give appointments and perform administrative duties delegated by the doctor.

The precedence for a delegated role was based on the division of labour between the sexes, and was a replication of the Victorian class structure within the hospital setting (Abel-Smith 1960). As medical science advanced, diagnosis and cure were seen as primarily male activities, whereas the process of care was a female, and subordinate, function. Traditionally, nurses were entrusted by doctors with clinical tasks and control of the patient's immediate surroundings as their principal contributions in the cure process (Dingwall et al. 1988). Carpenter (1977) observed that the process of 'cure' was separate from, and superior to, that of 'care'. Delegation and low status are features of nursing in general, but are particularly relevant to practice nurses in their employment by general practitioners. Much of the research undertaken into the work of practice nurses
has been by doctors and, as this literature review will show, there is frequent reference to general practitioners expressing the need to be the ‘lead’ health professional in primary care and to maintain control over the practice nurse.

Bevis (1982) considered that there have been four eras in nursing and that they are still present in nursing today. The nineteenth century was one of asceticism, where nurses were selfless, devoted to hard work and concerned for the spiritual health of their patients. The early twentieth century is described as the more ‘romantic’ era, with the nurse being hand-maiden to the doctor. This in turn, gave way to the post National Health Service era of ‘task orientation’ where the patient became a number in a bed. Bevis considered that from the 1960s a more humanistic approach developed where the patient became central to the planning of care.

Although Bevis describes the nineteenth century in laudable terms, there is no doubt that some of the care provided at the time was less than adequate, particularly in the workhouses (Dingwall et al. 1988). The romantic era of the early twentieth century perhaps refers to images of Florence Nightingale with her lamp, but it is questionable whether present day nurses, or Florence Nightingale herself, would accept as romantic the idea of being a ‘hand maiden’ to the doctor, rather than a partner in the delivery of health care. It is also debatable whether, in the cost conscious 1990s with its economic constraints (Taylor 1991), patients are still central to the planning of care.

Early accounts of the work of the practice nurse describe it as being part-time, requiring no previous experience and rarely being accompanied by a job description or contract of employment. There was no formal education or training
for the role and little regard was given to job satisfaction (Hunt and Wainwright 1994; Stilwell 1995). This state of affairs persists for some nurses employed by general practitioners at the present time (Atkin et al. 1993, McBeath 1994). For some time it has been suggested that, not only do general practitioners misunderstand the role of practice employed nurses and have little idea of their training requirements, but also that they pressurise them into doing work for which they are not trained (Hockey 1984; Clark 1987; Sheppard 1992; Ross et al. 1994).

The nursing work force in general practice is still predominantly female and 98% of nurses working in primary health care are women (DoH 1991). This is a higher percentage than in general nursing where 90% of the work force is female (Beardshaw and Robinson 1990). Nursing is still regarded as a woman's job and this is enhanced by the media portrayal of nurses as angels of mercy. Florence Nightingale's belief in a clean and healthy environment for the sick is still emphasised in the semi-domestic tasks associated with nursing, and these links with domestic labour have been blamed for nursing being held in low esteem (Salvage 1985).

More male nurses specialise in psychiatric and mental handicap nursing (DoH 1991) where they are still sometimes visualised in a more assertive, masculine role as guardians or attendants. Men tend to move into the areas of management and education and away from basic nursing, and the concentration of men increases in senior nursing posts, where the ratio is one to one in contrast to the average ratio of one man to 8.5 women (Salvage 1985). The lack of a career structure for nurses working in general practice and the part-time nature of the employment
may be a reason why there are particularly few men in this area of nursing at the present time.

Education and training have not been such a problem for health visitors and district nurses. Training requirements have existed for health visitors on a national basis since 1925, with the appointment of the Royal Sanitary Institute as the statutory training and examining body (Baker et al. 1987; Buttigieg 1995). In 1962, the education of health visitors was further expanded with the setting up of the body which later became the Council for the Education and Training of Health Visitors (CETHV). The CETHV was instrumental in moving all health visiting courses into higher education but, in 1982, the Council ceased to exist when it was absorbed into the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

Prior to 1981 it was possible to work as a district nurse without a post basic qualification, although by that time 80% of those practising as district nurses held the National Certificate in District Nursing (Baker et al. 1987). In 1981, mandatory training based on a new, extended course approved by the Panel of Assessors for District Nurse Training was introduced. The formal training in community nursing and health promotion undertaken by district nurses and health visitors has not been a requirement of nurses employed by general practitioners.
An Outline of Some Key Events in the Evolution of Primary Care and Community Nursing

In order to follow the development of practice nursing within the framework of primary care as a whole, an outline of some of the significant statements, documents and events that are discussed in this chapter, and which took place between the introduction of the National Health Service and the New GP Contract in 1990, are summarised in the table below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
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<tr>
<td>1946</td>
<td>National Health Service Act (effective 5 July 1948).</td>
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<tr>
<td>1952</td>
<td>College of General Practitioners established (subsequently Royal in 1967).</td>
</tr>
<tr>
<td>1965</td>
<td>The British Medical Association's Charter for the Family Doctor Service.</td>
</tr>
<tr>
<td>1966</td>
<td>Ministry of Health and Scottish Home and Health Department. Report of the Committee on Senior Nursing Staff Structure. (The Salmon Committee).</td>
</tr>
<tr>
<td>1980</td>
<td>United Kingdom Central Council (UKCC) set up. Became effective 1 July 1983.</td>
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The Development of the Primary Health Care Team

In the Preface to this thesis the contribution to early research in general practice made by Professor Richard Scott and his primary health care team in the Department of General Practice, University of Edinburgh, was touched upon. Between 1956 and 1957, over a twelve month period, a study was undertaken in the University practice to examine the nature of the roles of general practitioners, nurses and social workers (Scott et al 1960; Cartwright and Scott 1961). The study involved four general practitioners, two social workers and two nurses, all University employees.

In the course of the study year, from a list size of approximately 5000 registered NHS patients, each nurse had between 12 and 16 consultations per working day, and an average of one and a half consultations per year for each registered patient. During that time the nurses initiated 55% of their own consultations, 24% were referred directly from the doctor and 11% were patient initiated. Doctors were involved in only 40% of the nurses’ consultations. At 48% of consultations the nurses undertook dressings or therapeutic injections, and 41% of consultations involved giving advice on diet, nutrition and exercise.

Another feature of consultations was therapeutic listening. Scott et al. (1960) considered therapeutic listening as a form of therapy which could be undertaken by health care professionals. It was first described when referring to doctors’ consultations, and they reported that, on occasions when this was involved:

> the doctor eschewed exhortation, the giving of gratuitous advice, and the two-way discussion, becoming in his attempt to “comfort always” a passive agent who merely listened.

(pp. 12-13)
The activities of the nurses also included listening to what is described as the ‘doubts and dilemmas’ and ‘fears and frustrations’ of patients. This ‘therapeutic listening’ accounted for 22% of all consultations. The concept of therapeutic listening features throughout the content of subsequent chapters.

Results from the study revealed a relatively high consultation rate (6.6 per patient per year) and a low prescribing rate for the doctors. It was reported that much of the doctor’s therapeutic effort was concerned with giving advice and discussing disease management. Other issues included the provision of information on the availability of social and medical services, and on economic and personal relationship factors. The authors suggested that access to the services of a nurse and a social worker might be a factor in bringing nursing and social components of problems to the doctor’s attention, thereby preventing under-diagnosis and inadequate treatment. The emphasis here on the more holistic elements of patient care drew attention to the contribution nurses could make by listening to, and having informal conversations with, patients. These conversations it was suggested, could inform the doctor of important aspects of the patient’s personal environment which might reflect on their health and well-being.

It was also suggested more than 30 years ago (Crombie and Cross 1958; Cartwright and Scott 1961) that the employment of a practice nurse was instrumental in extending the range of care given to patients. Cartwright and Scott reported that ‘their’ nurse had assisted in clinical examination in 41% of consultations in their practice, although most related to maternity and child welfare in the antenatal clinic. The ‘extended’ aspects of the nurse’s work so described, in this context appeared to contain a mix of clinical expertise and the more holistic elements of an expanded role.
Throughout the 1950s there was a greater movement towards the introduction of primary health care teams within general practice, but many doctors were working in inadequate premises and any money spent on improvements to buildings or in the employment of staff meant a reduction in their income. There was an alternative to the employment of nursing staff and that was the introduction of attachment schemes.

**The Growth of Attachment Schemes**

In 1952 The College of General Practitioners was formed to give recognition to general practice as a meaningful clinical discipline, and also to reinforce the autonomy and independence of general practice. It attracted some doctors who had foresight into the potential of teamwork and this paved the way for the attachment of local authority nursing staff in the form of health visitors and district nurses (Bowling, 1981). The first experimental 'attachment' schemes were set up in the late 1950s in Oxford and Hampshire, with the attachment of health visitors to selected general practitioners (Swift and MacDougall 1964; Warin 1968). These experimental schemes worked well, but were only tentatively accepted and not introduced generally.


During the 1960s there were fears among general practitioners that the generalist nature of their work would make them redundant with the increasing specialisation of medical care, and morale was low (Cartwright and Anderson 1981). Further encouragement towards group practice was required. In 1963,
the Gillie Report (Central Health Services Council 1963) recommended group practice as the way forward in developing primary health care teams, and the Report also suggested that nursing staff in the form of midwives, district nurses and health visitors, employed by the Health Authority, should be attached to general practices. The rationale behind this approach was to change the traditional commitment of nurses to patients within geographical areas and make them responsible for patients on the medical list of one, or a group of, general practitioners. The proposals contained within the Gillie Report were endorsed by the Royal College of Nursing and the Royal College of General Practitioners, but attachment was slow to develop.

The Medical Advisory Committee in their report on ‘The Future Scope of General Practice’ (BMJ 1963a) supported the recommendations of Gillie, and stressed the importance of local authority attachment and of daily meetings. It is interesting however, that they thought it improbable that health centres would develop as once was envisaged. A supporting Leader in the British Medical Journal at the time the Gillie Report was published, also considered it important that in the future, general practice should include attached staff as part of the primary health care team. It was stressed however, that the family doctor should be clinical leader of the domiciliary team (BMJ 1963b). This emphasis by doctors on the importance of retaining control, and which had particular relevance for nurses, was to be a feature which would continue throughout the years.

Surveys carried out during the 1960s (RCGP 1965; Hockey 1966) reported that general practitioners did not wish to have health visitors and district nurses attached, mainly because they did not know what their qualifications meant, were ignorant of the assistance they could give and only a minority of doctors were
concerned about prevention. The potential of nursing within the general practice setting was still largely unrecognised because, as Hasler (1992) observes:

*General practitioners saw their role as reactive and their potential role in prevention of disease had not yet dawned on most of them.*

(p.232)

It is noteworthy that the introduction of the New GP Contract thirty years later, with its changes in the terms and conditions of service and the accompanying monetary incentives, would encourage doctors to improve health promotion services for their patients. This did not necessarily mean that doctors would change their attitude to prevention, but the New GP Contract was to provide an opportunity for nurses to contribute to such a service.

*Charter for The Family Doctor Service (1965)*

The British Medical Association's Charter for the Family Doctor Service (BMJ 1965), included in its proposals the availability of long-term loans to general practitioners for building and improving surgery premises. In addition, the changes in the doctors' terms of service approved reimbursement for 70% of employed staff members' salaries including practice nurses, and allowed general practitioners the freedom to delegate work to nursing and other non-professional staff in their employment. The medical profession maintained that payment by the capitation system resulted in an inferior service, and it took the financial incentives offered in 1965 to provide a more realistic setting for the employment and attachment of nursing staff so that a team approach could start to develop. It would seem however, that the move towards primary care reflected an emerging concern with prevention and health, rather than with disease.
Sanctuary et al. (1965) agreed that nurses should be attached to practices, but be financially supported by the Health Authority, and that they should be under the 'direct control' of the general practitioner. There was no explanation of this statement, but the authors supported the view that nurses should work within the geographical area of the practice rather than that of the Health Authority, and the system should be extended to include midwifery and health visiting. The authors also maintained that this would help to integrate the general practice and public health services.

*The Health Service and Public Health Act (1968)*

Closer working relationships between general practitioners and nurses were increasingly encouraged with the implementation of The Health Service and Public Health Act (1968), which was an attempt to develop the concept of the health team. This enabled Health Authority employed nurses (in England and Wales) and Health Board employed nurses (in Scotland) to work from doctors' surgeries and clinics as well as in patients' homes. The Act also empowered Health Authorities and Health Boards to negotiate cross-boundary visiting with neighbouring authorities. After this, general practitioners could both get partial reimbursement of salaries for employed staff, and have attached staff working in their practices. The numbers of nurses working in general practice began to increase.

*The Doctors' Dilemma: Attached or Practice Employed Nurses?*

A growing awareness developed among doctors of the value of delegation of many of the routine tasks which they did themselves, such as dressings and giving injections. With the spread of attachment schemes, it seemed at first that district nurses would be the obvious provider of care in the treatment room, because they
were there at no cost to the general practitioner (Baker et al. 1987). General practitioners reported however, that district nurses were unable to spend sufficient time within the practice setting and complained that the range of their activities was more limited than that of nurses employed by the doctors themselves. Reedy et al. (1976), reported that during the 1970s there were significant differences in attachment rates between regions, partly because of the limits within which district nurses and health visitors had to operate.

Several authors throughout the years have studied the work of district nurses who spend part of their time in the practice, and nurses exclusively attached to treatment rooms, and similar findings have been reported (McIntosh 1979; Cartwright and Anderson 1981; Bowling 1981; Cater and Hawthorn 1988). It was found that attached nurses undertook fewer ‘technical’ procedures such as venepunctures, than their practice employed colleagues, and were more likely to perform ‘traditional’ tasks such as dressings. This will be discussed further in the section on ‘attached nurses’.

General practitioners wanted flexibility of practice and reacted to these constraints by employing their own nurses (Hockey 1984; Baker et al. 1987; Hasler 1992), and practice employed nurses became more numerous as time went on. Several authors have reported on levels of attachment in the 1960s and 1970s, usually quoting figures that included all community nurses. For example, Anderson et al. (1970) reported that between 1968 and 1969 the proportion of attached nurses had risen from 11% to 24%. By 1973, it was reported (Hicks 1976) that about 75% of community nurses in the National Health Service (NHS) were attached to general practitioners. Ruthven (1976) conducted a survey of attachment in
Scotland prior to the NHS reorganisation of 1974, and it was estimated that 64% of general practitioners were working with attached nurses.

Other figures relate to attached nurses who worked in treatment rooms, and include practice employed nurses. Cartwright and Anderson (1981) reported that the proportion of doctors who had an attached or practice employed nurse working in the treatment room increased from 12% in 1964 to 84% in 1977. By 1977, they reported that 27% of single-handed general practitioners had an employed or attached nurse. In practices of four or more doctors, 71% had an attached nurse and 56% had an employed nurse.

By 1975, it was estimated that there were 650 (WTE) practice employed nurses in England (DHSS 1975). Comparable figures for Scotland at that time have not been found because, at that time, practice nurses were included in the statistics of practice staff employed by general practitioners. Nevertheless, it can be seen that at this time practice employment was less common than that of attachment. It is worth returning briefly to the 1974 NHS reorganisation at this point to examine its relevance to general practice at the time.

*The 1974 NHS Reorganisation*

In England and Wales, as a result of the 1974 reorganisation of the Health Service (National Health Service Reorganisation Act 1973), general practitioners came under Family Practitioner Committees, whereas in Scotland they were managed by Area Health Boards. The general practitioners nevertheless, maintained their right to be self-employed practitioners under contract to provide services to the NHS. A Leader in the British Medical Journal at the time (BMJ 1974a) stated that general
practitioners, continuing as independent contractors, 'may be relatively unaffected by the reorganisation' (p. 587). Although the 1974 reorganisation was intended to facilitate a sharing of knowledge and skills in a division of labour, general practitioners continued to question the leadership and management of teams (Allsop 1992).

In consideration of the Reorganisation and as a result of an initiative by the RCN, a joint working party was set up by the councils of the RCN and the Royal College of General Practitioners. In their report about nursing in general practice in the reorganised NHS, they suggested that a description of the activity or source of employment of the nurse should be used. The term 'practice nurse' for example, should be abandoned in favour of 'general practitioner-employed nurse'. Other descriptions of nurses working in primary care included 'treatment room nurse', 'home nurse' and 'area health-authority employed nurse'. Interestingly, the Working Party also suggested that job descriptions for nurses employed in general practice should give equal emphasis to nursing activities in the home as well as in the treatment room (JRCGP 1975).

The Working Party stressed the importance of nurses working in general practice being able to recognise 'serious psychiatric morbidity and emotional disturbances' and that they should know how to deal with these problems. Although the Working Party suggested that the nurse must be able to rely on support from other members of the team in these cases, they did not elaborate on the education and training for this component of the role. They mentioned in general terms the need for specialised post-basic training, but did not go into detail.
The 1974 reorganisation amalgamated the management of hospital and community services, and this was significant in terms of the autonomy and professional relationships of community nurses within the primary health care team (Baker et al. 1987). For example, nursing officers, who were sometimes without a community nursing qualification, had management and supervisory responsibilities for attached nursing staff without actual day-to-day involvement in the activities of the team. This resulted in breakdowns in communication and a degree of conflict.

As Allsop (1992) observes:

*Nursing and other staff and doctors tended to operate in different social, professional and organisational worlds, so there were difficulties in establishing efficient ways of working.*

(p. 70)

The political climate of the time included general disruption among those working in the NHS following the reorganisation, and was accompanied by various industrial disputes. In respect of nurses, this resulted in action through the Royal College of Nursing. In May 1974, a 21 day ultimatum was given to the then, Secretary of State for Social Services, Mrs. Barbara Castle. The RCN cited low pay, shortage of staff, lack of education opportunities and poor standards of care, and demanded action from the government, otherwise the College would advise its 100,000 members to resign (BMJ 1974b). As a result, an independent enquiry was set up to examine nurses' pay (Halsbury Report 1974). Although ultimately eroded, this resulted in the award of substantial increases to most grades and improvements in holiday entitlement.

In response to the anxieties in the NHS from the time of reorganisation, a Royal Commission was set up (Royal Commission on the National Health Service 1979),
and the work of the Commission in relation to nursing in the community deserves brief mention here.

The Royal Commission on the NHS

The Commission's overall approach was that, in the long run, better patient care could be achieved if all staff worked together in equanimity. Among the issues addressed, the Report drew attention to the shortage of nurses in the community, and the possible conflict of loyalties that attached district nurses and health visitors might feel between the primary care team and their nurse managers. Furthermore, the Commission suggested that consideration should be given to extending the role of nurses in the community. It was suggested that nurses could act as first point of contact, particularly for children and elderly patients, both in the treatment room and in the home, as well as undertaking more health education and screening. Further research was recommended into the workload of practice employed and attached nurses in the treatment room, as well as the role of the district nurses concerning domiciliary and practice-based care.

Up to this point, the origins of practice nursing have been touched upon, and descriptions given of the different methods of employment of nurses working in the treatment rooms of general practice. The higher percentage of women working in primary health care than in general nursing has also been noted. In addition, unlike health visitors and district nurses, practice employed nurses have not required formal training in community nursing and health promotion.

Any further exploration of the concept of the primary health care team cannot proceed without consideration of the development of health centre practice. In
order to do so, we have to step back in time to the 1950s, when a closer working alliance between general practitioners, nurses and other professionals was increasingly encouraged.

The Move Towards Health Centre Practice

One of the consequences of the implementation of the Charter for the Family Doctor Service (BMJ 1965) was to encourage doctors to move from single-handed practice to work in health centres or similar premises where suitable facilities could be provided. The concept of multi-disciplinary teamwork and purpose built premises for primary health care had been in existence for many years (Dawson Report MoH 1920; National Health Service Act 1946). In fact, in its conclusions the Dawson Report had suggested that:

A health centre will serve its community well, if it is conceived in the right spirit, put up in the right place and organised on the right lines.

The Report had the vision to recognise the value of formal and informal communication between primary health care professionals. Nevertheless, at the present time there are still indications that bringing community nurses and general practitioners together does not always promote teamwork (Cubbin et al. 1990; Robinson et al. 1993; Wiles and Robison 1994). In these articles the authors suggest that common aims are an important facet of teamwork, but they do not address whose aims are being represented. If the aims are primarily those of the general practitioner, then communication between attached nurses and general practitioners may suffer because, as employees of the Health Authority, nurses feel themselves drawn in two directions.
The vision for health centre practice in the 1950s was not a new one. In 1935, the Pioneer Health Centre, the first health centre in Britain, was set up as an experiment in Peckham in London, to investigate the nature of health (Pearse 1970). This experiment attempted to survey members of the general public not under medical care. The centre was built as a family club to provide leisure facilities for 2,000 families within an area chosen as more likely to house a healthy section of the population. Families were required to pay a weekly subscription and agree to an annual overhaul of everyone in the family.

By 1943, 1000 families (3911 individuals) had been examined, and only 10% were found to be without any clinically discernible disorders. This raised concerns about the creation of dependence and neurosis in the population, but health education offered in family consultations and exposure to social interaction at the centre, were reported by individuals to have improved their lifestyle. In 1950 the centre closed for lack of funds. The experiment had proved very costly in a time before and after the Second World War when spare money was not available for leisure because wages were low. The expectations of the National Health Service to improve the nation’s health made continuation of the experiment no longer viable. Pearse (1970) considered these expectations to have proved inadequate, and reflecting on ‘health’ commented:

It is not a state; not the absence of disease or disorder. It is a process. In the course of our investigation, we have come to define it as “mutual synthesis of organism and environment.” This definition implies that in health, action is mutually invoked by organism and environment, and emerges in the creative diversification of each.

(p. 151)

Sporadically, throughout the 1950s health centres continued to develop. In Scotland the first health centres were built at Sighthill in the West of Edinburgh, and in Stranraer, a small market town and seaport in the south-west in the region
of Dumfries and Galloway. The Stranraer Health Centre contained four two-man practices, and one single handed practice with a part-time assistant. Nursing support consisted of two attached health visitors and two district nurses. There is no reference to the contribution of the nursing staff within the centre, apart from the number of attendances at the dressings rooms which increased by approximately 3,000 in 12 years (Anon 1968).

Sighthill Health Centre opened in 1953 and housed nine general practitioners, in two partnerships of three, and two single-handed doctors (Dean 1972a, 1972b). By 1959, six health visitors were based in the centre. In the early years district nurses were reported as being available to do dressings in the treatment room during consulting sessions, but by 1969 the treatment room was operating a three shift system from 9 a.m. until 8 p.m. The number of nurses is not recorded. The ideology supporting the setting up of Sighthill Health Centre in Edinburgh is included in comments from the Health Centre's first annual report, which would appear to encompass the vision behind the recommendations of the Dawson Report:

The idea behind the health centre is to bring the different health services closer together, and enable them to co-operate to the advantage of the patient in the common aim of promoting health and preventing as well as curing disease.  
(Dean 1972a, p.161)

In September, 1969 the Department of General Practice, under the aegis of the Edinburgh Postgraduate Board for Medicine, provided the first of a number of one week residential courses for doctors already, or about to practice in, health centres (Stevenson et al. 1970). The author of this thesis was the only nurse present at this first course of 24 participants, half from Scotland and half from England and Wales, which focused on the theme of team working and discussion on the development of the health service. A follow-up questionnaire to participating
general practitioners revealed that there was great interest in the contribution that could be made in the health centre by a practice nurse, and it was hoped that more nurse participants would be included in future courses. Further courses did, indeed, include community nurses and medical social workers.

In spite of the interest and involvement in health centres and team working by committed general practitioners, nurses and other health care professionals throughout the 1970s and 1980s, the concept of the primary health care team was not universally supported in reality. In 1981 this was highlighted in the content of two reports relevant to the employment and attachment of nurses in primary care.

*The Harding and Acheson Reports*

As a consequence of the limited availability of attached nurses (Reedy *et al.* 1980a) and the fact that they were under the operational control of another employer (Bowling 1981), the value of attachment schemes became seriously threatened. The Harding Report (Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee 1981) examined the reasons for waning support for the concept of the primary health care team in some areas, and identified differences in levels of attachment. These differences became exacerbated when there was a shortage of community nurses in a particular locality, necessitating re-deployment often at short notice from one practice to another (Baker *et al.* 1987). Nurses reported finding it difficult to be well informed about their clientele when working with a doctor's list as distinct from a defined geographical population. In inner city areas some patients were not registered with a doctor and so failed to receive community services.
Other reported areas of dissatisfaction included unsuitability of doctors' premises and relationship problems between general practitioners and nursing officers in the community nursing service. Once again, there were conflicts about policy in terms of the expectations of what the Health Authority and the general practitioner thought a nurse should do. The Report also highlighted that in one area, one seventh of children under the age of five were not being visited by a health visitor because they were not registered with a doctor. In its conclusions the Harding Committee continued to endorse attachment schemes, but recommended the zoning of group practice areas, particularly in the inner cities, to make it easier for community nurses to operate more or less on a geographical basis.

In November 1981, the General Medical Services Committee (GMSC) in its response to the Report, endorsed the concept of a team approach to care in the community, but emphasised that the general practitioner must be the team leader. As we have seen, this was a repetition of the response given by the Medical Advisory Committee to the Gillie Report nearly twenty years earlier. The GMSC supported attachment but they wanted the range of procedures provided to be as wide as possible. Although the Sub-Committee had agreed to the proposals in the Report, the GMSC were adamant that general practitioners should employ nurses themselves, and therefore had reservations about Recommendation 22, which stated:

In the longer term health authorities should make sufficient resources available to enable these nurses [practice nurses] to be employed within the normal NHS structure in a fully integrated nursing service without prejudice to existing arrangements where these are working satisfactorily.

(Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee [The Harding Report] 1981)
The Acheson Report (London Health Planning Consortium 1981), which reported at the same time, broadly endorsed the findings of the Harding Committee, but elaborated on a number of issues particular to primary health care in London.

These included staffing shortages in some inner city areas, as well as the anomaly of many practices, and attached nurses, serving the same patients in the same tower block. The Committee also noted that the practice employed nurse could be ‘advantageous’ to the general practitioner, because she could perform tasks under the supervision of the general practitioner that Health Authorities did not authorise attached nurses to do. They did accept that employment by the doctor was not in the best interests of development and training, but the Committee rather evaded the issue however, by deciding not to make any recommendations that would ‘disturb the present balance between community and practice nurses’ (London Health Planning Consortium 1981).

As the millennium approaches, the vexed question of the composition of the primary health care team, the working relationships between the non-medical professions and the physicians and who should lead the team, remain an on-going problem. Comments by Brooks (1973), a general practitioner, seem just as relevant today as they were in the 1970s:

At present we do not know which is the best way to organise teamwork in general practice. Each team will struggle with problems of role definition, of leadership, of communication and of goals and priorities. Different forms of organisation will emerge, and several of these may prove to be equally effective ways of providing primary care.

(p.251)

As the study which is described later in this thesis describes the workload and working patterns of nurses either employed by the general practitioner, or
attached to practices by the Health Board, an attempt will be made at this stage to examine the literature on both types of employment.

Practice Employed Nurses

In 1968 the Royal College of General Practitioners (RCGP 1968), reported an experiment in North East England of the employment of nurses in four general practices. It found that, with the services of the nurses, there was a fall in the annual doctor-patient consultation rate, resulting in saved time and more job satisfaction for the doctors, as well as more accurate clinical predictions during this period. Above all, this report seems to highlight the benefits of general reorganisation within these practices and suggests that work study alone cannot provide answers about standards of medical care.

In the same report, two general practitioners, Hodgkin and Gillie (1968), commenting on work study in their practice, reported that the nurse did not save the doctors as much time as they expected, although subjectively, the doctors felt that the saving had been considerably more. There was a tendency to unconsciously utilise time saved by spending longer for example, with elderly patients and patients new to the practice. In this case delegation increased productivity and although the content of the consultations is unknown, it was suggested by the authors that increasing the doctors' effectiveness was a positive benefit in terms of patient care. No measure of patient satisfaction however, supports these comments.
Workload Measurement

Several studies have made simple quantitative measurements of the employed nurse's workload (Cartwright and Scott 1961; Dawes and Cottrell 1966; McIntosh 1975; Waters et al. 1980; Waters and Lunn 1981). Tudor Hart (1985), described practice nurses as an under used resource, because their work was mainly concerned with relieving doctors of simple tasks that doctors were anxious to delegate.

Although most practice nurses are Registered General Nurses (RGN), a study of workload in one Scottish health centre concerned the work of a practice employed State Enrolled Nurse (SEN), who undertook a variety of procedures (Bain and Haines 1974). It was reported that 51% of attendances to the nurse were self-referrals, and 81% of these self-referrals were for minor casualty, skin treatments and dressings. The enrolled nurse was able to cope with the majority of procedures, but it was noted that appropriate facilities should be provided in health centres for this grade of nurse to carry out the work efficiently. There appears to be little doubt in the content of the study that was reported, that the nurse who was the subject of the study was 'efficient'. It is possible that the authors were referring to the possibility of increased effectiveness if sufficient resources and the requisite training were provided.

The Practice-Employed Nurse as the First Point of Contact

The expansion of the role of the nurse includes areas of primary contact and management. This is not a new innovation however, because patients have had access to nurses in this way for many years. Smith and O'Donovan (1970) reported that nurses made 'first visits' to house calls, and Marsh (1976), and
Marsh and Kaim-Caudle (1976) described how the nurse helped to run family planning and well-woman clinics. The nurse employed by Marsh and Kaim-Caudle undertook home visits, but in a patient survey it was revealed that 41% of patients said that they would not like a nurse to come if they requested a home visit from the doctor. Patients who had received a visit from the nurse however, reported that they were satisfied with the treatment given, although 25% of that number would still have preferred to see the general practitioner.

Further innovative approaches to the role of the nurse within general practice were described in two separate, but similar, studies. The first involved work undertaken in a group practice in a London borough where the nurse was the first point of contact for the patient (Bevan et al. 1979). Four nurses were each employed to work for 16 hours a week. The nurse saw each patient in the consulting room, took a brief history and did a preliminary examination before the patient was seen by the doctor. Doctors, nurses and patients reported satisfaction with the new arrangements, although it is of interest that 10% of patients did not know that the doctor's co-worker was a nurse. This finding was identified in the patient satisfaction questionnaire in relation to the role of the nurse. The general practitioners also perceived their work as being less tiring because the system allowed them to spend more time on tasks that they considered central to the doctor's role. Although these judgements appear anecdotal, it was reported that the doctors did increase the number of referrals to the nurses.

Secondly, in a group practice in Worcestershire (Marriott 1981) patients were given open access to the nurse if they wished. From a sample of 3,000 attendances, 46% of patients took this option. Marriott suggested that observation of the nurse's work and good communication between doctor and nurse to discuss
problems, would provide adequate safeguards to allow the doctor to delegate work. Marriott concluded that patient care was improved by this system in their group practice, although he qualified this by saying that further research was required to audit the management of patients by nurses when patients have open access to them.

It is not clear what Marriott meant by ‘observation’ of the nurse’s work, and whether this was in relation to the more technical ‘medicalised’ tasks. For example, the nurse was taught by the doctors to recognise and diagnose Otitis Media. In relation to the nurse’s work generally, Marriott appeared to over-emphasise the accountability of the doctor for the actions of the nurse, rather than accepting that the nurse was responsible for her own actions.

More recently Marsh and Dawes (1995) report on a system within a group practice where a nurse was trained within the doctor’s surgery to deal with patients requesting same day appointments for minor illness. Of 696 consultations in six months, the nurse managed 86% (n=602) of patients without contacting the doctor, although half required to have a prescription signed. Seventy nine per cent (n=549) did not re-consult about that episode of illness, and 50% (n=343) were given advice on self care only. As over half the patients required a prescription this raises the issue of nurse prescribing, and having to wait for a doctor to be free to sign prescriptions. The authors acknowledge that immediate availability of a doctor was essential, although they do not raise the issue that the nurse may still have been required to wait until the end of a doctor-patient consultation, unless she interrupted it.
Further Experimentation with the Expanded Role

Over thirty years ago, the view that the nurse had an expanded role to offer was proposed by Gunn (1966) and MacDougall (1966) who saw the nurse operating as a detector of illness and also in a preventative role. Other studies have described how nurses run clinics and monitor conditions within general practice (Marsh and Kaim-Caudle 1976; Martys 1982; Gibbins et al. 1983), each suggesting that such tasks result in better use of the doctor's time and a more efficient service for the patient. Cartwright and Anderson (1981) reported that practice employed nurses did things that the doctor would do if there was no nurse. Seventy five percent of those with an employed nurse felt this in comparison to 45% of other doctors. They reported that often joint appointments were a waste of manpower resources if the nurse was capable of performing the procedure alone.

McBeath (1994) has recently conducted a survey of 153 (out of a total of 166, 93.4 WTE) practice employed nurses on behalf of Lothian Health, which is as yet unpublished. Eighty percent of nurses and 79% (n=30) of a random sample of general practitioner principals in Lothian agreed 'to a large extent' that practice nurses should develop their role from basic nursing roles to that of counselling and advice. Although 50% of nurses and 41% of doctors thought practice nurses should never prescribe drugs, doctors were generally more positive about expanding the role of practice nurses than the nurses themselves. Three quarters of the practice employed nurses identified lack of training as a disincentive to an expanded role and, in an attempt to meet this training need, Lothian Health in association with colleges of higher education, have been proactive in negotiating a professional outcome as part of the BA/BA (Honours) in Community Health,
leading to a qualification of General Practice Nurse. Similar activities are being undertaken elsewhere.

The expansion of the role of the practice employed nurse, with the wide variations in working patterns, has increased the problem of role definition. As the role has expanded, nurses have moved from the traditional treatment room model of carrying out delegated tasks to several more innovative models, including disease management, screening and health promotion activities. Many practice nurses are now undertaking work in these areas that have not previously been done by doctors. Atkin and Parker (1992) in their study of practice employed nurses, describe three types of role. Some nurses practice within the traditional treatment room model, while others are developing additional aspects of their work alongside the more conventional treatment roles. A third group see themselves as nurse practitioners and are employed to provide quite specialised services such as counselling or prevention. These, and other models will be discussed further in the next chapter.

*Autonomy and Accountability*

Practice employed nurses have independence from the framework of Health Board or Health Authority nursing management and the potential to initiate and manage their own work, but not without constraints. They have no defined professional or nursing management structure and being employed by another professional has been reported as resulting in a loss of control and direction in their work (Bowling 1981; Hockey 1984). There is also the question of the vicarious responsibility that arises from the delegated care of the patient and the necessity for nurses to be diligent in terms of professional accountability for their actions.
Several authors have expressed the view that practice employed nurses have a broad, but poorly defined role (Hockey 1984; Stilwell 1987; Atkin et al. 1993), although Beardshaw and Robinson (1991), indicate that other forms of nursing have a similar problem. It is worth noting however, that there are few branches of nursing at the present time that have such potential for development. In the third edition of the UKCC's Scope of Professional Practice (1992b), clause two reads:

...ensure that no action or omission on your part, or within your sphere of responsibility, is detrimental to the interests, condition or safety of patients and clients.

There is a certain lack of clarity in this statement where it refers to the 'sphere of responsibility' of nurses. In being directly accountable to the general practitioner without a line of nursing management, the practice nurse can undoubtedly, be in a tenuous position. If nurses are recruited with different levels of skill, they may be at a disadvantage when asked to undertake tasks for which they feel poorly equipped and may have little provision for further training. At an earlier stage, Hockey (1984) identified this predicament when she said that the nurse was an asset to the doctor, especially if she could save time and money:

...the main benefit of the practice nurse is her 'pliability' within the framework of the practice, undertaking whatever tasks her employers identify for her.

(p.102)

Hockey contrasted this 'pliability' with the insecurity and lack of entitlement to continuing education, and by 1993 Atkin et al. were reporting that this problem still existed. Only a third of practice nurses have a specified number of paid study days a year, and taking study days does not seem to be an automatic entitlement with the job (Atkin et al. 1993). It has been suggested, however, that the autonomy realised by not having a defined management structure can be a positive
feature. Johns (1989) considered that such autonomy was an important requisite of professional behaviour and Hockey (1977), expressed the view that:

*A professional nurse should have the freedom and the knowledge to make her own decisions to perform those tasks which she considers to be of benefit to her patients and which are within her area of competence.*

(p.151)

More recently Jewell and Turton (1994) consider that flexibility at the early stages of job progression may have a limited lifespan. They draw attention to the financial incentives attached to the health promotion part of the 1990 GP Contract, and the number of nurses employed to take on some of the extra work. When the system was changed from being open ended to one of setting targets, it is reported that some of the nurses employed to run health promotion clinics lost their jobs. The insecurity inherent in this type of flexibility the authors suggest could be overcome by a unified postgraduate education system for all community nurses, including practice employed nurses. As will be discussed, the Cumberlege Report (DHSS 1986a) addressed this issue, and this has more recently been raised again by the NHS Management Executive (NHSME 1993).

By assuming responsibility for some of the tasks that have been previously undertaken by medical colleagues, Wright (1995) considers that practice nurses are becoming more technical in their expertise, which is often accompanied by greater administrative responsibility. The question of competence is inextricably linked to accountability (Hunt and Wainwright 1994), and this in turn must encompass the contemporary challenges of the changing and expanding role. Ashworth and Morrison (1994) also observe:

*Since technical expertise is currently of higher status in our society nurses tend to view the expansion of the sphere of the profession in this direction as an advance.*

(p.40)
This could be a retrograde step which, unless handled carefully, could erode central elements of the nurse's role. Benner (1984) suggested that these elements include caring, listening and sensitivity and, although not exclusive to nursing, they are the essence of it. Whilst the importance of education and training in areas of an expanded role such as health promotion and disease prevention should not be debased, it is important to reflect on the personal skills and qualities the nurse brings to the holistic aspects of patient care.

Attached Practice Nurses

Levels of Attachment

In 1973, Medical Officers of Health and Directors of Nursing Services in Scotland were asked to complete a record of community staff (health visitors, district nurses and midwives) in their area who were attached to one or more general practices, and all 55 Local Health Authorities submitted a return (Ruthven 1976). It was found that 64% of general practitioners in Scotland were working with attached nurses, the proportion having an attached nurse increasing with the number of partners in the practice.

The results of this study were compared with earlier Scottish figures of 1969 (Ruthven 1976), and showed an increase in the numbers of nurses and general practitioners participating in such schemes. English data for this period however, demonstrates that attachment schemes were considerably further advanced there (DHSS 1973). The data for England reported by Reedy (1977) stated that the proportion of district nurses attached to general practitioners was 77%, and the proportion of health visitors was 79 per cent.
Studies of Attached Practice Nurses

In contrast to the amount of research (usually undertaken by doctors), into the workload and working patterns of practice employed nurses, there has been less research conducted in recent years into the work of their attached colleagues. Nevertheless, a number of authors have investigated this area, including Swift and MacDougall (1964), Sanctuary et al. (1965), Pinsent (1968), Dawes and Hodgkin (1968), MacGregor et al. (1971), McIntosh (1975; 1979), Reedy et al. (1980a), Bowling (1981), Cartwright and Anderson (1981), Cater and Hawthorn (1988).

Although all the studies reported involved delegation, several described the work of the attached nurse as being extended or technical in nature, whereas others indicated that it was a traditional role involving simple tasks. Doctors were generally in favour of 'extending' or 'expanding' the role of the attached nurse, particularly if she worked alone in the treatment room. Overall, doctors did indicate however, that practice employed nurses could undertake procedures that attached nurses were not allowed to perform.

Workload Measurement

One of the early attachment schemes in Hampshire (Swift and MacDougall 1964) described how nurses, midwives and health visitors worked exclusively with family doctors, the authors concluding that the nurses' contribution enabled the family doctor to give comprehensive medical care to the patients. In another study Dawes and Hodgkin (1968), recorded the number and type of technical duties performed by 'their' attached nurse. They reported that as her venepuncture rate
increased, there was a concurrent rise in diagnostic activity by the doctors throughout the practice. This was concluded to be a result of the doctors having more time to spend with patients, although the authors do not say how this time was spent. Vaccination and immunisation rates doubled as a consequence of the nurse undertaking these procedures.

In another early study, Pinsent (1968) claimed that having two district nurses attached to a three-man practice of 8,500 patients had saved time in certain areas and allowed the doctors to provide a higher standard of care for their patients. Activities in the treatment room included dressings, injections, ear syringing, suture removal and diagnostic tests. The author suggested that the service was popular and patients approved of the new service. The study does not however, formally measure patient satisfaction as an outcome.

In a later study Forman (1974) surveyed general practitioners in South West England to ascertain levels of attachment and opinions about its effectiveness. There was a 60% response rate, a reported 93% of whom had nurse attachment, the majority also replying that they had ‘no problems’ with attachment. No figures are given for ‘the majority’, and it is possible that the 40% of doctors who declined to answer the questionnaire had a range of views different to those who responded.

**Delegation and the Expanded Role**

A number of early studies described delegation of work to attached nurses. Hasler et al. (1968) reported that nurses attached to their group practice had, by performing delegated medical tasks, enabled the doctor to spend more time with
each patient. Boddy (1969) conducted a random survey of Scottish general practitioners, the majority of whom questioned were willing to delegate procedures, such as dressings and injections.

MacGregor et al. (1971) reported that the effects of attaching district nurses directly to the practice resulted in more thorough clinical medicine. These were the main results of a study set up in 1968 in a North Edinburgh group practice. Its aims were to measure the effects of attaching two district nurses directly to the practice and, by extending their role, it was hoped that there would be increased efficiency of medical care and an improvement in the doctors’ performance. The practice operated from two surgeries and the clinical work of the practice was measured in two identical blocks of time, before and after, the attachment. A sample of patients were interviewed by questionnaire and their views analysed. The conclusions were that there was greater job satisfaction for all, and there was overwhelming support for the experiment by the patients.

Reedy et al. (1980b) found that attached nurses were more likely to perform ‘traditional’ roles rather than ‘technical’ procedures such as venepuncture. In this instance traditional roles were allied with caring and were more likely to consist of bed baths and toiletting in the home. Technical procedures were associated with what Reedy and colleagues described as ‘an extended role’ and one previously undertaken by doctors. This included taking cervical smears, syringing ears and recording electrocardiographs. At the present time, many of these procedures are undertaken by practice nurses on a regular basis, and are nowadays, less likely to be regarded as an extension of their role. Reedy et al. also reported that employed nurses were less ambitious than their attached colleagues, 6% saying that they would like promotion compared to 41% of attached nurses. This is an interesting
observation, considering that more practice employed nurses were reported to be undertaking an expanded role. It is possible that attached nurses were more used to working autonomously, whereas the practice employed nurses usually had a doctor on the premises while they were working.

Miller and Backett (1980) conducted a postal survey of 533 randomly selected doctors and found two-thirds in favour of delegation and an expanded role for the attached nurse. This approval was qualified by the proviso that the nurses were appropriately trained and were supervised by the doctor. Other authors have reported that attached nurses were less likely to undertake technical procedures than practice employed nurses - McIntosh (1975; 1979); Wilson (1977); Cartwright and Anderson (1981); Bowling (1981); Dunnell and Dobbs (1982); Bowling (1988a); Cater and Hawthorn (1988).

Interestingly, Reedy et al. (1976) found that practices with an attached nurse were more likely to employ a nurse, 26% in contrast to 20% without one. They did not differentiate however, between attached nurses who spent their time in the treatment room and those whose work was spent in domiciliary visiting. Cartwright and Anderson (1981) reported a small swing in the opposite direction. They found that 34% of doctors with an attached nurse would employ a nurse, as opposed to 43% who would not, although their data were based on doctors as opposed to practices. It was suggested that attached nurses working in the treatment room were sometimes used as a substitute for employed nurses. The authors proposed that this was because the general practitioners felt that, unlike attached nurses, practice employed nurses could undertake similar procedures to those of a doctor. Another example of the medicalised focus of the role.
The Attached Practice Nurse as the First Point of Contact

Reedy et al. (1980b) reported that there was a trend towards an increasing proportion of 'first treatments' being given by district nurses in the surgery premises as opposed to patients' homes, and quoted a figure of 55.2 'first treatments' given by district nurses in the surgery in 1976, compared to 40.5 first treatments in 1972. There is no description of the content of the first treatments, so it is impossible to know the nature of these contacts. Although the context may not be the same, in contrast to the findings of Reedy and colleagues, Cartwright and Anderson (1981) reported that general practitioners felt that it was less appropriate that patients should have direct access to, or to make first contact with, an attached nurse in the surgery.

Joint Studies of Practice Employed and Attached Nurses

A questionnaire survey of 20 general practitioners and 15 nurses (ten attached and five practice employed nurses) in a Scottish New Town (McKinstry and Gillies 1988), reported that there was a general desire to develop the role of the nurse in practical fields, but there was disagreement between doctors, and nurses themselves, over the extent to which nurses should undertake diagnostic and therapeutic roles. Attached nurses felt less confident than their practice employed colleagues about undertaking certain tasks. From a list of 17 conditions, including items such as a patient with a rash, cough or a minor laceration, attached nurses each averaged 2.4 tasks, whereas the practice employed nurses each averaged 13.6 tasks.

In response to a question on 'extended' roles for nurses, the results unfortunately did not differentiate between practice employed and attached nurses. Doctors and
nurses all agreed however, that the main barriers to role extension included lack of indemnity cover, restrictive policies of the Health Board, lack of encouragement from nursing superiors, followed by inadequate training, and lack of time and resources. It is of note that the attached nurses in the study reported that there were differences in what they were allowed to do, depending in which area they worked. This apparent lack of continuity was thought to be a consequence of some nursing officers trying to defend attached nurses from undertaking expanded roles without appropriate training.

Cater and Hawthorn (1988) used a postal questionnaire survey to examine the role of practice nurses. The nurses all worked in the treatment rooms of general practice, although their commitment to these duties was varied. The sample consisted of 79 practice employed nurses, 18 attached nurses employed exclusively by the Health Authority to work in the treatment room, and a third group of 71 district nurses who spent part of their time there. It was reported that practice employed nurses were more likely to give dietary advice and undertake administrative tasks than the other nurses. They were also more involved in screening procedures. There was little difference however, in the investigation and treatment activities of the nurses who worked exclusively in the treatment room. District nurses were more likely to undertake dressings or injections, just as they would normally do in the patient’s home.

More of the practice employed nurses (82%) thought they had already expanded their role towards that of the nurse practitioner, in comparison to 26% of attached nurses and 21% of district nurses. This survey illustrated the extremes of a nurse undertaking only delegated tasks at one end of the scale, and a nurse operating in
a nurse practitioner role at the other, seeing patients for a variety of conditions without reference to a general practitioner.

Power, Control, Delegation and the Expanded Role

Attitudes towards an expanded role for nurses working in general practice have long been a contentious issue and remain so up to the present time. It was reported by Reedy et al. (1980b) that doctors preferred to employ their own nurses because of the lack of constraint on nurse activities. Attached nurses were reported to be performing a more traditional caring role than that of the practice nurses, who undertook a variety of technical tasks. The lack of external constraint on the activities of practice nurses allowed the doctor to have control and independence from nursing management. This study again draws attention to traditional roles, in this instance 'traditional' being described in terms of the 'caring' aspect.

Even earlier, Reedy (1977) reasoned that the general practitioner should lead the team by co-ordinating the care it gives, but said that the doctor requires training for this and should learn to become a 'first among equals' without automatically becoming 'first'. He considered that only the doctor has the training to carry out what he described as the four main functions of a primary health care system - health maintenance, illness prevention, diagnosis and treatment of illness and rehabilitation. It is presumed that 'first among equals' refers to other medical practitioners.
Greenfield et al. (1987) found that the most important factor which prevented practice employed nurses from extending their role was the general practitioner's attitude. Although they did not directly indicate what was meant by 'attitude', it is possible that they were referring to control. In addition, 85% of practice nurses reported that the doctors usually addressed them by their first name, whereas only 26% of nurses addressed the doctors by their first name. Roles are also associated with status, and each member's place in the hierarchy of the team is determined by the comparative status of their role. Indeed, Fizurki et al. (1987) considered that nursing, of all the professions subject to sex-role stereotyping, seems the most severely handicapped in that nurses are doubly conditioned into playing a subservient role - firstly by society generally, and secondly by the medical establishment.

More recently a pilot study of general practitioners in Hampshire found that only 30% of general practitioners surveyed agreed that nurses should be independent practitioners, suggesting that doctors want to retain control of the practice nurse's role and its expansion (Georgian Research Society 1991). Further, the study reported that nurses were undertaking tasks of greater complexity than ever before, although nurses cited inadequate resources, rather than the attitudes of general practitioners, as being the most common factor limiting the expansion of practice nursing.

The philosophy behind the development of the expanding role is dependent on a more specialist body of knowledge, and this is gradually coming to fruition with the introduction of modular degree courses for nurses in primary care (Bryan 1992). There are continuing anxieties expressed however, about the lack of power, status and influence of nursing (Bendall 1977; Greenfield et al. 1987;
Rowley (1994) has a more positive approach despite these criticisms. She considers that:

*There is a need to ensure that an open and effective communication system prevails, despite the different conditions of employment, physical environments, the arbitrary divisions of labour and professional prejudices.*

(p. 141)

Rowley suggests that, if practice nursing is to continue to develop it will require to accommodate the changing demands of society, complemented by a course of educational preparation which should be shared wherever possible with other community nurses. Rowley does not however, suggest the inclusion of general practitioners in shared education.

The various studies described seem to highlight the problems of delegation, independent working and relevant communication between the professionals involved in patient care. Indeed, throughout the 1980s, overlap of roles, duplication of effort and poor co-ordination of services between hospital and community were still being noted (Dunnell and Dobbs 1980). These issues were directly addressed by the Cumberlege Report (DHSS, 1986a). In her letter to the then, Secretary of State, Julia Cumberlege said that the Review Team recommended ‘evolution’ not ‘revolution’ and that, if their recommendations were accepted, they should be used as a tool for change.

A number of the recommendations of Cumberlege will now be examined, as will the outcome of the Report, in relation to another Government discussion document published at the same time - ‘Primary Health Care: An Agenda for Discussion’ (DHSS 1986b).
‘The Cumberlege Report’ and ‘Primary Health Care: An Agenda For Discussion’

In the Report of the Community Nursing Review (DHSS 1986a) members of the Review Team found on their visits to districts that there was little evidence of good communication, and much uncoordinated effort by health workers. Community nurses were considered to be under-using, and often never using, some of their professional skills, because they were tied to traditional working methods. In this instance ‘traditional methods’ were described by the Review Team as old methods of working without clear objectives. They considered these methods of working were exacerbated by inadequate information from the nursing hierarchy, who in turn were unclear about Health Authority policy or areas of priority. This lack of direction made it difficult for community nurses to use their professional skills to the potential of their education and training. In their evidence to the Review Team, the District Nursing Association said:

Too often, we have had district nurses tell us they are ‘acting down’ instead of being encouraged to use their skills in rehabilitation, counselling, health education, promotion of positive health, teaching and management of patient care.

(DHSS 1986a, p. 12)

In its examination of the role of practice employed nurses, a key proposal of the Cumberlege Report was the recommendation that the subsidy to general practitioners who employed practice nurses should be phased out, and that ‘neighbourhood nursing’ services should be set up instead, and managed within the District Health Authority. In particular, the members drew attention to general practitioners' ability to claim 'item-of-service' payments for immunisations undertaken by the practice employed nurse, the judicious use of which could easily cover the cost of her employment. General practitioners could also obtain a fee for an item of service undertaken by an attached nurse who was not an
employee. Once again, the issue of control was raised and it was commented in the Report that:

We have great sympathy with the view expressed to us by the Royal College of Nursing that, as a matter of principle, nurses should not be subject to control and direction by doctors over their professional work.

(DHSS 1986a, p. 41)

The Royal College of Nursing were concerned about the lack of training provided by doctors for their employed nurses, and felt that these nurses lacked the professional support which is often required. The College felt that this lack of nursing support resulted in a fragmented, and less than adequate, clinical nursing service. The Review Team sympathised with this view, but acknowledged that if general practitioners wished to employ their own nurses, and if these nurses wished to work for them, then that was their prerogative.

Unfortunately, the controversy produced by the Community Nursing Review obscured two innovative recommendations. Firstly, the principle of introducing the nurse practitioner, a nurse with advanced skills and expertise into primary health care and secondly, the setting up of a limited list of items which could be prescribed by community nurses as part of a nursing care programme. The Report did not clarify who would fulfil the role of nurse practitioner, apart from stating that any community nurse with appropriate qualifications could do so, but they did not specify what the qualifications should be. In addition, the practice nurse was not identified as possibly fulfilling this role.

The recommendations of Cumberlege that the subsidy to general practitioners who employed practice nurses should be phased out were never implemented, possibly because the government's discussion document on primary care (DHSS 1986b) which was in favour of maintaining the 70% reimbursement, was published on
the same day. General practitioners rejected the recommendations of the Community Nursing Review because they had concerns about the possible loss of control over the role of practice nurses. In addition, the conclusions of Cumberlege that community nurses could enter into working contracts with general practitioners and provide the required services, was not supported by doctors, or indeed by practice employed nurses.

*Responses to the Reports: ‘Cumberlege’ and ‘Primary Health Care: An Agenda For Discussion’*

There were a number of responses to the Cumberlege Report and to Primary Health Care: An Agenda for Discussion (DHSS 1986b). Among these responses were those of Chapman, a professor of nursing in Wales, who commented in a letter to the British Medical Journal at the time (Chapman 1986), that general practitioners would consider the contents of the Report ‘revolution’ and not ‘evolution’ as Cumberlege suggested. He suggested that general practitioners would be afraid that they would lose the right to claim for specific items of care normally carried out, without payment, by practice nurses. He also reported that practice employed nurses were averse to returning to the National Health Service hierarchy, that they saw themselves as having an equal partnership with general practitioners, and that this was fundamental for the functioning of the primary health care team. Chapman did not provide any evidence to support his statement that practice nurses felt themselves equal to doctors. Indeed, the socialisation of the role of the practice employed nurse had been one of doctor’s assistant, and as we have seen from the data reported in studies so far, one where delegation and control were evident, even in areas where the role of the nurse was expanding.
Nevertheless, practice employed nurses were angered at the threat to their position and a number of them resigned from the RCN and joined other unions. The RCN had sympathised with the recommendations of Cumberlege and practice employed nurses saw this as a betrayal, because there would be no guarantee that their jobs would be prioritised in a new system. In their reply to the Cumberlege Report, the RCN (1987) supported the development of the practice nurse role into that of nurse practitioner, but felt that the two roles should still be distinct. The College also suggested that patients should be registered with practices instead of with doctors, so that patients could choose whether to see a doctor or a nurse. This suggestion is rather difficult to understand, as patients are not usually denied access to a nurse in the surgery, although the College may have been referring to nurses as the first point of contact, and it would depend on the 'appropriateness' of the presenting problem.

In November 1986, at their annual conference, the General Medical Services Committee (GMSC) of the British Medical Association (BMA) discussed the contents of the Cumberlege Report (BMJ 1986a). There were few positive responses. The Committee opposed the nurse practitioner role until it was 'properly defined', although they did not elaborate on this. They totally rejected the idea of a formal written agreement between general practitioners and attached members of the primary health care team. There was some support for the recommendation that community nurses could prescribe a limited range of dressings, appliances and medication without recourse to a doctor. They were totally opposed however, to the attempt to remove practice employed nurses from the ancillary reimbursement scheme.
Furthermore, The Royal College of General Practitioners (RCGP 1987) stressed the importance of advancing the practice nurse role toward that of the nurse practitioner as long as general practitioners could maintain control. In its response to Cumberlege the College stated:

_The further development of the role of the practice nurse is central to the future of primary care. The College looks forward to the practice nurse acquiring increasing responsibility and clinical independence without the intervention of nurse managers who are based outside the practice itself, and who may not have experience of practice nursing._

(RCGP 1987, 5.8, p. 9)

The BMA also gave a cautious welcome to the document on Primary Health Care (DHSS 1986b) identifying improved quality, value for money and better consumer choice as the main themes emerging from it (BMJ 1986b). In their comments on ‘Primary Health Care’ to the Social Services Committee (BMJ 1986c), the BMA said that community nursing services should be provided on a practice basis with nurses attached to practices. They also lent their support to an extended role for appropriately trained nurses. The conjecture here is that the extended role is one of a more technical, task-oriented nature and one delegated by doctors. The BMA did not elaborate either on what they meant by ‘appropriately’ trained.

In the discussion of both documents (DHSS 1986a; 1986b) the medical and nursing professions emphasised the importance of working as members of multidisciplinary teams. Nevertheless, Cumberlege highlighted, as the Harding Report (Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee 1981) had done earlier, that the team approach was not recognised everywhere. There was also anxiety among community nurses that the widening availability of services offered by practice employed nurses would affect the delivery of care undertaken by other members of the primary care team. By
this they meant that there was danger of role overlap or possibly gaps in the delivery of care. Nevertheless, the role of the general practitioner employed practice nurse continued to develop and this will be examined further.

The Development of the Practice Nurse Role

As we have seen there were suggestions that some nurse managers restricted the range of tasks that attached nurses could perform (DHSS 1986a; RCGP 1987). Robinson (1990) comments:

*General practitioners often feel nurse managers do not share their aims and direct employment of the practice nurse by the general practitioner provides the mechanism for rapid decisions about patterns of work, so permitting adaptation to the changing needs of the practice without the need to negotiate change with the community nursing managers.*

(p.132)

When the document 'Promoting Better Health' (DoH 1987) was published there were some objections that health promotion and screening might become the province of practice employed nurses and general practitioners, to the exclusion of community nurses, because of the 'task' oriented approach to health promotion. The United Kingdom Central Council (UKCC) felt obliged to respond to these criticisms in their document 'Statement on Practice Nurses and Aspects of the New GP Contract' (UKCC 1990a). While observing that directly employed nursing staff could result in role overlap with the delivery of care offered by other nurses, the UKCC accepted the development of the practice employed nurse role. It was emphasised that, when they delegated treatments or procedures, general practitioners should be satisfied that the person to whom they delegated was competent. The document noted that in the best interests of patient or client, sound policies for practice were to be developed.
Hasler (1994) suggests that the dilemma for community and practice employed nurses is whether to maintain their individual domains of work with inevitable role overlap, or form a real nursing team. These issues will be discussed in relation to the introduction of the New GP Contract.

The New General Practice Contract

In April 1990, the New General Practice Contract came into force. Kenneth Clark, who was then Minister for Health, created a controversial new contract for general practitioners which placed emphasis on, among other things, the provision of targets for new registration and elderly screening, immunisations, cervical smears and health promotion. If general practitioners were to cope with the increase in workload demanded by the Contract and meet the targets required for payment, it soon became clear that they would have to delegate. With the realisation that the 70% reimbursement of the costs of practice staff (including training) would continue to be met, the practice nurse seemed to be the most obvious member of the primary health care team to help to meet the many demands of the New Contract. As described previously, this was not an innovation to many practice nurses, because they had been doing this type of work for some time.

The Effects of the New GP Contract on the Employment of Practice Nurses

As documented earlier, prior to the 1990 Contract some doctors did not employ practice nurses. The new arrangements resulted in a rapid increase in the number of practice employed nurses and an extension of their role (Morrell 1991; Goodwin 1991; Hasler 1992). Between 1987 and 1992 there was a four-fold increase in the number of whole-time equivalent practice nurses employed in
England and Wales (Rowley 1994). Indeed, the new General Practitioner Contract of April 1990 has been one of the greatest influences to date in the area of practice nursing in terms of numbers of nurses employed, particularly between 1989 and 1990, and also in terms of expansion of their role. This will be examined further.

The Evidence: The Scottish Experience

The following graphs compiled from statistics supplied from the Information and Statistics Division of the Scottish Health Service Common Services Agency (ISD 1993; 1996) show how quickly this area of nursing has been expanding. The figures presented relate to Scotland, but there has been a similar increase in England and Wales, where at present there are about 9,500 whole time equivalent (WTE) practice nurses (Atkin et al, 1993).

Practice Employed Nurses in Scotland

Figure 2-1 Practice employed nurses in Scotland - WTE

![Practice Employed Nurses in Scotland Graph](image-url)
Figure 2-1 shows that between April 1982 and April 1988, practice employed nurses in Scotland were increasing in number at the rate of 10% per year, but between 1989 and 1990 there was a sudden increase of 98 per cent. Between 1990 and 1995 the WTE of practice employed nurses has risen by 39 per cent. This means that between 1982 and the present time, the WTE of practice employed nursing staff has risen by 600 per cent.

*Practice Employed Nurses in Scotland by WTE per 100 General Practitioners*

The same information is illustrated in Figure 2-2 by WTE per 100 general practitioners.

*Figure 2-2 Practice-employed nurses in Scotland - WTE per 100 GPs*

This shows that:

- In 1982 there was one practice employed nurse for every 26 general practitioners employed in Scotland.
• By April 1990 this had risen to one practice employed nurse for every 6 general practitioners.
• By April 1995 this figure was one practice employed nurse for every 4 general practitioners.

Practice Employed Nurses in Lothian

As the Practice Nurse Study concerned the Lothian region of Scotland, information about Lothian was extracted and shows a similar trend. Statistics for 1982 indicate that there were 17 WTE practice employed nurses at that time (Figure 2-3). By 1989 figures indicate that there were 32 WTE practice employed nurses, and that this complement increased to 74 WTE in 1990. This represents a percentage change of 131.8 between 1989-1990. In 1991 there were 79 WTE practice employed nurses, representing a percentage rise of 7.4 between 1990 and 1991. Overall, between 1982 and 1995 there has been a WTE increase of 589 per cent.

Figure 2-3 Practice-employed nurses in Lothian - WTE

Practice Employed Nurses in Lothian
WTE (1st April 1982 to 1st April 1995)
Practice Employed Nurses in Lothian by WTE per 100 General Practitioners

Again, this same information is depicted by WTE per 100 general practitioners in Lothian (Figure 2-4):

Figure 2-4 Practice-employed nurses in Lothian - WTE per 100 GPs

In 1982 there was one practice employed nurse for every 29 general practitioners employed.

By April 1990 this had risen to one practice employed nurse for every 7 general practitioners.

By April 1995 this figure was one practice employed nurse for every 5 general practitioners.

Health Board Attached Nurses in Lothian

In 1989, at the time the study was designed, current information of this kind in respect of attached nurses was unfortunately, not available to me. In my quest for available figures relating to practice employed and Health Board attached nurses
in Lothian, I found that that there was very little available data of any kind, particularly about Health Board attached treatment room nurses.

In 1988, a similar finding was reported by Meldrum (1988), who reported in her literature search that data on attached nurses was minimal, and that attached nurses and practice employed nurses represented a very small proportion of nurses working in the community, particularly in Scotland. Meldrum examined the background, workload and opinions of attached nurses in Lothian using a postal questionnaire approach. Her study found that 21 out of 93 practices (23%) in East and Midlothian had at least one Health Board attached nurse, making a total of 40 nurses (28 WTE). By 1995, according to Lothian Health Board’s Practice Nurse Adviser, there were less than 20 (WTE) Health Board attached nurses in Lothian.

In relation to the Practice Nurse Study, further attempts to obtain information on attached treatment room staff in 1990 and 1991 proved unsuccessful because Lothian Health Board were unable to access this type of data at the time. These difficulties will be expanded upon in Chapter Four, in the section on Recruitment and Response Rates.

*Disease Management and Health Promotion: Delegation to the Practice Employed Nurse*

Traditionally, nurses employed by general practitioners have worked within the practice premises, rarely visiting patients at home. The implementation of the New GP Contract resulted in many practice employed nurses being delegated by the general practitioner to undertake screening, disease management and health promotion activities. These included annual assessment visits to the homes of patients in the over 75 age group who were unable to attend the surgery (Atkin et al. 1993).
The caseload of district nurses and health visitors has always consisted of a high proportion of elderly people. While district nurses offer a mix of curative care and counselling in their service to clients, health visitors focus predominantly on offering health promotion and disease prevention services to the well population (Atkin et al. 1993; Hunt and Wainwright 1994; Cain et al. 1995; Buttigieg 1995; Hyde 1995). It has been difficult to measure the effectiveness of their activities however (Buttigieg 1995; Lock 1995), and successes and skills are often undervalued by the nurses themselves.

The issue of home visiting by practice employed nurses in a health promotion situation, particularly to elderly people, has resulted in an overlap of roles with community nursing. Atkin et al. (1993) report that over half of the practice employed nurses in the census visited patients at home, but only 14% of these held a community nursing qualification. The problem of role boundaries with community nursing, and levels of education and training of practice employed nurses, have been questioned by several authors (Robinson 1990; Ross 1991; Atkin et al 1993).

Under the new terms of service, general practitioners are required to offer certain services in order to qualify for a higher capitation fee or a target payment. According to the New GP Contract, health promotion and illness prevention services can be offered and provided by the general practitioner, or by another member of the practice team. As an employee of the doctor, the ‘other’ member of the practice team is often the practice nurse (UKCC 1990a; Hasler 1992; Hunt and Wainwright 1994). In their census, Atkin and colleagues (1993) report that 86%
of practice nurses undertake new patient screening and 84% give advice on common minor illnesses.

Nearly 20 years ago, Zola (1978) was concerned that the health strategies of the time were akin to pulling people out of the river and attempting to resuscitate them, rather than looking up stream to find out who was pushing them in. More recently however, Tettersell and Luft (1994) question whether the emphasis on the setting of targets for health promotion will result in improvements in health, and suggest that it may even produce stress in individuals, making them feel that they will be labelled as perverse or non-compliant if they do not accept these services as expected. They question whether health promotion is an activity that can be 'done' to someone, and suggest that the promotion of health is an aspiration that does not mean telling individuals how to change their lifestyle, often against their will and without consideration of how they can achieve it. Rather, it is about respecting the freedom of the individual and helping to facilitate healthy choices. These views are similar to those expressed twenty five years ago by Pearse (1970) in respect of the Peckham Health Centre experiment.

The value of involving practice nurses in preventive health care was described by Fullard (1987) in the Oxford Prevention of Heart Attack and Stroke project. A practice nurse was either specially employed by the practice for a maximum of ten hours to undertake the screening procedures required or, in some cases, an existing nurse extended her hours. Patients in the target age group (35-64 years) who attended the surgery for any reason, were invited to have a health check by the nurse. A statistically significant increase in the preventive medicine activities in the practices that had been 'facilitated', in comparison with control practices, was reported. The project team suggested that the enthusiasm and commitment by
the practice nurses in extending their role may be a recommendation for them to lead the team in the health promotion of the future.

A less enthusiastic view of the contribution of practice nurses in health promotion was reported in the randomised control trial conducted in the OXCHECK study (ICRF OXCHECK Study Group 1994). The object of the study was to assess the effectiveness of health checks by nurses in reducing risk factors for cardiovascular disease in patients from general practice. Although not stated, it is assumed the practice nurses so described were practice employed. The trial found that nurses were ineffective in measures to decrease smoking levels, but had greater success in dietary advice and in reducing total cholesterol. The Study Group questioned the efficacy of giving other health promotion messages at the same time as advice on stopping smoking, and suggested that this may have been one of the reasons for lack of success. In their conclusions they suggested that practice nurses may be more effectively used with patients established as being at high risk.

Both these studies (Fullard 1987; ICRF OXCHECK Study Group 1994) describe the technical abilities of the nurses involved, but do not discuss the more holistic contribution that nurses may have made to the consultations. Fullard says that patients found the health checks ‘reassuring’ and that they were happy to see a nurse. Did patients feel reassured because their results were satisfactory, and what of those who did not attend, were they at greater risk and more anxious?

Practice nurses complement the work of general practitioners and nursing in general practice continues to change. The emerging role appears to be moving towards what has been variously described as an ‘advanced practice nurse’, ‘nurse
consultant’, ‘nurse clinician’ or, more commonly, a ‘nurse practitioner’. The concept of the nurse practitioner role is inevitably based on models of the role conceived in the United States of America (USA) over forty years ago. Resistance from doctors and some nurses has reasonably been based on the adaptability of an essentially North American product to the British Health Service. The nurse practitioner has unfortunately been stereotyped as a cut-price doctor and it has proved difficult to upset this image (Bosanquet 1990). It is in the context of redefining the role of practice employed and community nurses that the origins, and present state of the nurse practitioner role, along with the future needs of service users is now examined, particularly in relation to primary care.

**The Role of the Nurse Practitioner**

For some time, the process of change has been fostered by the suggested development of an independent nurse practitioner role, and this is being seen by many professionals in the primary health care team as the way forward for community and practice employed nurses in the United Kingdom (Stilwell 1982; Stilwell et al. 1987; Bowling 1988a; O'Hara Devereaux 1991). As recently as May 1995, the then Secretary of State for Health, Virginia Bottomley, at the North Downs Community Health Trust Conference entitled 'Developing Nursing Practice in Primary Care', spoke of the increasing importance of nurses in primary care, citing technological advances and the ability of nurses to instil trust in patients and carers, and interpret needs effectively. Mrs Bottomley was quoted as saying:

*There is growing interest in the developing role of the nurse practitioner. Doctors find this role works well in primary care, improves patient care, and enhances nurses' job satisfaction.*

Mrs Bottomley expressed interest in the response of nurses to the challenge to provide innovative and imaginative care for patients. Her observations are open to
debate however, as there has not been universal agreement among doctors about the advancement of the nursing role, and the potential loss of its subordination to medicine (Bowling 1981; Stilwell 1986; Traynor 1991; Robinson et al. 1993; Venning and Roland 1995).

A Description of the Nurse Practitioner Role

Various definitions of the nurse practitioner role have been given (Bliss and Cohen 1977; Salvage 1991). Broadly, nurse practitioners are registered nurses with an expanded nursing training in the provision of primary health care, which encompasses assessment, diagnosis, treatment and discharge according to protocols. The role was first officially defined by the American Nurses Association in 1974 as being that of a registered nurse who has successfully completed a formal programme of study designed to prepare registered nurses to deliver primary health care.

Bliss and Cohen (1977) described the work of nurse practitioners as the provision of instruction and counselling to individuals, families and groups in the areas of health promotion and maintenance, and the involvement of individuals in the planning of their own health care. This the nurse practitioners do in collaboration with other health care providers and agencies. This description by Bliss and Cohen appears to have many similarities with the work of health visitors in the United Kingdom.
The Development of the Nurse Practitioner Role

North America

From the late 1950s the role of the nurse practitioner was evolving in the USA. In an attempt to improve health care facilities, Eugene Stead a physician at Duke University in North Carolina, and a nurse Thelma Inglis, devised a master's degree for nurse practitioner training. The evolution of this type of role was felt to be a response to the country's changing health needs (Sultz et al. 1979) and medicine's inability to deal with simple medical problems (Rogers 1977). Since 1949 there had also been a steady decline in the numbers of physicians working in general practice. Between then and 1963 the numbers had fallen from 64% to 38%, and by 1973 had declined to 24 per cent. The USA suffered particularly because inner city practice was costly to run, and rural areas were so isolated and offered little professional exposure, socially and educationally (Stilwell 1988; O'Hara Devereaux 1991). The master's degree programme for nurse practitioner training devised Stead and Inglis was rejected by the National League of Nursing however, on the grounds that nurses would be undertaking inappropriate medical tasks which could also be dangerous.

It was not until 1965 that the University of Colorado became the first site to introduce a nurse practitioner programme, in this case to prepare registered nurses in the area of paediatric care. It was found that nurses were highly competent in assessing normal and abnormal physical findings in children and were well accepted by parents, children and paediatricians (Henry 1983). As a result of this initial training programme, others were developed to provide primary care to people of all ages, and included family health, school health, geriatrics, obstetrics, gynaecology and midwifery. The nurse practitioner was
trained to collect historical, examination and laboratory data in order to make a diagnosis, similar to the role of physician's assistant (Stilwell 1988a). The programmes required the entrants to be registered nurses, but varied in content and level and resulted in either a certificate or a master's degree. To obtain the latter, entrants usually had to have a bachelor's degree in nursing.

The physician assistant role was a parallel development to that of the nurse practitioner, involving technical tasks previously performed by doctors but which did not require the physician's level of training. Where there was emphasis on the technical aspect in the physician assistant role however, the nurse practitioner role took a more holistic approach. In this case the priority was the management of disease, and health education. As explained earlier, many nurse practitioners specialised in particular areas such as paediatrics, and were differentiated from the physician assistant by their autonomy and clinical expertise.

Nurse practitioners were instrumental in improving access to primary care and in providing high quality service, especially in rural and remote areas. A variety of research projects demonstrated patient satisfaction with the process of nurse practitioner care in the USA (Wolcott Choi 1981; Molde and Diers 1985; Campbell et al. 1990), but there has been a decline in the publication of studies in recent years. It is suggested that this is perhaps due to acceptance of the role and less need to justify its existence (Stilwell 1988a; O'Hara Devereaux 1991)).

There is considerable evidence of the contribution nurse practitioners have made to the care of patients with chronic disease. This has been reported by several authors (Runyon 1975; Ramsay et al. 1982; Fagin 1982; Diers and Molde 1983). Runyon (1975) and Ramsay et al. (1982) for example, reported that nurses were
effective in achieving reduction in blood pressure of hypertensive patients attending clinics run by the nurses. Fagin (1982) reported that chronically ill, elderly people in an inner-city area of Boston, cared for by nurse practitioners, were less likely to have a hospital admission and if they did, were more likely to be discharged early.

Loretta (1982), when writing about North America, considered that no other change in recent times had produced such a dramatic effect on nursing as the development of the nurse practitioner role and commented that, what was a new and a deviant idea in nursing in 1965, had become one of the normative and recognised roles in nursing world-wide. In 1981 it was estimated that there were about 14,000 qualified nurse practitioners providing primary care services in the USA (Mauksh 1981), and this number had risen to 25,000 by 1995 (Lamm 1996). Nevertheless, Stilwell (1988a) revealed that, although acceptance of nurse practitioners by doctors was high in the 1970s, it is now low. There is now an over supply of physicians in the USA (Lamm 1996), and nurse practitioners are seen as a threat to their numbers. Further information on numbers will be required in the future in order to examine any effects of these observations.

The Canadian Experience

During the 1950s and 1960s, similar changes to those experienced in the USA were occurring in Canada, because it also suffered from a lack of doctors, as well as having a scattered population. This is because approximately 90% of Canada's population live along the border with the USA. The remaining 10% live in scattered communities of varying size of population in a land mass totalling one
and a half million square miles, in an area comprising the Northwest Territories, Yukon and Labrador (Hope-Toumishey 1983).

Hope-Toumishey described how Canada, like the United States, initially rejected the expansion of the nurse's role in favour of that of the new role of physician's assistant. The Canadian Nurses' Association however, were concerned that there was a large pool of nursing manpower available who could undertake greater medical responsibilities with a little extra training. In many rural communities nurses were taking over from doctors who had retired simply because there was no physician available to fill the gap. In response to this, the Victorian Order of Nurses (VON), a voluntary organisation, was established to provide care to individuals and families in their own homes on a 24 hour basis, seven days a week. By the 1980s the organisation was financially supported by the government and provided most of the home nursing services in Canada (Hope-Toumishey 1983; Bajnok and Wright 1993).

Another historical development in areas where the population was too small and outlying to allocate a hospital or a health centre, was the establishment of nursing stations. These stations were equipped as out-patient clinics as well as having the facilities to deal with emergencies, including delivery. A few beds were provided to provide temporary care to those waiting for transport to hospital. The stations were serviced by the 'outpost' nurse, whose status was highly respected and cherished.

Hope-Toumishey described the role and function of the outpost nurse as an initial response by a health professional to a request for aid. This could be from any individual who appeared unable to assume the responsibility for making important
decisions for health for self or for others. This seems to have a strong correlation with the nurse practitioner role and indeed, Hope-Toumishey reported that programmes were developed to prepare nurses as family nurse practitioners, nurse-midwives, paediatric practitioners or a blend of these roles.

Since its inception the nurse practitioner role in the USA and Canada has become firmly established. Studies have demonstrated safe practice (Spitzer et al. 1974; Runyon 1975; Mauksch 1981), cost effectiveness (Bliss and Cohen 1977; Fagin 1982) and patient acceptability (Ramsey et al. 1982). Spitzer et al. in their randomised controlled trial of nurse practitioner care also highlighted the improved efficiency in working practices where there was good communication between doctor and nurse practitioner.

The expanded role in less developed countries is now examined briefly.

**The Expanded Role in Less Developed Countries**

The expanded role has essentially developed out of necessity in many under-developed countries. Apart from a few medical missionaries, there were often no doctors in the country at the time. Being the most skilled type of health worker, nurses provided primary health care to rural populations. In these areas health workers who have had a limited education, but who have followed a short training period, can perform simple first-aid procedures and give health advice in the village setting (Stilwell 1988a).

Morrow and Amoako (1980) described a paediatric nurse practitioner course which was set up in Ghana to train nurses to provide primary health care services
for children. In addition, Ngcongco and Stark (1986) reported that, from the time that Botswana became a republic in 1965, independent nursing practice was encouraged. The nurses provided primary health care for rural populations who seldom had vehicle access and who lived in villages of less than 500 people. By the 1980s, 90% of people were living within 15 kilometres of a health centre and family nurse practitioners were taught to manage various health problems. More recently, Ngcongco (1991) reports that there are a total of 80 family nurse practitioners in Botswana working in hospitals, health centres, clinics and educational institutions.

The nurse practitioner has also proved to be an effective provider of primary health care to communities in Sudan, Colombia, Jamaica, Thailand, Korea and Singapore (Maglacas 1991). In Singapore their primary aim was to assist doctors in sexually transmitted disease clinics. Although the aim was to relieve doctors of routine tasks, the nurses' skill in diagnosis matched that of the doctors and patient waiting time was reduced by 25 per cent (Rajan and Pang 1978).

The environments of these different countries demonstrate that they prepare their nurse practitioners in different ways and that, at the present time, training can range from a basic level of understanding, through continuing education, to an advanced degree level. Naturally, training methods have to be responsive to the present and anticipated needs of each community but as Maglacas (1991) states:

*Health planners and decision makers must ensure that this category of health professional is strengthened and institutionalised to extend health coverage effectively to underserved and unserved populations.*

(p.8)
Nurse Practitioners in Europe

There is a paucity of information on the work of nurse practitioners in Europe, and nurse practitioner developments in much of Europe are unbalanced. Farrell (1991) reports that international studies on health professions are extremely rare, and not all countries collect equivalent data. The numbers of nurses can range from 12 per 100,000 population in one country to 158 per 100,000 population in another.

Following the 1978 Alma Ata declaration of 'Health for All by the Year 2000', a meeting of nurses took place in Geneva in 1981. One of the recommendations of the meeting was that the concept of primary health care should be included in the curriculum for nurse training. Unfortunately, the political turmoil in Eastern Europe at the present time is at odds with the challenge to improve both health care and nurse training. For example, Slajmer-Japelsh (1996) reports that the world health global targets are not very relevant for people in Slovenia at the present time. She considers it important that community nurses have education in the social sciences, economics and health politics, and that quality assurance is extremely important in order to improve standards in her country.

The United Kingdom Experience

A similar trend to that which had taken place in North America had occurred in British general practice in the 1960s, where the lure of specialisation with higher pay and greater status resulted in a manpower crisis. General practice was regarded at the time as non-intellectual and a 'second choice' career. As Curwen (1964), a general practitioner, observed at the time, when describing the then present, and possible future of, British general practice:
As yet there is no formal educational definition of the nurse practitioner role in the United Kingdom, although the issues surrounding it have been debated at length throughout the 1980s. The UKCC does not recognise the term 'nurse practitioner' at the present time, considering that all nurses are practitioners in their own right (UKCC 1993). In spite of this, nurse practitioner courses were introduced and nurses came forward. The first of these, with a two year curriculum, was introduced in October 1990 and had 15 participants. All the participants came from the primary care sector and comprised ten practice employed nurses, two district nurses, one nurse adviser in general practice, one nurse from a single homeless team and one community nurse manager. The course was held at the Institute of Advanced Nursing Education which is attached to the RCN, and was validated by the RCN and Manchester University (Mayes 1992). The participants were encouraged to have both a nurse and doctor preceptor in their work setting. Mayes advocates an expanded role for nurses and partnership with general practitioners:

I envisage nurse practitioners having an expanded role in the 1990s, with a nurse practitioner in most community teams and in general practice. Hopefully in five years time the role of the nurse practitioner will be deemed an essential part of the community care team as well as in other branches of nursing.

(p.602)

The influence of several factors, including the New GP Contract and the NHS and Community Care Act 1990 (DoH 1990c), with the consequent shift from secondary to primary care, have stimulated an interest in a more flexible type of nurse with an expanded role, to incorporate aspects of the general practitioner's role within their practice (Mitchinson 1996).
Various studies have been conducted into the work of nurses in the United Kingdom who have expanded their role (Stilwell et al. 1987; Fullard 1987; Salisbury and Tettersell 1988; Atkin et al. 1993; Wood et al. 1994; Muir et al. 1994). Seminal work was undertaken by a nurse practitioner, Barbara Stilwell, in an inner city community in Birmingham from 1982 to 1985. During 1983, and over a six month period, a study of her working style and pattern of consultations, was described (Stilwell et al. 1987). The practice had 4728 patients and three doctors (two single-handed male doctors for the first three months, joined by a female doctor for the second three months). Patients were offered a choice of whether they wished to consult the nurse practitioner or the doctor, the nature of the work being advertised in the waiting room and explained further by the nurse when meeting the patient. The nurse practitioner held surgeries and gave advice about the management of illness, monitored certain conditions and prescribed from a limited range of drugs, with prescriptions being signed by the general practitioner.

The largest proportion of consultations (50%) were for preventive medicine, with 20% for advice and health education, followed by 20% for social, marital and family problems. Forty five per cent of cases were managed without referral, investigation or prescription. Although the largest number of problems presented were for prophylactic procedures (59.8%), the next highest category was for symptoms, signs and ill-defined conditions (10.5%). This study demonstrated the range and potential of work that can be undertaken by a nurse practitioner.

In a second study, Drury et al. (1988) investigated the acceptability of the nurse practitioner to a random sample of 126 patients. Women were three times more likely to consult the nurse practitioner than men. Comments from patients related
particularly to being treated as an individual, and the time the nurse took to listen to the problem. Patients also felt that they could participate in the consultation. It was suggested that a combination of these factors may facilitate learning about the nature of illness and treatment, and encourage patients to make educated decisions about their health. A supportive role encompassing all of the above, while not exclusive to nursing, is an essential element of it, and the place of therapeutic listening within the consultation will be discussed further throughout this thesis.

The data (Drury et al. 1988) suggested that nurse practitioner care was acceptable to most patients, but that further studies were required to support the theory that health outcomes in terms of self-reliance and control are particular to this process of nursing care.

Earlier, Cartwright and Anderson (1981) reported that consultations with the general practitioner for family problems declined from 40% in 1964 to 30% in 1977, although the percentage of consultations considered inappropriate or trivial had not changed. These included colds, sore throats, bruises, headaches, and non-infected bites. There is no evidence in the study by Drury et al. (1988) however, that the vague symptoms that patients presented to the nurse practitioner for reassurance or advice are those classed by general practitioners as trivial, inappropriate or unnecessary. Nevertheless, their paper suggested that the role of the nurse practitioner could be one of the provision of anticipatory care and emotional support.

Another important study reported the work of Barbara Burke-Masters, a nurse practitioner in the East End of London who provided a service for vagrants and alcoholics, seeing people that general practitioners were unwilling to have in the surgery. Burke-Masters considered that one of her main tools was listening, and
felt that special groups with special needs required a special service that could not properly be provided in a conventional general practice (Cohen 1984; Burke-Masters 1985; 1986). Burke-Masters recognised that general practitioners were reluctant to treat patients of no fixed abode, particularly if they presented to the surgery in a dishevelled or drunken state, but also found that doctors were unwilling to accept referrals from her, of to refer on to a specialist on her behalf. She concluded by saying that although her role had extended into the area of medicine, the nature of her work was still primarily that of nursing.

In 1992, the Healthcare Division of Touche Ross Management Consultants was commissioned by South East Thames Regional Health Authority (SETRHA) to undertake a two year evaluation of 20 pilot sites where nurse practitioners were being introduced to primary, hospital and community health care (Touche Ross 1994). Patient satisfaction was reported to be relatively high for general practitioners at 78%, but was highest for nurse practitioners and practice nurses at between 83% and eighty four per cent. Patients particularly rated nurses higher on the interest taken in them and in the thoroughness of the nurses. The Report also highlighted the problem of determining cost effectiveness in the absence of agreed outcome measures. In part this was because most of the nurse practitioners were undergoing training, and it was considered that their consultation times might be longer than those for mature and experienced practitioners. Among the conclusions of the Report was the view that primary care showed the greatest scope for the development of the nurse practitioner role in managing a comprehensive caseload jointly with general practitioners.

More recently in 1994, in the evaluation of the Derbyshire nurse practitioner project (Chambers 1994), patients appreciated that the nurse listened and
explained things to them, and liked having a choice between doctor or nurse practitioner consultation. Three part-time nurse practitioners worked in three volunteer practices, and Chambers questions the strength of the study design when volunteer practices are used, a similar weakness of the Practice Nurse Study, which will be acknowledged in Chapter Four, in the Methods section.

The Pathway Towards Practice Nurse Education

The reform of nursing education has been a long, slow process with many of the reforms stretching back to the 1940s. Unlike medicine, nursing education has traditionally been a vocational type of education with a strong service element linked to an educational programme (Smith 1994). As discussed earlier, the resultant over emphasis of the service side was sometimes detrimental to placing the practice of nursing on a sound educational foundation.


By 1969, in recognition of the increasing use of nurses in primary care, the General Nursing Council was indicating in its syllabus that nurses in training should be exposed to the concept of community care (Hodes 1972). From 1975, education for nurses in community care was underpinned by the importance placed on it by the Report of the Committee on Nursing, known as the Briggs Report (DHSS 1972).

The Report drew attention to areas of practice where there were overlaps with other professional groups, particularly medicine, and called for closer co-operation between them in the best interests of the patient. At the same time, medical
education and general practitioner training were emphasising the importance of
the more holistic context for treatment of the patient as being as important as
clinical expertise. Although the holistic approach was not new to nursing, it was
recognised within the Report that the traditional differences in some of the
activities between nursing and medicine were becoming blurred, particularly as
recognition of an expanded role for nurses became more widespread.

Although the nursing role had to adapt to the changing needs of society, it could
not be considered adequately in isolation from the role of other members of the
National Health Service. The Report endorsed statements made to them by the
General Nursing Council for England and Wales that firstly:

...the role of the nurse must always be closely related to the needs of the patients.

(13, p.3)

and secondly that:

...these needs are never static, but vary according to individual patients, medical and
technical advances, and developments such as the possibility of a unified nursing
service. Thus, the role of the nurse is continually changing.

(13, p.3)

The Briggs Report also placed importance on the value of health teams, and
expressed the view that the time would come when the public would come to
expect a network of medical services starting with services based on group medical
practice within or outside health centres. It was considered that the growing trend
to concentrate acute medicine within hospitals, and the consequent development
of an expanding domiciliary service based on group practices, would require an
increasing number of attachments of health visitors and nurses to general practice.
General practitioners however, continued to see themselves as leaders of the
primary health care team.
By 1976 the Briggs Report had still not been implemented, partly because of the long response to the recommendations by the government and the nursing profession. The prolonged delay occurred partly as a result of considerable disagreements within branches of nursing in regard to the Briggs concept of unification of the differing sections of nursing, with further specialisation after basic training. This perhaps reflected nursing’s mistrust of the proposals in view of previous experience with the Salmon (MoH 1966) and Mayston (DHSS 1969) Reports. In its terms of reference, the Salmon Report was intended to modernise nursing management in three tiers of responsibility in hospital, and make more efficient use of nursing labour. A parallel scheme was later recommended for local authority nursing by the Mayston Committee.

In relation to the delay in implementation of the Briggs Report, it was noted in the Health Services in Scotland Report (SHHD 1977):

*On 30 November 1976 the Secretary of State for Social Services on behalf of all Health Ministers announced to a meeting of representatives of the nursing profession that in the present financial climate and with no prospect of legislation in the current session of Parliament it would not be possible to proceed with the implementation of the recommendations contained in the Briggs Report in the near future.*

(8.21, p. 61)

Eventually, in 1977 a further period of consultation ensued with the setting up of a Briggs Co-ordinating Committee. This committee consisted of departmental officials and representatives of the nursing organisations who discussed the necessary legislation, and in 1978, a bill was finally introduced.

In the event, nursing chose to have separate statutory committees. Despite the recommendations of the Briggs Report, the Nurses Midwives and Health Visitors Act (1979) resulted in the establishment of four national boards which were set
up in Scotland, England, Wales and Northern Ireland, to supervise training and be responsible for discipline. In addition, as a result of the Act (1979) the statutory nursing bodies were disbanded, including the General Nursing Council. They were replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), whose principal aims included the improvement of standards of professional conduct, and decisions about qualifications required for registration. Most significantly, the 1979 Act introduced a change in the system of nurse training, but left the type of changes to be determined by the new organisations.

There were some major implications for nursing in the 1980s which can only be touched on briefly here. Demographic changes implied that by the 1990s the size of the cohort of 18 year olds with appropriate entry qualifications would reduce as a result of the fall in the birth rate in the 1970s. Until the latter part of the 1980s, only 40% of student nurse time was spent on education and training, and by 1986 nearly 6,000 student nurses a year were leaving nurse training (Clay 1991). Another central problem was how to use the limited supply of nursing hours most effectively if nurses were to become students in reality.

In May 1986, the UKCC published its proposals for the reform of nursing education, but by March of 1988 the government was still considering the cost and manpower problems. This was reminiscent of the proposals of the Wood Report (MoH 1947) forty years earlier, the Platt Report (RCN 1964) and the Briggs Report discussed earlier, which also recommended that nursing education should be separated from employee status. Towards the end of the 1980s there was a reduction in recruitment to nurse training in some areas and a lack of availability of trained nurses. In addition, as Clay (1991) notes, virtually all the other
professions allied to medicine had moved into further or higher education for their preparation for practice. Eventually Project 2000 was set in motion.

**Project 2000 and PREP**

The proposals of Project 2000 (UKCC 1986) aimed to raise the quality of nursing education not only by setting a higher standard, from certificate to diploma level, but also by changing the status of nurses from part of the workforce to that of supernumerary student. The main objectives in setting up Project 2000 were to look at the health needs of the population in the 1990s and beyond, and to determine the type of practitioner required to meet these needs. In the autumn of 1989 the first Project 2000 programmes began in 13 'demonstration districts' in England and progressed from there, with different timetables for its introduction in other sites. In September of the same year it was introduced in Scotland. Apart from agreement to move to one level of nurse, one of the most important developments was to prepare the nurse to work in both community and institutional settings.

Further career progression was encouraged with the introduction of the post-registration education for practice proposals (PREP) (UKCC 1990b; 1990c), which intimated among its recommendations, that periodic registration would be required every three years and during that time a five day period of study should be completed. Evidence of this study would be required in a personal professional profile. Newly registered practitioners would be given support through mentorship, so that they could draw together what they had learned and consolidate their skills.
The PREP proposals initially caused some disquiet, because it was felt by community nurses, and in particular health visitors, that their special skills were not being recognised. They were concerned that Project 2000 training would be considered sufficient to produce a ‘generic’ community nurse. Gradually, the proposals for PREP have been refined (UKCC 1993; 1994) and community nursing has been recognised as a specialist area requiring more than that of first level practice. It is anticipated that the newly qualified community nurse will develop into a ‘specialist’ practitioner, able to practice in a more holistic way.

Opportunities for Education and Training for Practice Employed Nurses: Past, Present and Future

The education of practice employed nurses is currently progressing from the level of a mere ‘statement of attendance course’ towards that of a community health care nurse qualification. This progress is due to the not inconsiderable efforts of practice employed nurses during the 1980s. The statutory requirement for vocational training for general practitioners stimulated joint training between trainees, trainers and practice nurses. The formation of interest groups facilitated by the RCN and supportive general practitioners spread to become a national network (Damant et al. 1994).

In order to strengthen their political profile, practice nurses gained access to the Royal College of General Practitioners through their general practitioner employers. The result of this was the establishment of a working group to examine the training needs of the practice nurse. There was some disappointment when The Report (RCN 1984) was produced because it did not recommend a compulsory training requirement, and the syllabus was considered inadequate to
provide quality nursing care in general practice. The Report did not appear to address the different training and experience of some practice nurses, and the working group had differing perceptions of the role and function of the practice nurse (Baker et al. 1987). The Report listed procedures and techniques which had a medical focus, such as venepuncture and electrocardiography screening. This raised the question of whether the role was that of medical assistant, practice nurse or nurse practitioner.

In 1990, a broader based and more detailed analysis of nurses employed in general practice was completed by the English National Board Review (Damant 1990) and was better received. This review of education and training for practice nursing concluded that the role and function of the nurse in general practice is supported by a range of complicated processes. These processes include problem solving and decision making, clinical, management and research processes, and the Review Committee called for more flexibility of practice, and emphasised a multi-professional framework. The flexible practitioner is envisaged as one who will respond to, and initiate, innovation while maintaining stability for patients. As Damant et al. (1994) observe:

> Change is inevitable but offers the opportunity for development and progress. An important principle in the process of change is stability. The patient is still the prime consideration and general practice would not be general practice if nursing was not part of it.

(p.104)

**Summary**

An attempt has been made within this literature review to explore the issues surrounding the development of practice nursing, the division of labour between nurses in different employment categories and the emergence of the nurse
practitioner role. The importance of education and the contribution of research have been highlighted, as has the role of nurses within the primary health care team.

It has been detected throughout this chapter that there is a lack of clarity in the roles and titles given to nurses working in general practice. There is considerable ambiguity in the use of the terms ‘extended’ and ‘expanded’, although a number of authors have sought to describe the differences. In addition, it has been found that nurses are practising with differing levels of expertise and with a variety of educational and professional qualifications.

Several authors have also talked of ‘traditional’ and ‘technical’ roles from differing perspectives. These variously describe the traditional role as one of caring, or one where the nurse performs ‘simple’ tasks, such as dressings. Technical roles are described as having a medicalised focus, but also carry administrative responsibility. It is also suggested that the nurse practitioner role has a technical component, but differs from that of physician’s assistant in that it has an holistic approach.

There have been several references to the ‘flexibility’ or ‘pliability’ of the practice nurse. Throughout the years, general practitioners have expressed the wish for nurses to be flexible in their practice, and have contrasted the lack of flexibility of attached nurses with nurses they employ themselves. The Cumberlege Review Team (1986a), the NHS Management Executive (NHMSE 1993), and Jewell and Turton (1994), considered flexibility of practice to be detrimental to security of tenure for practice employed nurses. Hockey (1984) contrasted pliability with insecurity in terms of the lack of access to continuing education for practice
employed nurses but, like Damant (1990), talked about flexibility of practice. In this context flexibility requires the nurse to accommodate the needs and demands of patients, not to be responsive to the influence of other professionals such as general practitioners.

It has emerged throughout the course of this literature review that general practitioners are a key group in determining the acceptance of autonomy for nurses in primary care because of the powerful position of doctors in this setting. Medical commentators have talked about ‘supervision’ of, and ‘delegation’ to, nurses and have emphasised the importance of the general practitioner as the leader of the primary health care team. This raises a predicament for nurses. On the one hand, if they accept delegated authority from the general practitioner as the pre-eminent evaluator of their competence, studies report that this may make a broadening of the practice nurse or nurse practitioner role more acceptable to their medical colleagues. On the other hand, nurse commentators have recently raised the issue of autonomy in consideration of partnership with general practitioners. It is not entirely clear however, whether partnership implies a financial arrangement or a professional partnership. Hockey (1978) however, considered that professionalism and autonomy were inter-twined:

_A professional nurse may adopt different roles in the course of her work. Some may appear to be an under-utilization of skills and knowledge, others may give the opposite impression. The professionalism lies in the individual autonomy over decision making in the ability to reason why, when, and how different roles are adopted. It is exactly the ongoing, informed change of role in response to changes in other spheres which increases rather than threatens the professional autonomy so anxiously guarded by many._

(p. 580)

The study which is the focus of this thesis examines the nature and level of delegation of work to practice nurses by general practitioners, as well as the so-
called traditional and expanded roles. The processes of care undertaken by the nurses in the study are examined, and as Hockey (1978) pointed out, the nurses are seen to adopt different roles in the course of their work. Hockey's comments were made nearly 20 years ago, but seem very appropriate at this time of immense change in practice nursing.
Chapter Three

**NURSING THEORY, NURSING PRACTICE AND NURSING RESEARCH: THEIR RELEVANCE TO PRACTICE NURSING**

*It should not be forgotten that science is not the summa of life, that it is actually only one of the psychological attitudes, only one of the forms of human thought.*

(Carl Jung)

**Introduction**

In this chapter the present uneasy relationship between nursing theory, nursing practice and nursing research is examined. While this is by no means an exhaustive account of nursing theory, the development of nursing knowledge is explored where it has relevance to practice nursing. This is done in an attempt to set the scene for what follows and, although all of the themes explored here will not be developed further, areas more relevant to the study of practice nursing will be advanced in Chapter Eight.

Certain perspectives which have relevance for nursing in general, are particularly useful for practice nursing. These include reflection and experiential learning, and the concepts of holism and therapeutic nursing. Further, it was identified in a review of the literature that there were several recurring themes in relation to practice nursing. These included the relationship between traditional and
innovative modes of practice, which were found to have different interpretations. Issues surrounding professional and managerial control were identified. These have particular significance for practice nurses because of the differing nature of their employment by general practitioners, and Health Boards or Health Authorities, and the level of delegation involved in their work to date. There are also implications in terms of accountability and autonomy, because nurses need to be in control of their professional practice in order to expand their role. In addition, several authors have drawn attention to the lack of definition in the practice nurse role, and the variation in educational and professional qualifications that they possess. These topics are given further attention in this chapter, because I consider them to be particularly relevant to nursing in primary care.

From Tradition Towards a Development of Nursing Knowledge

When members of the public are asked to describe nursing, they provide descriptions of nurses 'doing' things (Chapman 1985). This concept of nursing as an essentially practice-based discipline is sometimes attributed to Florence Nightingale's emphasis on tasks and procedures, and obedience to authority. Historically, nurses undertook practical tasks under the supervision of the doctor and the Nightingale code continued this theme by emphasising personal qualities of sobriety and good character, not educational ability. Training requirements for potential nursing students of the time stressed that a minimum of educational attainment and a maximum of moral stature were the essential requirements of nursing (Abel-Smith 1960).
Over 20 years ago a number of authors reviewed the tradition of service and low status that were considered to be the essence of nursing. Murphy (1971) indicated that much of the body of knowledge used in nursing is derived from the accumulation of unreasoned experience, the transmission of superstition, speculation and an unquestioning acceptance of what was taught. Even earlier, Henderson (1966) considered that nursing was steeped in tradition passed down from one generation of nurses to another, too often without any justification. Johnson (1974) suggested that, because nursing is an occupation created by society long ago to offer a distinct service, it has no scientific heritage. Although still ill-defined in practical terms, it is a profession without the theoretical base it seems to require. It is interesting that more than two decades later the nursing literature still finds that traditional approaches are influencing nursing practice. Aggleton and Chalmers (1986) agreed that nursing practice was largely based on traditional methods which included instinct and empathy at the expense of a more rational approach to nursing.

Although Miller (1989) did not provide evidence to support her comments, she considered that practising nurses were unlikely to be using nursing theory, perhaps because the present theories are not considered relevant to nursing practice. Miller supported the view that direct nursing care is based on traditional rather than professional foundations of nursing. By this she meant that tradition implies a knowledge of sciences other than nursing, and is based on administrative rules and regulations and personal values and preferences. Clark (1991) suggests that there is a traditional view of nursing that considers that it is not obligatory to understand the necessity for a task or what its effects will be, however competently skills are executed.
She comments:

Within this view nursing has no knowledge base of its own, nor does it need one: its skills are essentially manual and technical and reflect the knowledge of other disciplines.

This fits well with the concept of the practice nurse undertaking delegated tasks under the direction of the doctor with no direct involvement in the decision-making process. Indeed, 'doing', was for many years considered the responsibility of the nurse. Nurses have been described, or have indeed described themselves in the literature, in this way as 'doers' (Loomis 1974; Brykczynska 1993), while in contrast, 'thinking' was considered the province of the doctor. As Loomis (1974) suggested, nurses had little time to think, reflect or question their own practice because of the emphasis on tasks and procedures. In addition, Loomis implied that this task-oriented perspective on nursing, while requiring training to develop skills, had a concomitant lack of emphasis on a sound knowledge base.

This trust in procedures, it was argued by Austin (1979), exacerbated the subordination of nurses by nurses themselves, but she was confident that they would, in time, expand their role toward that of a health care practitioner. Nearly two decades later, it would appear that her confidence in nursing has been well founded, because nurses are indeed expanding their roles. This has particularly been the case for practice nurses (Bryan 1992; Damant et al. 1994) since the implementation of the New GP Contract. It has been a slow process however, because of problems of acceptance by the medical profession and not least, by nursing management itself. This raises the question of power relationships within nursing and medicine.
Issues Surrounding the Professionalisation of Nursing

The subject of what constitutes a profession can only be touched on briefly here. The view that a body of knowledge is one of the essential components of a profession is supported by many sociological and management texts (see for example, Pavalko 1971; Friedson 1977; Kast and Rosenzweig 1985). The authors suggested that preparation for a profession must be an intellectual as well as a practical experience. A vexed issue has been that of producing a usable definition of what constitutes a profession. ‘Tradition’ plays its part in this context in that the status and prestige accorded to the ministry, the law and medicine led these occupational groups to be regarded as the original professionals (Dingwall et al. 1988).

Kast and Rosenzweig (1985) suggested that professionalism should be described as a continuum, with the ideal type of profession at one end, and the non professions or unorganised occupational categories at the other. They included in this continuum the authority invested in the professional by dint of superior knowledge which is recognised by the clientele. This authority is highly specialised but is contained within the professional's sphere of knowledge. In addition, they suggested that there is a broad social sanction which confers on professionals certain powers and privileges, and professionalism carries a code of ethics which imposes self-discipline as a basis of social control. Finally, there is a culture sustained by organisations which is generated by the interaction of formal and informal groups and is unique to the profession, a professional culture.

One wonders what Florence Nightingale would make of the debates about professionalism in nursing, being one of a group who strongly opposed all attempts to steer nursing along this course. She considered state registration of
nurses was against the public interest, because registration would imply that the nurse was a good nurse, whereas the qualities that made a good nurse included vocation and an understanding of the ‘art’ of nursing (Fawcett 1989).

Observations about the meanings of tradition and professionalism continue to be debated in the nursing literature today, but over twenty years ago there was already a call for a less traditional, and a more systematic and analytical approach to nursing care. Florence Nightingale’s views on professionalism do not negate the early contribution that she made to the development of theory. Although she did not use the term ‘environment’, she stressed the importance of light, ventilation, low noise, and cleanliness (Nightingale 1969). She linked health with environmental factors, care with methodical data collection, and hygiene with well-being. This resulted in a clear conceptual model of the patient and goals for nursing. Indeed, her emphasis on the environment is now seen as one of the fundamental elements of nursing theory, and is focused on by many nursing authors including Peplau (1952); Rogers (1970); Riehl and Roy (1980); Roper et al. (1980); Fawcett (1989). As time goes on nursing’s viewpoint has broadened to encompass an holistic perspective that recognises the interaction of humanity and the environment.

Nursing already accommodates some of the categories that mirror a profession and is moving towards achieving complete professional status. A code of ethics is deemed to be one of the marks of a profession and nursing has had a Code of Professional Conduct since July, 1983 (UKCC 1983). It has, however, undergone several revisions over the years, the latest being in 1992 (UKCC 1992a). The Code was established to provide professional guidance, but it is not law and there has been increasing criticism about its inadequate support for the actions of nurses.
Smith (1994) considers that there is a dilemma for nurses. They not only have to satisfy the moral and ethical obligations of the Code, and be accountable for their actions, but also try to meet the expectations of their employer, who is operating with increasing demands and reducing resources.

Watson (1995) suggests that accountability is the essence of professionalism, because it sets professions apart from other kinds of occupations. Sharing knowledge and information with different members of the primary health care team requires a professional maturity that welcomes the contribution of others and does not feel threatened by it. In relation to primary care, as the role of the practice employed nurse in particular continues to expand, accountability becomes increasingly important.

**Autonomy and Accountability**

Shea and Leather (1995) describe accountability and responsibility as key facets of a profession, but point out that the two terms are used interchangeably and sometimes, erroneously. To be both accountable and responsible for one’s actions, a level of authority is needed to ensure that the action is carried out. They go on to propose that accountability reflects a willingness to be answerable for your own actions or omissions, whereas responsibility means accepting the consequences for your own actions or omissions. The UKCC’s Code of Conduct goes some way to providing direction on these topics. If accountability and responsibility are examined in the context of practice nursing, responsibility is more task-oriented and can be related to delegation. As suggested by Claus and Bailey (1997), a responsible person can be delegated authority to do a task, which they have the
duty to perform adequately. Accountability on the other hand, supersedes responsibility and is associated with autonomy and more innovative practice.

There are many definitions of autonomy, but basically autonomy means having the freedom to choose, to be able to carry out plans and policies, make decisions and be held accountable for actions and behaviour (Weir 1995). As described in the review of the literature on practice nursing, practice nurses cannot be considered truly autonomous because they are not, at present, self-employed. They are either employees of the general practitioner or attached to general practice by the Health Board or Health Authority. The employer will naturally place restrictions and choices on the scope of employment (Smith 1994), and this exercise of management control means that nurses are not truly autonomous. It was identified in the literature review that there are problems and advantages connected with both types of employment, and that role expansion can result in tensions between practice nurses and general practitioners.

As discussed in Chapter Two, many nurses choose to be employed in general practice because of the degree of flexibility offered in working arrangements, and the fact that they are outwith the nursing management structure. Hockey (1984) and Peter (1993) however, criticised practice nursing for its uncertain and ill-defined role. This was also the view of locality purchasers and managers of community nursing provider units in the National Census of practice nurses in England and Wales conducted by Atkin et al. (1993). Atkin et al. report that practice nurses and general practitioners did not share this interpretation. The practice nurse and general practitioner respondents emphasised the flexibility of the practice nurse role and its ability to adapt to the changing demands of general practice and local circumstances. FHSA advisers shared these views and
emphasised the skills of practice nurses and their contribution to general practice. Practice nurses reported that their work had expanded beyond that of treatment room tasks and they did not like practice nursing’s reputation that it was merely task oriented. Unfortunately, although the issues are raised in the Census, Atkin et al. do not address accountability, autonomy and professional control in any depth.

There are problems in that general practitioners who have limited, or no previous experience of working with practice nurses may also have little knowledge of their potential (Bowling 1988b; Damant et al. (1994). This can result in unnecessary restrictions on the nurses’ activities. Paradoxically, it is suggested that there may be expectations that practice nurses, and practice employed nurses in particular, can undertake expanded roles beyond their level of competence to do so. For this reason it is argued (Bowling 1988b; Damant et al. 1994), that practice employed nurses who have greater freedom to plan and manage their own work must learn to be accountable for their own actions.

Thus far, certain attributes consistent with professionalism have been identified and discussed. These have included tradition, a body of knowledge, ethics, autonomy and accountability. It was also identified that practice nurses are exposed to differing types of control depending on the source of their employment. This is discussed further.

*Professional Control and Interprofessional Relationships*

As we have seen, external forces may govern the actual work that practice nurses do, rather than what they would like to do. Their working practices may be
constrained by the general practitioner's or Health Board's views, or by their own lack of training and education for the role.

Patriarchy can be seen in the doctor-nurse relationship by drawing parallels between the husband and wife in the family, with the doctor deciding on the relative importance of the work and how it was to be done, while the nurse looked after the physical and emotional environment (Oakley 1984; Draper 1990b). The idea of 'care' itself is seen as an extension of the female role and less privileged in status. Control is also manifest in delegation. Delegation is described by Claus and Bailey (1977) as:

*the act of entrusting authority to someone who then performs as the representative of the person who gave authority. Control is utilized when authority is delegated.*

(p.60)

They take the view that the person delegating always maintains part of the authority for the actions of the subordinate, and a part of the responsibility. Related to these issues is decision-making, as making choices implies that there are decisions to be made. Acceptance of responsibility is what opens the door to authority and power, and is the basis of accountability. While there is evidence (UKCC 1988) that there are changes taking place in the nurse training curriculum, influences still remain of a system where conformity was encouraged and innovation opposed. Rodwell (1996) argues that it is essential that the nursing profession develops an intrinsic philosophy of valuing and empowering its members in order that nursing can take charge of its practice, and enable its clients.

Friedson (1984) measured medical dominance of the allied health professions along four dimensions. First, the work and knowledge of health professionals is
approved by doctors and stems directly from medical knowledge and research. Secondly, doctors assist in diagnosis and treatment. Thirdly, the work of health care providers is usually requested and supervised by doctors, and finally, the status of health care providers is not equal with that of the medical profession.

Friedson argued that as long as the medical profession retains control over aspects of the work of other health professionals, they will not be truly autonomous and as a result will remain subordinate to, and of a lesser status than the medical profession. Hasler (1994), a general practitioner, observes that traditional general practice dictates that access to medical care is via the doctor, and that this is because the doctor’s chief role is to diagnose and initiate management and treatment. This view has relevance for practice nurses because Hasler speaks from a primary care perspective.

Dowrick et al. (1996) reported on general practitioners’ views on which types of care were most and least appropriate for doctors to undertake. They reported on a semi-structured questionnaire sent to general practitioners in Merseyside. Acute and chronic physical problems were most often listed as appropriate by general practitioner respondents, whereas minor or self-limiting complaints were not considered appropriate. Social issues, spiritual worries and welfare rights were also considered inappropriate. General practitioner respondents in this study appeared to hold the view that they should work to a bio (psycho) rather than a bio-psychosocial model of health care. Some of the issues highlighted by the doctors as inappropriate represent the areas in which practice nurses are expanding their role. It could be argued that this is delegation in another form, because nurses are undertaking work that doctors do not want to do.
Mackay (1996) describes previous research involving nurses’ and doctors’ views regarding ideal types of the ‘good nurse’ and the ‘good doctor’ which may reflect some of the problems in everyday professional working relationships. Nurses consider the good nurse to be sensitive and caring towards the needs of patients, whereas for doctors, the good nurse is competent, anticipates and uses initiative. The good doctor as described by nurses, is one who has well-developed interpersonal qualities, is a good listener and who treats nurses as equals, respecting their opinions. Doctors’ evaluations of the good doctor focus mainly on levels of skill.

Interprofessional communication between members of the primary health care team is important, but is particularly so between doctors and nurses. Where communication is poor everyone suffers, patients and health care providers (Mackay 1996). Mackay suggests that each group has its own sphere of competence, and greater recognition needs to be given by one to the other. If this was the case, some of the tensions encountered in working together could be overcome.

There appears to be agreement that working as a team is beneficial, but there is an assumption that teamwork develops automatically, although poor communication is a recurring theme in the literature (McClure 1984). In a postal survey undertaken to examine the roles and perceptions of practice nurses in a health district in the north-east of England, (Mackereth 1995) reports that the majority of practice employed nurses and practice managers attend business oriented meetings whereas community nurses do not. The author suggests that an ‘inner’ team is developing, comprising the general practitioners and those employed directly by them.
The shifts in power demonstrated by the potential to directly employ attached practice nurses, health visitors and district nurses by fundholding general practitioners may have implications in terms of inter-professional dynamics between nurses and doctors (Atkin et al. 1993). They suggest that there can be difficulties when trying to integrate the nursing team, because of differing employment and managerial structures, and especially with regard to conflicting priorities. Commissioning authorities and community nurse providers have emphasised that current general practitioner management works against more strategic use of the whole primary care nursing resource. Nevertheless, general practice fundholding has integrated some nursing teams. Atkin et al. report on the Premier Healthcare model of self-managed nursing teams, which has resulted in closer liaison between district nurses and practice nurses. The team work more closely together to meet the needs of the practice population, as well as their own needs, more effectively.

The primary health care team has been strongly identified as the focus for nursing activity outside acute care (NHSME 1993). Additionally, based on a survey of 10% of general practitioners in the United Kingdom, an Inner City Task Force Report for the Royal College of General Practitioners (Lorentzon et al. 1994), provided impressive evidence that doctors wanted more nurses in their teams. It was detected that they would like nurses to act both in ‘traditional’ roles and to fulfil the newer ‘extended’ functions. It can be argued however, that the degree to which practice nurses develop their roles depends largely on the team’s cohesion and effectiveness. Management theory suggests that, in order for change to take place it requires motivation, commitment, good communication, and the capacity for individuals to integrate ideas into their own value system (Marrow 1969). Similarly, Lorentzon et al. point out that, as practice nurses expand their role and,
if change is to be accepted, there has to be mutual co-operation. Without the support of the medical profession change will not occur.

As time goes on nursing’s viewpoint has broadened to encompass an holistic perspective that recognises the interaction of humanity and the environment. Although such a perspective is not unique to practice nursing, as the role of the practice nurse continues to develop it appears to be moving from a task-oriented, activity-based model to one that requires the development of different levels of nursing knowledge in order to practice safely, and autonomously. It is important to explore what theoretical underpinning is required to allow this to take place.

Nursing Theory and Nursing Practice

Much emphasis has been placed on the practical and task-oriented approach associated with nursing. This was highlighted in the previous chapter in a number of studies of the work of practice nurses, and raises several questions about nursing theory. Where do theories and models fit in to the work of nurses, which theory of nursing is appropriate and does theory comes before practice and research? These issues are explored further.

Traditionally North America has led the field in the development of theories and models of nursing practice, which can be used as guides to practice. From the 1950s' references to theoretical frameworks and nursing models had begun to appear (Peplau 1952; Rogers 1970; Orem 1985; Roy 1970, 1971, 1973; King 1971, 1975). A proliferation of these nursing models were based on a systems approach in an attempt to give nursing a more academic profile.
**Systems Concepts and Holism**

In 1950, a theory of knowledge which he called *General Systems Theory*, was first described by the biologist Ludwig von Bertalanffy in a paper presented to a meeting of the American Philosophical Association (von Bertalanffy 1951). In the past, traditional knowledge had progressed along well-defined subject lines, but von Bertalanffy suggested that the various fields of modern science have had a continual evolution toward a parallelism of ideas which has laid a foundation for understanding and integrating knowledge from a wide variety of specialised fields.

These ideas in turn, provided an opportunity to formulate and develop principles that hold for systems in general, and are particularly relevant in the social sciences as a means for exploring social change. von Bertalanffy (1952) stressed this view:

> If we survey the various fields of modern science, we notice a dramatic and amazing evolution. Similar conceptions and principles have arisen in quite different realms, although this parallelism of ideas is the result of independent developments, and the workers in the individual fields are hardly aware of the common trend. Thus, the principles of wholeness, of organisation, and of the dynamic conception of reality become apparent in all fields of science.

(p.176)

A key element of the systems approach is the basic tenet of *holism*, which is especially appealing to nursing. Holism emphasises that the whole cannot be viewed simply as a sum of the parts, the system itself can be explained only as a totality (Kast and Rosenzweig 1985). It is interesting to note at this point, that holistic care was conceived in 1898 by a doctor, Alfred Adler, while working in Vienna as an ophthalmologist. He later moved into general practice and neurology, and eventually founded the Adlerian school of psychotherapy (Holden 1990).
Holism is the opposite of elementarism or the division of labour, which views the total as a sum of its individual parts. Nowadays however, the breakdown of a complex task into components is often more acceptably known as 'job specialisation' (Stoner and Freeman 1992). The perceived advantages of the division of work can be applied to skill mix in nursing. It creates a variety of jobs, letting people choose, or be assigned to, positions that match their education and training. There are disadvantages, however, in that there may be a loss of control over one's work, and lack of job satisfaction.

Holism is a central concept for modern professional nursing, and the environmental factors that influence health and well-being are relevant to practice nursing. Several authors, including Newman (1979); Neuman (1980) and Meleis (1991) offer theoretical perspectives on health that have utility for the management of individuals and families. In contrast to hospital based medicine which tends to define patients more narrowly in terms of pathology, general practice attempts to care for ‘individuals’ as ‘whole’ people. The model of care adopted by practice nurses is therapeutic in its concern with the nurse-patient relationship and an understanding of the patient’s experience of both illness and health. The therapeutic relationship is based not on the activity itself, but on the process of carrying it out. This is an amalgam of knowledge, skill and specialised activity that complements medical practice.

Part of the process of the therapeutic relationship can be located in the notion of partnership. Salvage (1992) submits that there is an attempt to locate the idea of partnership in the tradition of women healers before the time of nursing’s domination by medicine. There is also a traditional view that advocates a one-to-
one professional relationship between expert and client. She describes the ideology of partnership as being one which:

'...draws heavily on humanistic psychology, with its emphasis on openness, trust and honesty in the discovery of self through relationships with others.'

(p.14)

McMahon (1991) emphasises that partnership is a two-way process. He suggests that, as partners, both the nurse and the patient have responsibilities to, and expectations of, each other. King (1971; 1975) emphasised the interactive nature of the nurse-patient relationship and the processes of action, reaction and transaction. King described the specific goal of nursing as health, and the aims to be that of assisting individuals, and families, to meet basic needs when they cannot do so themselves. These themes fit well in this study, because practice nurses are involved with individuals and families in the course of their work, and with the provision of care and counselling services. Using a systems framework in this setting, nursing intervention in family care problems may entail negotiation of mutually acceptable goals that reflect the desired changes. Strategies for achieving these goals can then be worked out.

A systems approach could seem at first to be rather unwieldy and time consuming. Allowing for variability in working patterns, how can the nurse possibly have time to devise a strategy for care based on a model which is in itself composed of several parts? As a fundamental principle however, the systems approach is quite basic. It simply means that everything is interrelated and interdependent, and encompasses the notion that any given system influences the environment and the environment in turn influences the system.
In promoting holism, Holden (1990) cautions practising nurses and nurse educationalists against rejecting the medical model of care. She considers that there is a tendency to wrongly speculate that a medical diagnosis labels and de-humanises the patient. The problem is rather, who does the labelling? It is the individual health professional as the labeller who converts the patient into an object and a ‘diagnosis’. This is a logical argument, because it would seem arrogant for nursing to assume that they alone have an holistic approach to care. As Holden suggests, the present antagonism to the medical model does nothing to establish channels of communication that will allow these differences to be resolved, to the ultimate benefit of patient care.

Benner and Wrubel (1989) argued that the term ‘model’ is mechanistic and should be applied to objects, where it will increase understanding. They argued that when this perspective is used as a basis for studying people, it produces confusion, poor understanding and a non-caring stance in care givers. For this reason, the term ‘model’ does not adequately explain the complexity of nursing and the context in which nursing takes place.

The Muddle of Theories and Models

Hempel (1965) argued that the use of the term theoretical model rather than theory is confusing, and may indicate that the systems in question have limitations, compared with advanced physical theories. Meleis (1985; 1991) argues that there is what she calls a myth, a halo and a contradiction surrounding theory development, about who can develop theory and who should be able to develop theory.
The myth is that “idea people” are “ivory tower” people only, the halo is that only super-intelligent persons can do it, and the contradiction is that there are theoreticians and there are practitioners; the former can’t practice and the latter can’t theorize.

(1985, p. 81)

Meleis (1991) contends that there is now agreement among those who have discussed theory development, that its place lies within nursing practice. Although it could be argued that these are not exclusive to nursing, central concepts include environment, sense of well-being and interaction, among others. Additionally, over ten years ago Meleis (1985) said that different labels are different in emphasis rather than different in substance, and that concepts such as conceptual frameworks, models and theories have sometimes been used to describe the same thing. More recently, (Meleis 1991) maintains that the confusion that persists because of this has resulted in stilted theory development in nursing. She laments the emphasis on method and process to the detriment of content and consequences.

Fawcett (1989) disagreed with writers who considered the difference between models and theories to be one of semantics. She argued that conceptual models of nursing should be distinguished from nursing theories, a view which had also been taken earlier by Chinn and Jacobs (1983). Fawcett (1989) emphasised:

The primary distinction between a conceptual model and a theory is the level of abstraction. A conceptual model is an abstract and general system of concepts and propositions. A theory, in contrast, deals with one or more relatively specific and concrete concepts and propositions.

(p. 26)

Chinn and Jacobs (1983) considered that there is a distinction between ‘describing’ and ‘evaluating’ nursing models. They said that description involves the identification of nursing goals, concepts from which the model is constructed
and any relationships between them, as well as assumptions made about ideas which may emerge. Evaluation requires attention to the clarity of definition and use of concepts and the consistency with which the concepts are adopted. They argued that a model should be simple, generalisable and predictive of what happens in the real world of nursing. This statement is highly relevant to practice nursing. In 1989, a review of practice nurse education and training (The Damant Report) was commissioned by the English National Board in collaboration with the other National Boards and the UKCC, and the working group reported its findings the following year (Damant 1990). Damant argues that theory should logically, come before practice, but practice is not always underpinned by an adequate theoretical base. Practice nursing is described as a clinically based discipline whose theory grows out of, and is tested in, practice. It could be argued that an abstract, theoretical approach would not be generally acceptable to practice nurses.

Primary health care is a general concept which is not bound by disciplines, but in terms of nursing practice, it is nursing care. Salvage (1992) argues that the nursing contribution to the primary health care of individuals and families, requires nursing knowledge. Evolution of the professions because of the contribution of information technology in the next century may result in the disappearance of status differentials between those who hold and use highly specific knowledge, and those who do not. The need for a commitment to knowledge development of caring and sharing will remain.

Management theorists, Kast and Rosenzweig (1985) suggested that one of the most important ways of increasing knowledge is by continual research, and by the evaluation of innovations. Hockey (1982), and later Wilson-Barnett (1986), indicated that in the past, nursing research tended to avoid nursing practice
because of its complexity and because many of the earlier research nurses with a sociology background had more concerns about administration and education. Wilson-Barnett's views are relatively unchanged at the present time because she says:

*In reality, there is an apparent chasm between the research evidence and application in nursing practice.*

(Wilson-Barnett 1994, p. 181)

Interest in the development of nursing theory and models of nursing has produced some divergence of opinion concerning the most appropriate methodologies to be adopted. Concerns about intuitive practice within nursing were also raised by Aggleton and Chalmers (1986). They observed that these concerns resulted in a desire among some nurses to seek research findings with a scientific base, although others suggested that the profession should be autonomous from the medical and paramedical professions and have its own research base. Damant et al. (1994) point out that greater opportunities now exist for practice nurses to participate in research. General practice audit can benefit from a nursing contribution, and personal research into the evaluation of different methods of practice are essential to document the discipline base.

It would also appear that, however well theories are applied as models, they can never quite capture the intangible skills that encompass practice. This underpins the point made by Polanyi (1958) that practice is not totally communicable. Learning to swim and riding a bicycle can be communicated by instruction, but keeping afloat in the water and achieving the ability to balance are indefinable, although many of us learn 'how to do it'. Nursing practice is similar in that theory cannot describe accurately and comprehensively the skills required to undertake
nursing activities. Florence Nightingale herself suggested that: *...the very elements that constitute nursing are all but unknown.* (Roper et al. 1980).

Dickoff and James (1975) considered that practice (the actual activity performed) is the vehicle by which a desired position in nursing is accomplished, and is the basis for descriptive theory as well. Earlier still, Dickoff *et al.* (1968), suggested that:

*...theory is born in practice, is refined in research, and must and can return to practice if research is to be other than a draining off of energy from the main business of nursing and theory more than idle speculation.*

(p.415)

Booth (1995) protests that it is the 'non-doers' that write theory and control the discussion, but one could equally argue with him that there is nothing to stop the practitioners from developing their own practice-based theory. There is a danger nevertheless, that although theory may provide an accurate account of one or two influencing factors, if these are over-emphasised they may preclude taking into account other factors which are equally important. As an exemplar, behaviour and experience can be the product of many factors.

The capacity a theory may have to encompass the detail, subtleties and nuances of human behaviour and experience may depend on the power of differentiation it effects (Newman 1979). Logically, the more differentiated a theory is, the better it is, in that it can give us more information about what is taking place. The question is, how accurate is it? However divergent the description, Newman claimed, it is of little use unless it is reasonably valid in that it corresponds in some way to a 'reality' which we assume to exist independently of the observer. He suggested that nursing theorists have become more accomplished at describing what *theory* is rather than what *nursing* is.
Kurt Lewin, a management psychologist, contended that there is nothing so practical as a good theory (Marrow 1969). Can we then presume that the consequence of a poor theoretical text is practice which remains uninformed by theory and therefore unproductive? However differentiated the description, it is of little use unless it is approximately valid in that it corresponds in some way to a 'reality' which we assume to exist independently of the observer. In his studies of organisational behaviour, Luthans (1985) argued that theory and research go hand in hand, because theories allow the researcher to present logical proposals or hypotheses that can be tested by acceptable designs. Theories are therefore ever changing on the basis of the research results. Another theorist of organisational behaviour Miner (1980), argued that a theory should be stated in the simplest possible terms. This has not always been a feature exhibited by some nursing theorists, nor has their use of similar but inconsistent terminology.

There are similarities between the approach of organisational theory and nursing theory. The similarities are understandable because modern management theory realises the limitations of attempting to rationalise and quantify all processes. Management theory, like nursing, has 'borrowed' theory, but from within. The original dominance of classical scientific theory has been overtaken by a more comprehensive human relations approach. The complexity of modern organisations requires the integration of ideas from other management theories. Hitt et al. (1989) considered that there can be few static or universal management principles, because of the complexity of individuals and their differing motivations, needs, aspirations and potential. Meleis (1991), suggests that so-called 'borrowed' theories from disciplines such as psychology, biology and sociology, become 'shared' theories when used within a nursing context. In a
review of the literature, there were also found to be some similarities between management theory and nursing theory, particularly where it linked with the study of behavioural systems.

Management theory has been referred to in this chapter because its subject matter is complex and controversial, because of its similar struggles with a universal identity and because it exhibits ‘gaps’ between theory and practice as does nursing. By adopting a systems approach, nursing has the opportunity to bridge that gap by studying people, health, nursing actions and environment at one and the same time. Using the four concepts of Fawcett’s (1989) metaparadigm, this multidimensional approach can be both explanatory and predictive.

The arguments about nursing theory ebb and flow, but there appears to be agreement among many writers and commentators on nursing theory that there are gaps at various levels between theory and education; theory and practice, theory and research, and even between theory and theory. Some of these arguments are now examined.

**The Theory-Practice Gap**

It would seem that theory can never quite capture reality no matter how hard it pursues practice to that end. Benoliel (1977), in descriptions of her evolution as a researcher and her exposure to the interaction between practice and theory, considered that there was an explanatory and interpretative nature to theories which was of value in understanding human behaviour in health and illness. This, in turn she considered, permits nursing intervention to facilitate the promotion, maintenance and restoration of health.
From the United Kingdom perspective Booth (1995) suggests that, perhaps the perceived split between theory and practice is a result of arguments in the academic literature, and that this makes nurses regard theory with a degree of mistrust. All this in spite of the UKCC’s stress on the need for theory to relate closely to practice in their proposals for Project 2000 nursing courses (UKCC 1986).

Miller (1985), Draper (1990a) and McCaugherty (1992) likewise, claim that a gap has arisen between nurse theoreticians and practising nurses because the literature describes theory in such depth that there is a resultant detriment to practice. McCaugherty questions whether models and theories have any value for the ordinary clinical nurse. He determines that theory must relate to what nurses actually do and stresses the importance of relating such concepts to the nurse-patient relationship.

Both Miller and Draper consider that the theory-practice mismatch lies with inadequate theory, although Appleton (1993) implies that it has been caused by conservative and unimaginative practice. The gap between theory and practice is sometimes referred to as the difference between the 'real' and the 'ideal', and Miller suggested that nurses cannot be expected to accept unrealistic methods of change, especially when they feel these cannot be achieved within the constraints of the system. Clark (1982) argued that models can be used as a practical tool to analyse practice and highlighted the significance of nursing having its own distinct identity. She noted that this may be unacceptable to those that see nursing as a collection of jobs to be done, and this concept is particularly relevant to practice nursing where nursing work can be very task-oriented (Bowling 1985).
Dale (1994) argues that there is not a theory-practice gap, but a theory-theory gap. She supports the view that theory taught in the classroom differs from theory on which practice is based. She suggests that if a theory-practice gap existed it would have resulted in nursing which lacked purpose and was unplanned, and this was, and is not, the case. She advocates a lecturer-practitioner role to support the development of experiential knowledge in students. The benefits of such a role are worthy of experiment and a lecturer-nurse practitioner role is presently adopted in primary care in some areas of the United Kingdom.

There are criticisms that nursing theory is linear, and that it is not conditioned by time or situation, whereas in clinical practice, nursing is bound to time, people and place. However according to Miller (1985) theory does need to be narrow with simple models, so that it can usefully be applied to practice. She also observed that in the clinical field, nursing is what nurses ‘do’, whereas in theory, nursing is what nurses ‘ought to do’. As has already been suggested however, there is a danger (and this applies to all theory), that the proponents of particular theories exaggerate the explanatory power of the theory they endorse.

Meleis (1991) argues that the development of nursing was neither evolutionary nor was it revolutionary. If it was revolutionary, it would deny nursing’s scientific status, and if it was evolutionary, it would presume systematic development with theory based research and theory evolving out of research. Instead, she considers that:

The discipline of nursing evolved through peaks, valleys, detours, circular paths, retracing of steps, and series of crises as well as an evolutionary process.

(Meleis 1991, p.78)
There are competing claims as to how knowledge should be validated or judged and so forth. If knowledge from other disciplines is to be useful to nursing it requires interpretation. Field (1987) argued that models and theories by themselves are not an adequate basis for nursing judgements. They are only indicators to the area of practice which is nursing, as distinct from the other health professions. The development of conceptual models of nursing and nursing theory have, in themselves, resulted in a body of nursing literature devoted to trying to identify criteria which will provide guidelines for appropriate approaches to care in particular nursing contexts.

On the whole there has been limited guidance on nursing judgements and decision-making. The Scope of Professional Practice (UKCC 1992b) criticises a purely task-based approach to nursing. It advocates greater decision-making by nurses and supports independent judgement and an expanded role. Benner (1984) maintained that a smooth performance was commensurate with clinical judgement resulting from a sound knowledge base and experience. Luft (1994) suggests that creative thinking based on reflection can aid decision-making, especially if it is shared. These themes are considered further.

**Reflection, Expertise and Judgement**

Assessment and judgement are valuable tools for practice nurses. The accuracy of assessment is dependent not only on the level of available information to the nurse about individual patients under her care, but requires an interest in the health needs of the practice population. The practice nurse makes judgements and plans patient care based on details recorded in case notes, her own observations and through communication with the patient. The number and character of
interactions with patients that occur throughout the working day require a continuum of fairly quick judgements. As Luft (1994) suggests, it is crucial to the decision making process that the practice nurse reflects on the data that she has accumulated, so that she can make deductions from them.

Nevertheless, many practice nurses may argue that they have little time to reflect on their actions. Not only are they seeing patients who have appointments with them, but they have to cope with direct referrals from general practitioners who are consulting at the same time. Dingwall (1983) would argue that nurses should have time to reflect on their actions because decisions about the use of time are a personal responsibility and it cannot be said that someone else 'wasted' it for you.

Several theorists have analysed the processes of reflection in learning. These include Habermas (1977); Benner (1984); Powell (1989); Schon (1992); Atkins and Murphy (1994). Schon describes reflection in several ways, and distinguishes between reflection-on-action and reflection-in-action. The first consists of retrospective analysis where the practitioner may speculate on how the situation could have been handled in a different way, thereby contributing to knowledge and skills that can be developed for future practice. The second, reflection-in-action, describes 'on-the-spot' problem solving that is not always accompanied by a high degree of skill, but requires one to stop and think in order to proceed. Reflection-in-action also includes reflection where there is no conscious attention to the process, because the 'know-how' is embedded in the action itself.

It can be seen that reflection is a very personal process and to make a difference to practice the outcome must include a commitment to action. This may be in the
form of internalised action rather than an observable accomplishment, but the outcome must include learning. According to Schon (1992):

\textit{It seems right to say that our knowing is in our action. And similarly, the workaday life of the professional practitioner reveals, in its recognitions, judgements and skills, a pattern of tacit knowing-in-action.}

(p.54)

This type of reflection, it could be argued is implicit in the performance of the 'expert' nurse described by Benner (1984). Cognitive psychologists such as Norman (1985), also considered reflection an important aspect, but emphasised that performance and skill have not been given their due attention. He argued that skill has a knowledge base and uses judgement, being a combination of learning and performance. He suggested that separate skills could be 'separable', as opposed to 'independent.' Although he accepted that the specialised function of human cognition cannot be ignored, he felt that:

\textit{We are neither general purpose computational devices, all knowledge and abilities being treated alike, nor are we highly specialized subsystems, each independent of the rest.}

(p.333)

In this sense, Norman advocated that skills were somewhere in between these two views. The expert has different skills and addresses a task differently from a non-expert, and these differences are both quantitative and qualitative. Bartlett (1958) described timing as being a major difference between the expert and the non-expert. The expert practitioner performs tasks with ease and appears to think ahead, always anticipating the next move, and makes the difficult look simple.

Hunt (1974) suggested that the whole idea of skilled performance was based on its adaptability and ability to cope with new and different stimuli. The non-expert tends to work backwards from the problem, may not manage to handle difficult
situations, and is usually rushed, making the difficult task look difficult. There are also differences in perspective. As expertise develops, the individual becomes less aware of subsidiary actions that have to be performed, until many facets of a task become as natural as walking. Eventually, the individual becomes aware of the differences in the quality of their performance, although they will be unable to articulate their decision making processes. Experts acquire highly organised domain-specific knowledge, the underlying principles of which can then be reformulated for use in different situations (Aitkenhead and Slack 1985; Kahney 1986).

There are few who would deny that nursing is a practice-based discipline, but it has received considerable criticism in the past because of its intuitive approach to practice. Such an approach emphasised instinct and empathy at the expense of a more systematic and rational assessment of care. This does not deny however, the importance of the perceptual awareness that is central to good nursing judgement. Rapid, intuitive assessments by nurses have been discussed by a number of authors including Henderson (1982); Benner (1984), Dreyfus and Dreyfus (1985); Field (1987), and the strategies of experienced and less experienced nurses have been examined. This has relevance for practice nurses who have differing levels of education and training and limited, or more extensive, experience of working in a primary care setting.

**Knowledge, Experience and ‘Therapeutic’ Nursing**

Experience is the basis of knowledge and is an active process (Henderson 1982; Kolb 1984; Kast and Rosenzweig 1985; Meleis 1991). Meleis describes experience as a synthesis between the impression of what may be experienced and
impressions as they are actually received. While theory is crucial in terms of describing, explaining and anticipating situations, there is always more to a situation than the theory can predict (Benner 1984; Lawler 1991). Benner suggests that only concrete experience can provide adequate learning about these nuances of practice. This type of experience as described by Benner, is not the experience derived from chronological age or from length of time in a position, but rather is an active process. It assumes that there is a complexity in all practical situations that cannot be described by formal theories and textbook descriptions. The kind of experience outlined is one of an active process which adapts to actual situations by refining and changing established ideas.

In encountering clinical situations with their many nuances, qualitative differences, and confounding problems, clinicians gain a different understanding of theory or preconceived notions.

Benner (1984 p.178)

Kolb (1984) suggested that experiential learning has a circularity, its path around the circle being through concrete experience, examination and reflection. This circularity allows experiential learning to be used as a tool to form new hypotheses with which to guide practice and create additional new experiences. Kolb described this cycle as having two important elements, that of the importance of learning from the immediate personal experience and the value of the response. The feedback mechanism involves problem solving and the engendering of further information gathering.

Work such as that of Henderson (1982) and Benner (1984) demonstrated that expert nurses use past experience as examples to see situations as a whole. Benner described how experienced nurses often intuitively grasp the meaning of a situation directly, rather than through analytical thinking. Benner's approach emphasises the importance of knowledge gained from clinical experience which is
again useful for practice nurses. In addition, the development of skills for reflection have particular importance for the expanded role and accountability. Atkins and Murphy (1994) suggest that reflection can bridge the gap between theory and practice.

Because reflection involves exploration of a unique situation, new knowledge may be generated. Reflection therefore has the potential to address issues in practice in a way that the straight application of theory to practice does not.

(p.54)

Earlier, Kuhn (1970) observed that the ‘know how’ experiential knowledge and skill that nurses apply to their work is not always accompanied by theoretical knowledge about the mechanism of the activities they perform. This ‘know how’ knowledge is difficult to elucidate, and may, or may not, be accompanied by the theoretical ‘know that’ knowledge of theories or models. Nursing, as described by nursing theory, has been criticised in recent years by several authors including Miller (1985) and Cook (1991) in terms of its relevance to clinical practice. ‘Knowing’ became more valuable than ‘doing’, devaluing the skills of bedside practice. Lawler (1991) likewise describes nurses who have the sort of knowledge that comes from practical professional experience. She considers that nurses operate from a knowledge base that is explanatory, contextual and integrative of object and subject and she calls this a somological approach.

Henderson (1969) believed that, because the nurse spends more time with the patient than anyone else, there is a sharing of life experiences and greater opportunities for communication. She emphasised the knowledge that can be gained from experience, some of it not always logical, and the importance of ‘knowing’ the patient, not as a body to be managed in a clinical way, but as an individual and as such, as a ‘whole’ person. In order to form a relationship with a patient, she suggested that it is important that the nurse engages in discourse with
the individual to build up background knowledge that may be considered relevant to their future care.

As intimated earlier in this chapter, learning by experience can also be inefficient unless situations can be matched in all respects because, as Handy (1987) pointed out, past experience may not be appropriate to learning for the present situation. He argued that it is easier to learn from failure than it is to learn from success. Success is sometimes accepted as such and therefore not subject to analysis, whereas there may be motivation to investigate the reasons for failure and take some action to rectify the problem. This could be a revolving argument unless nurses are taught to reflect on their actions as part of the data gathering process. It also raises the question once again, about traditional and more innovative methods of learning and working. It is equally arguable that there exists a gap somewhere in all this that prevents nursing action being translated in a way that nurses can understand and utilise.

'Experts', in contrast to 'non-experts' as described by Benner (1984), appear to take a more holistic view of situations, and the work of Benner in particular made a major contribution to eliciting awareness of the intangible caring role of expert nurses. Benner identified that very experienced nurses became aware of a patient's problem without necessarily being able to rationalise the reasons for this in scientific terms.

The position taken by Henderson (1966; 1969; 1982), Benner (1984), Benner and Tanner (1987), Benner et al. (1992a, 1992b) and other like-minded contributors to nursing literature, that intuition, reflection and experience-based knowledge are an important domain for nursing as a practice based discipline would,
likewise, seem pertinent for practice nursing. Henderson (1982) argued that intuitive judgement based on clinical knowledge is often ignored in favour of the nursing process, which she considered to be only one measure of problem solving.

Kast and Rosenzweig (1985) argued that professional judgements can be influenced by many factors such as values, beliefs and personal inclination, and the systematic problem-solving approach, although it has its place, is not always applicable in practice. They also suggested that one of the most common barriers to effective understanding and empathy is a lack of perception of the different knowledge and background experience that individuals bring to a situation. Since the same phenomenon can be observed from different perspectives, inconsistencies can arise from both verbal, and non-verbal communication. Most real-life situations are not verifiable and are heavily value laden. Even when facts are accepted, there may be considerable variation in understanding of their meaning or significance.

Although practical experience is a fertile source of learning, Atkins and Murphy (1994) suggest that there are people who have practised for years, make the same mistakes and never seem to learn from experience. This, they suggest, stems from an inability to analyse a situation and see what can be learned from it. In other words, there is inadequate reflection on experience that can be utilised for the future management of patient care. Benner (1984) drew attention to the importance of not always having to do for a patient, noting the equal importance of being with a patient. Benner did emphasise however, that experience-based skill acquisition is safer and quicker when it rests upon a sound educational base. In her studies of nurses during the course of their practice, Benner’s description of
one encounter by an expert nurse could be equally apposite to that of an experienced practice nurse:

It is a person-to-person kind of thing, just being with somebody, really communicating with people. And sometimes I just feel a closeness. You talk about empathy or whatever, but somebody is frightened -- and just sitting down and listening to people, it's not that you even have to say anything.

(Benner 1984: p. 57)

It could be said that therapeutic listening requires the insight to remain silent and the shrewdness of intelligent compassion. As Oliver Wendell Holmes put it so well in his poem, “The Poet at the Breakfast Table”, - It is the province of knowledge to speak and it is the privilege of wisdom to listen. One of the most important means of communication is listening. Indeed, Benner (1984) described the ability of experienced nurses in their encounters with patients, to recognise important nonverbal as well as verbal cues, while ignoring the irrelevant.

Peplau (1952) describes as ‘professional closeness’, the relationship between a skilled nurse and a client. In this relationship the nurse seeks to provide a safe environment where clients can learn more about themselves, for their short and long-term benefit. Each new nursing situation provides a learning experience for the nurse, which can be added to her knowledge base for future practice. Burnard (1991) argues that effective interpersonal skills based on reflection and minimal counselling ability are:

sufficient to enable nurses to help their patients, clients and colleagues in a positive and therapeutic way.

(p. 37)

The concept of ‘therapeutic listening’ was described by Scott et al. (1960) as a form of therapy (see Chapter Two, page 16). Similarly, my personal construction of ‘therapeutic listening’ is one that embodies listening to the patient in such a way
as to encourage recuperation and rehabilitation of the 'inner self', without filtering the reflections of the individual in a manner that is in any way judgemental. Touch is also an integral part of nursing care which has been explored by several authors including Turton (1989) and Tutton (1991). They report that nurses in primary and secondary care are increasingly using complementary therapies involving touch in their work, for example massage and the use of essential oils for stress and pain relief.

While therapeutics in itself, as a science, is not specific to nursing, McMahon (1991) describes therapeutic nursing as the promotion of health and healing for clients under the care of the nurse. The notion that a certain form of nursing has a powerful effect on health and healing puts it above the level of a simple relationship with a patient which may not always be positive. Hockey (1991) argues that it is impossible to nurse a patient without some sort of relationship developing, but it can be healing or harmful. She suggests that a purposeful relationship designed to have a healing effect is a fundamental form of therapeutic nursing.

Benner (1984) also suggested that there is a healing power in caring. This does not necessarily translate as a ‘curing’ element, but more as a reintegration of the individual within his or her social world. She submitted that the nurse can act as interpreter between doctor and patient, and between patient and doctor, to help to de-mystify medical jargon and reduce any fear that may be blocking the patient’s understanding. She calls this kind of power advocacy power, because it is the kind of power that by being supportive, and by helping the patient to relax and reflect on their condition, has an enabling capability.
Silva (1977) upheld the view that nursing is an 'art' and suggested that experience influenced by intuition and reflection should be valued as much as knowledge arrived at by scientific means. Appleton (1993) presents a similar argument, claiming that nursing is an art as well as a science, and that each patient is a unique individual. The nurse who can identify with what the patient is experiencing and who recognises his or her need for help, can then respond by expressing compassion for the patient, thus allowing a caring relationship to emerge. By respecting the integrity of the patient as a human being, the nurse accepts that the individual has the right and responsibility to make choices for their own personal well-being or quality of life.

A number of other authors have sought to remind us that science is only one component of what constitutes nursing (Johnson 1968; Benoliel 1977; Field 1987; Draper 1990; Schon 1992; Meerabeau 1992; Appleton 1993). They describe the 'art' of nursing, the moral and ethical issues, and the need to develop nursing theory that reflects the reality of practice. Draper (1990a) suggests that the development of good practice in one setting can enhance the practice of nursing in other settings. He considers that models developed from practice theories are less likely to be rejected as being unworkable because nurses can relate to their usefulness.
Summary

In this chapter the ebb and flow of theories of knowledge about nursing and their relationship with the more concrete realities of nursing practice have been examined. In the exploration of nursing’s ‘traditional’ roots it was identified that there was a lack of a scientific or theoretical base, a paucity of objective research and it was reactive in nature. The complexity of nursing theory was explored with reference to the development of nursing and the move towards professionalisation, as well as the ‘gaps’ identified in different approaches. The importance of the acquisition of knowledge and skill was identified, and the themes of experiential and ‘expert’ knowledge, intuition, reflection and anticipation were explored, because I consider these topics to be important to practice nursing.

Reasoning that if nursing theory is to have any relevance to nurses in their day-to-day work it must reflect what happens in practice, this study of practice nurses has its foundation in practice. Smith (1981) suggested that:

_Nursing practice can be enhanced by a knowledge of the concepts, ethics, foundations, and techniques available, which in turn, enables them to be blended into a unique mix which helps to build a theory of nursing._

(p. 22)

This piece of practice-based research evolved into an inquiry about the relevance of theory and research within the framework of practice nursing. As has already been suggested, nursing has the difficult but important function of co-ordinating _cure_ with the _cure_ function prescribed by the doctor, and nurses play an important part in the group dynamics of the organisation.

The delegated role is applicable to nursing in general, the doctor being the diagnostician and the nurse undertaking tasks or procedures as directed.
Delegation will be examined further in subsequent chapters in the context of the Practice Nurse Study. As McCaugherty (1992) suggests, nursing grew up in the shadow of medicine and nurses performed the more mundane and repetitive practical aspects of patient care. Damant (1990) reports that some practice nurses identified task-orientated modes of practice which had a greater obligation to medicine than to nursing or the primary care team as a whole. Indeed, practice nursing traditionally developed from within general practice itself. It was largely 'incident' led, with the general practitioner having direct and immediate authority over the nurse concerning the medical aspects of the patient's treatment.

Traditional and innovative modes of practice have implications for an expanded role for nurses in primary care. Practice nursing, perhaps more than any other branch of nursing today, works to different models, although the nurses themselves do not always articulate this. As discussed in the previous chapter, some nurses work within a framework of delegated treatment room work. Others are developing their expertise in areas such as health promotion, and a third group has acquired specialist knowledge and skills to allow them to make independent judgements within agreed protocols. Both delegated and more autonomous roles, and their effects on nursing workload, are investigated in the study that supports this thesis, as is the knowledge base of practice nursing in view of the continued expansion of the role. The implications of this and its relationship with holistic care and experiential learning are described in later chapters.
Chapter Four

_The Practice Nurse Study: Aims, Design and Methods_

The reason Piglet had his unfortunate meeting with the Heffalump was that Winnie the Pooh's sampling technique was seriously defective. Pooh and Piglet had agreed to bait the Heffalump trap with honey. Pooh had taken a large jar from the shelf and satisfied himself that the label read HUNNY. He was suspicious that the honey might have been replaced with cheese, so he took a large lick. It tasted like honey, but Pooh was still worried that there might be cheese at the bottom. Eventually he satisfied himself that it was honey, right the way down. That is the problem with sampling. You can never be sure that it is honey right the way down.

Blacktop (1996 p.5)

Introduction

In this chapter the background to the research, and the aims and design of the Practice Nurse Study are described, and the methods of data collection reported.

In Chapter Two, data relating to the increase in numbers of nurses employed in general practice were reproduced. The data highlighted the growth in numbers of practice employed nurses particularly between the years 1989 to 1990, prior to the introduction of the New GP Contract (1989a). A breakdown of numbers of practice employed nurses in Lothian was included because of the relevance to this study. Attention was also drawn to the paucity of information about attached nurses generally, and the reasons that numbers were declining in Lothian. One of
the limitations of the study was the small numbers of attached nurses from which to draw a sample, and this proved to be a stumbling block to recruitment.

Background to the Study

In 1987, I was involved in a workload study of 85 general practitioners in Lothian, undertaken by the Department of General Practice, University of Edinburgh. In that study, the participating doctors recorded information on all surgery consultations on one day in every 15, for a year. The results of the study have been reported elsewhere (Howie et al. 1989; 1991). Although the focus of that study was not about nurses, data exhibited that general practitioners were less likely to undertake technical procedures, particularly diagnostic tests, if there was no nurse available at the time that they were consulting. The study of general practitioners reinforced my interest in the level of delegation to practice nurses among other things, and I decided to focus my thinking into the development of several research questions. The overall purpose of the Practice Nurse Study therefore, was to examine working patterns and changing roles, and the perceptions of community nurses, general practitioners and patients at a time of change.

Apart from this study being opportune because of the introduction of the New GP Contract, one of the aims of the Practice Nurse Study included the investigation of potentially different types of workload. Namely, the working practices of practice employed nurses, and nurses attached to the treatment rooms of general practices by Lothian Health Board. The New GP Contract also provided the chance to study the work of the nurses before, and one year after, its implementation.
The primary health care reforms that were proposed in the White Paper, 'Working for Patients' (DoH 1989b) and in the New GP Contract itself, aimed to swing the balance away from a 'disease' oriented service by expanding health promotion activity. The New GP Contract enlarged the workload of general practitioners by setting target payments for certain activities, including cervical cytology, childhood immunisations and pre-school boosters for children under five years of age. Changes to the terms of service included capitation fees for child health surveillance, new registrations (except the new-born) and elderly patients aged 75 years and over, providing certain procedures were carried out. As well as continuing remuneration arrangements for the employment of nursing staff, the New GP Contract obliged general practitioners to provide health promotion/illness prevention for patients aged 16-74 at a consultation initiated by the patient, or at a clinic session. General practitioners were also obliged to issue an invitation to patients on their list who had not been seen within the last three years, to come for a 'check-up'.

The Contract also suggested that 'another member of the practice team' could undertake some of the tasks involved, and it was considered that this role would be delegated mainly to the practice nurse. Not surprisingly, in the run-up to its introduction, general practitioners soon realised that they would need additional professional support to achieve the required targets. In 1989, there was an appreciable increase in the number of nurses employed to work in general practice.

In Chapter Two the data illustrated that between 1989 and 1990 in Lothian, practice nurse employment by general practitioners increased by 132% (ISD 1993; 1996). In relation to attached nurses, Meldrum's (1988) data suggested that there
would be enough attached nurses in post in Lothian from which to draw a sample. In reality, this was not so easy to achieve. This and other difficulties will be expanded upon in the section on Recruitment and Response Rates.

Aims, Design and Methods

Aims:

1. To describe how health board attached and practice employed nurses spend their working days, before and 12 months after the implementation of the New GP Contract in April 1990.

2. To describe the flow of patients through the nurse's treatment room, and to examine the process of care, particularly when patients referred from the doctor are 'fitted in' between the nurse's own patients, before and 12 months after the implementation of The New GP Contract.

3. To identify differences in the working practice of practice employed and health board attached nurses.

4. To monitor changes in the employment of practice nurses during the 12 months after the introduction of The New GP Contract.

5. To measure patient satisfaction with consultations with practice nurses, and to assess patients' views of the changing role of practice nurses, and community nurses.

6. To identify practice nurses', community nurses' and general practitioners' perceptions of future developments in primary care nursing so as to identify areas of common interest and of potential disagreement.

7. To identify potential future educational and training opportunities for primary care nurses.
Design

Polit and Hungler (1991) comment that the research design is the researcher’s overall plan for answering the research question, and Presly (1989) notes that there is no single all-purpose experimental design. Cochrane (1972), while emphasising the importance of randomised controlled trials in guiding decisions about health care, accepted that sometimes trials are not feasible. This study had a quasi-experimental or naturalistic design, as it lacked true randomisation because the nurses were volunteers, and the study did not have a control group. Quasi-experimental research designs are used more frequently in nursing research because true experimental control is often impractical (Oldham 1994).

The quasi-experimental approach was appropriate to this study because it covers instances in which the setting is already established and operating, and adds a measure of data collection. In other words, it studies real life conditions. This study involved nurses, patients and other health professionals, all of whom were interacting with their environment, and who had differing motivations and expectations. Other studies in practice nursing involving a quasi-experimental design include that of Cater and Hawthorn (1988) and Jeffreys et al. (1995).

Bush (1985) has argued that because nursing studies usually involve people and people are found in a great many places that are difficult to control experimentally, compromise in sampling can be acceptable. Furthermore, Bush (1985) suggested that a quasi-experimental design has the advantages of practicality, feasibility and generalisation to a certain extent. Seaman (1987) and Oldham (1994) however, caution against over generalisation because there is a possibility that the results may be due to some external influence. Such an
additional phenomenon is the ‘Hawthorne effect’, which will be described in the section on ‘limitations of the research design’.

Using quota sampling, the intention was to recruit twenty practice employed and twenty attached nurses to the study. Quota sampling is described by Seaman (1987) as:

‘a means by which samples reflect certain characteristics of the population being studied, without the use of random selection’

Quota or purposive sampling is not random and Wilson (1985) suggested it may or may not sample proportions that are representative of the population. Nevertheless, Treece and Treece (1986) considered that this can be an efficient and effective manner of sampling where there is good evidence that the subjects are representative of the total population to be studied. In quota sampling the researcher makes a decision, based on judgement, about the best type of sample for the study (Wilson 1985).

Sample size is dependent upon the purpose of the research, the design, and the size of population, and it is generally accepted that the larger the sample, the more valid and accurate the study. Howie (1989) pointed out that numbers presented in tables of results should be 20 or above, and if they fall below ten they can produce difficulties in statistical analysis. Fox (1982) however, suggested that sample size is far less important than its representativeness. He suggested that:

‘no data are sounder than the representativeness of the sample from which they were obtained, no matter how large the sample’.

If, according to Meldrum (1988), there were approximately 40 attached nurses in Lothian at the time of her study, 20 nurses in each group for the Practice Nurse
Study would be fairly representative, a manageable number geographically, and would produce an adequate data return from the participating nurses. Although this sample of nurses was not random, it was considered that they would be fairly representative of different types and sizes of practice.

The Practice Nurse Study was a before and after study of two sets of 15 half days of practice nurse workload, one year apart.

**Intervention**

The specific intervention of interest in terms of the study was the New GP Contract in April 1990. There were a number of other primary care changes which followed that may have impinged on the study and on nursing, but were not a focus of it. One of these was the NHS and Community Care Act (DoH 1990c) mentioned earlier, which raised concerns for general practitioners and community nursing staff regarding the divisions between health care and social care, and provision of funding. These anxieties were factors to be taken into consideration when analysing responses to questionnaires from the participating health care professionals in the study.

**Recruitment and Response Rates**

In January 1990, a meeting was held with the Directors of Nursing Services, Primary Care and Community in Lothian and West Lothian, to explain the purpose of the study and from whom information on the numbers, names and location of Lothian Health Board attached nurses was obtained. Similar information on practice employed nurses was requested from the Primary Care Administrator at
Lothian Health Board, who gave the Board's approval to access the data. Delays in obtaining information resulted in the study starting later than the original starting date of the beginning of April 1990.

As previously stated, the number of nurses in the study was based on recruiting 20 practice employed and 20 attached nurses, and each nurse recording information for a period of four hours a day, five days a week for three weeks (fifteen days). This would provide a total of sixty nurse hours data collection from each nurse. On the basis of each nurse seeing four patients an hour who came by appointment, with the addition of one direct referral from the doctor, this would add up to twenty patients during each recording half-day, 100 per five day week and 300 over the fifteen days. In terms of forty nurses, this would produce 800 pieces of workload data each day and 4000 per week, with 12,000 data returns over each 15 day recording period. This would potentially produce 24,000 data returns over both recording periods, and it was possible that this estimate was conservative.

ESTIMATES OF DATA RETURNS BASED ON RECRUITMENT OF 40 NURSES

ONE RECORDING PERIOD

Each nurse consulting at:

5 patients an hour for four hours = 20 consultations per day
= 100 consultations per 5 day week
= 300 consultations per 15 days

40 nurses to record for three weeks = 15 days (Monday to Friday)

Total data returns from 40 nurses:

per day = 800
per week = 4000
per 15 days = 12,000

Over both recording periods (15 days x 2) = 24,000
Summary

The Practice Nurse Study had a quasi-experimental or naturalistic design. It lacked true randomisation because the nurses were volunteers and there was no control group. It consisted of a before and after study of two sets of 15 half days of practice nurse workload, one year apart. The specific intervention relevant to the study was the New GP Contract. Using quota sampling, the intention was to recruit 20 practice employed and 20 Health Board attached nurses to the study. Estimates suggested that workload data from 40 nurses would produce 12,000 data returns over each 15 day recording period.

*Invitation to participate in the Study: Part A*

*Recruitment of Practice Employed Nurses*

Letters were prepared for each doctor (Appendix 2-1) and nurse (Appendix 2-2) which included information about the aims of the study, as well as copies of the research instruments. A ‘tear-off’ slip was attached to the foot of the letter on which the doctor was asked to indicate whether the nurse(s) employed by the practice could be contacted about the study, and the names of the nurses if approval was given. A stamped-addressed envelope was included.

In early January 1990, personal letters were sent out to 78 of the 85 doctors in 38 practices who had taken part in the study of general practitioners (SHHD 1990) (Appendix 2-3). It was hoped that doctors who had taken part in that study would similarly be interested in adding to information on workload and workflow, by examining the contribution made by the nurses in their practices. Seven of the
doctors from this cohort were not contacted because it was known that two had retired, two had resigned and three did not employ a practice nurse.

A further 54 'new' doctors (33 practices) were similarly contacted by extracting their names from the Lothian Practice Directory to widen the sample and to allow for negative replies or non-responders (Table 4-1). The Lothian Practice Directory is provided to practices by Lothian Health Primary Care Services. It supplies the names and mailing addresses for all Lothian general medical practitioners, and is updated on a regular basis. The addition of 54 'new' doctors from this list provided a total of 132 general practitioners and 71 practices in Lothian who were circulated with a letter requesting permission to approach their practice-employed nurses about the study.

<table>
<thead>
<tr>
<th>Table 4-1 Number of practices and general practitioners approached regarding recruitment of practice-employed nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practices</td>
</tr>
<tr>
<td>Practices</td>
</tr>
<tr>
<td>Number of GPs</td>
</tr>
</tbody>
</table>

A list of practice employed nurses working in Edinburgh City, East, West and Midlothian, was supplied by Lothian Health Board towards the end of January. The list contained the names and practice addresses of 60 nurses but did not identify their working hours. No 'new' nurses or practices were identified by this list. The numbers were smaller than that suggested by the Information and Statistics Division of the Common Services Agency (ISD 1993; 1996), whose figures identified a complement of 74 (WTE) practice employed nurses working in Lothian in 1990. In terms of an available sample to be drawn for the study, it was found that out of these 74 nurses, 42 had been in post in 1989 and 32 were newly appointed in 1990.
Reminders

In late January 1990, practices who had not responded were contacted informally by telephone and doctors were asked if they were interested in the study or would like further information. Replies came back slowly until the end of February, by which time 26 of the 71 practices (37%) agreed to take part in the study.

Non-Participating Practices

Of the remaining 45 practices, ‘tear-off” slips or personal letters were received from 30 practices (42%) who declined to participate. Two practices gave no reason for non-participation. No reply was received from 15 practices (21%). Five single-handed doctors in Lothian were identified and although none of them replied, the list from Lothian Health Board showed that none of them had a practice employed or attached nurse at that time. Seventeen of the practices who declined and five who did not reply were from the original practices who had participated in the 1987 workload study of doctors. This represented in total a 63% (n=45) non-response/non-participation rate. Response rates by type of practice are illustrated in Table 4-2.

Table 4-2 Responses to Part A of the study by type of practice

<table>
<thead>
<tr>
<th>Type</th>
<th>Agreed to participate</th>
<th>Declined to participate</th>
<th>No reply</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>15</td>
<td>13</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>Original</td>
<td>11</td>
<td>17</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>30</td>
<td>15</td>
<td>71</td>
</tr>
</tbody>
</table>

Reasons Stated for Declining to Participate

Twenty eight of the 30 practices who declined to take part gave reasons for so doing. A general practitioner in one of the practices that had no nurse in post at
the time responded, and indicated a willingness to participate in future as it was their intention to employ a nurse. Two practices reported that their practice employed nurses were new to the practice having come from the acute sector, and were reluctant to participate because of the pressure of adapting to new working patterns. One of these practices was within a large health centre which housed six practices. The doctor who responded to the letter had a fairly negative view of attached nursing staff and stated:

Because of the New Contract and because Health Centre Treatment Room nurses are limited in what they can do in terms of the New Contract, we have recently appointed a practice nurse to perform cervical smears and counselling and screening. The nature of attached nurses' work is controlled by Health Board regulations and they are not likely to be changing their work pattern to suit a New GP Contract.

In the remaining 25 practices however, the overwhelming reason given for non-participation was the extra work already being performed by all categories of practice staff in preparation for the New Contract. The following were typical of comments received:

The doctors regret that at the moment, due to the work involved with the White Paper, they do not have the time to undertake the completion of questionnaires and our practice nurse has only been with us for six weeks.

(Practice Manager)

Sorry about this, but our practice nurse had doubts about it, and our staff were not at all keen to tackle any extra work at this present time of change and transition. There are enough grumbles as it is.

(General Practitioner)

I would be grateful if you did not approach our nursing staff at this present difficult time. Our main full-time treatment room nurse left just before Christmas, and as she was health board employed she is not being replaced. The two part-time nurses still working are therefore under a considerable amount of pressure and myself and my partners feel it would be unfair to add to their load with this study.

(General Practitioner)
Two nurses who were told about the study and indicated their willingness to participate, were refused permission to do so by their general practitioner employers.

The responses from the general practitioners concerned were:

Our nurses will not be able to take part because any information we would be able to give at this time would not be at all helpful for your purposes.

(General Practitioner)

My hair is re-growing from grey to mousy after taking part in the 'Doctor Study' so we are unhappy for you to contact our nurses! * [SHHD, 1990]

(General Practitioner)

Reflections on Reasons for Declining to Participate

In 1992, I gave a talk about the results of the study to the Lothian Treatment Room Nurses Group. This group had initially been set up in 1989 by attached nurses in response to increasing disquiet about their continuing tenure and rumours of transfer of employment to general practitioners. The group met monthly to discuss policy issues and usually had an invited speaker who gave a talk on a subject related to nursing in general practice. Membership of the group was not confined to attached nurses however, practice employed nurses were also welcome and did indeed join and participate. Five practice employed nurses who attended the talk, said that they would have liked to participate in the study if they had known about it. When they were informed that the doctors in their practice had been approached about the study, they reported that they were never shown any of the research material at the time, or asked if they would like to take part.
Recruitment of Health Board Attached Nurses

During January 1990, at the same time as recruitment of practice employed nurses was proceeding, the Directors of Nursing Services Primary Care and Community, Lothian Health Board, gave support to the recruitment of treatment room nurses attached to practices.

Frequent requests were made to Lothian Health Board between December 1989 and February 1990 for a list of attached nurses. For various reasons including sickness and holidays, it proved difficult to obtain the information. In order to speed up the recruitment process, the researcher approached the Secretary of the Lothian Treatment Room Nurses Group to obtain a list of current members. From the list provided with members’ permission, the names and practice addresses of 22 attached nurses in Edinburgh and Midlothian were identified. Shortly afterwards Lothian Health Board supplied a list of attached nurses in North East, North West, South Edinburgh and Midlothian, from which a further nine new nurses were identified. This brought the total number of attached nurses available to be approached to thirty one.

At this point, general practitioners who had attached nurses working in the treatment rooms of their practices were sent a letter explaining the aims of the study and asking for their ‘co-operation’. The attached nurses were contacted directly with a personal letter.

In the event the desired number of 20 nurses proved difficult to achieve, due to Lothian Health Board’s recruitment policies at that time, which included a decision not to employ any more attached nurses. Some of the attached nurses who were
approached were under considerable stress in practices where colleagues had resigned for various reasons and had not been replaced. Although they would have been willing to take part under normal circumstances, they felt that they could not cope with any extra responsibilities at a time when they were unsure about the implications of the New Contract on their workload. In total, 11 nurses indicated that they were willing to participate, but two of these nurses subsequently withdrew before the start of the recording process, as described later in the text. Sixteen attached nurses declined and four did not reply.

Summary of Response Rates

*Initial Responses to Part A of the Study*

To summarise, 26 (37%) out of 71 practices agreed to participate, 30 practices (42%) declined and there was no reply from 15 practices (21%). Non-responders were not followed up because it was assumed that their lack of response was probably a reflection of the impending New Contract.

As illustrated in Table 4-3, a total of 91 nurses were identified and contacted about the study. Sixty practice employed nurses were approached through their general practitioner employers. Two nurses who agreed to participate were found to hold ‘dual’ appointments. These nurses were employed by the Health Board to undertake a number of hours work in the treatment room in the morning, and were also employed by the general practitioner to do some extra sessions in the afternoon. These nurses were included in the numbers of ‘practice employed’ nurses for initial recruitment purposes only.
Thirty out of 60 practice employed/dual appointment nurses agreed to participate in the study (50%), 17 (28%) declined and no reply was received from 13 nurses (22%). Eleven out of 31 attached nurses (35%) indicated that they were willing to participate, 16 nurses declined (52%) and four (13%) did not reply.

Table 4-3 Initial nurse responses to part A of the study

<table>
<thead>
<tr>
<th>Type of employment</th>
<th>Agreed to participate</th>
<th>Declined</th>
<th>No reply</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice-employed/dual</td>
<td>30</td>
<td>17</td>
<td>13</td>
<td>60</td>
</tr>
<tr>
<td>Attached</td>
<td>11</td>
<td>16</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>33</td>
<td>17</td>
<td>91</td>
</tr>
</tbody>
</table>

As shown in Table 4-3, these initial replies produced a total of 41 out of 91 nurses who indicated that they were willing to participate, representing a 45% response rate. These numbers decreased prior to the start of the study however, and the reasons for this are given in the next section.

Final Participants: Nurses and Practices: Part A

Forty-one nurses were originally recruited from the 26 practices, but six nurses (from three practices) withdrew prior to the start of the study due to anticipated pressure of work, and one nurse from a fourth practice left to take up employment in a non-participating practice. Five of these seven nurses were practice employed and two were attached nurses. In total, 34 nurses from 22 practices agreed to participate in Part A of the study. Of these, 23 were practice employed, nine were Health Board attached, and two held a dual appointment (Table 4-4).

Table 4-4 Nurses participating in Parts A & B of the study

<table>
<thead>
<tr>
<th>Nurse employed by:</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Health Board</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Dual appointment</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>33</td>
</tr>
</tbody>
</table>
The average participating practice had six general practitioners. The largest was a health centre with 13 general practitioners and the smallest were several partnerships of three doctors. Patient list size ranged from 6,000 to 19,000.

The intention was to repeat the same exercise with the same nurses in 1991, a year after the introduction of the New GP Contract to see if there had been any change in workload over time.

*Invitation to Participate: Part B*

*Changes in Nurse Employment within Practices*

Circumstances within seven of the practices participating in Part A had changed within the subsequent year. Two nurses had taken maternity leave, one had reached retirement, two had moved house out of the area and three felt unable to take part for a second time because of increasing pressure of work. This number comprised three practice employed and five attached nurses. This resulted in a loss of eight nurses to the second part of the study, leaving a total of 26 nurses.

As eight nurses were no longer going to be in post for Part B of the study, seven other practices were approached in March 1991, and asked if their nurses would like to participate. Treece and Treece (1986) advise that it is permissible to include more subjects into the sample, but it is important to beware of bias in such a procedure. Consequently, the recording patterns of any additional nurses may require to be analysed separately if necessary, if they appeared to be different from the other nurses. From these seven practices, three nurses within two practices agreed to participate, four practices did not reply and one practice declined due to
a shortage of medical staff. The reason seven practices were approached was that there were only seven practices left on the list supplied by the Primary Care Administrator at Lothian Health Board that had not been contacted previously.

Final Participants: Nurses and Practices - Part B

Twenty three of the nurses who had recorded in Part A of the study were still in post, three had changed and in two of the practices where previously there had been only one practice nurse, an additional nurse had been employed. These two nurses agreed to participate in Part B of the recording. Fortunately, one of the practices that had withdrawn prior to the start of Part A of the study due to 'anticipated' pressure of work, also decided to take part. This produced two attached nurses (Table 4-5).

<table>
<thead>
<tr>
<th>Table 4-5 Nurses participating in Part B of the study</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Part A</td>
</tr>
<tr>
<td>Practice employed</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>17</td>
</tr>
<tr>
<td>New to Part B</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>Changed</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>23</td>
</tr>
</tbody>
</table>

Thus, of the 22 practices who participated in the first round of recording, 18 agreed to do so a second time. The addition of two new practices and the one that had initially agreed but had withdrawn from Part A prior to the start of the study brought the total to 21 practices. The nurses comprised 23 practice employed, seven attached and three who held dual appointments, a total of 33 nurses. In both Part A and Part B of the study, nurses were located in practices in Edinburgh City, Midlothian and West Lothian. No nurses participated from the remaining area of East Lothian.
Twenty nine nurses completed recording by the end of July 1991, but two practices (four nurses) intimated that they had been exceptionally busy and, although anxious to participate, felt this was not possible until later in the Autumn. As these were practices who had participated in the first half of the study, it was felt necessary to accommodate them for completeness of the analyses.

*Participants: Part A and Part B of the Study*

In total, 34 nurses from 22 practices agreed to participate in Part A of the study. Of these, 23 were practice employed, nine were Health Board attached, and two held a dual appointment. In Part B of the study 21 practices participated. The nurses comprised 23 practice employed, seven attached and three who held dual appointments, a total of 33 nurses. In both parts of the study nurses were located in general medical practices in the City of Edinburgh, Midlothian and West Lothian. No nurses participated from East Lothian.

*Strengths and Weaknesses of the Research Design*

The Practice Nurse Study did encounter some difficulties. The unforeseen problems in trying to access information about the numbers and practice locations of nurses resulted in delay in starting the study. The time constraints resulted in an inability to properly pilot the research instruments for validity and reliability. The small sample size in terms of nurses was a major problem, because this potentially weakened the results. Although the sample of nurses was modest, data collected on consultations and by patient questionnaire produced acceptable numbers, and was large enough to be considered reliable and able to be replicated by other researchers. Criticism of sample size can equally be levelled at the work
of other authors, including Stilwell et al. (1987), Salisbury and Tettersell (1988) and Marsh and Dawes (1995). All these studies had small sample sizes, and in the case of Stilwell et al., there was no measurement of patient satisfaction. Salisbury and Tettersell compared one nurse practitioner with one doctor, and based patient satisfaction on only 73 responses. Marsh and Dawes based their study in one general practice setting, with one practice nurse and 696 consultations over a six month period. As this nurse was one of three nurses in the practice, it makes it difficult to generalise from the results reported.

In terms of selection, the nurses in the Practice Nurse Study were volunteers and likely to be a biased sample, and a number of subjects left or changed during the study. It was acknowledged that a weakness of this study design was the lack of a control group and true random allocation of subjects. Indeed, Morse (1991) and Sullivan (1996) state that the major criticism of volunteers in a sample is that of self-selection, a problem that may influence the results.

Morse cautions that volunteers may be motivated by reasons other than to ‘contribute to science’ by taking part in a study, and Oldham (1994) suggests that an additional problem with quasi-experimental design is that of the ‘Hawthorne Effect’. One of the reasons for volunteering may be the possibility that individuals are flattered by the prospect of attention being paid to them by the researcher, and the resultant bias that ‘self-selection’ may produce. The name “Hawthorne Effect” is derived from the Hawthorne Studies that took place in the Western Electric plant in Chicago between 1924 and 1932. These studies were headed by the behavioural science researcher, Elton Mayo, and their purpose was to test the relationship between workers’ production and various environmental conditions. Unfortunately, the experiment was invalidated because the subjects were aware
that they were being observed, and productivity increased despite any changes in the environment (Kreitner 1995).

It was recognised that the Practice Nurse Study did not have the qualities of full experimental control and, while aware of the possible Hawthorne effect on the nurses, the researcher was confident that, because they were not being directly observed in this study, their behaviour would not be unduly changed. In addition, in quasi-experimental designs the researcher must consider that subjects, particularly patients, may be anxious to please and provide the ‘right answers’ or ‘do the right thing’ (Oldham 1994). During the course of the analysis it was also important to remember that the results may have been due to some external influence and, as such, confidence in the data could be diminished.

On the other hand, Morse (1991), states that participants must possess a certain body of knowledge and be a particular type of informant to be included in the study. This was the case in this study because, as will be shown, all the nurses had considerable experience and were not new to practice nursing. Bush (1985) and Sullivan (1996) suggest that as long as you are aware of the limitations of the study you design, you have to do the best you can with the resources available at the time of the study. Sullivan (1996) also cautions that the researcher must be aware of the strengths and weaknesses of the sampling method chosen. Blacktop (1996) considers that if the researcher is knowledgeable about the population from previous studies, and has integrity in interpreting the data, then the process is probably more effective than random selection in some cases.
Methods of Collecting Data

Data collection took place over two distinct periods of time, before and after the introduction of the New GP Contract:

Part B - between April and September, 1991.

Each nurse was asked to record 15 half-day sessions in Part A and Part B. This sample was studied on the basis of recording work flow over a period of six weeks, one week on and one week off.

Research Instruments

Nurse Workload Measurement

(a) Reception Label (N2 White - Appendix 2-4):
The reception area was provided with a digital clock which was synchronised with a clock in the nurse’s treatment room. All patients attending the nurse on study days were given a small self-adhesive label on arrival at reception. On the front of the label the receptionist was asked to enter the day, the date, the time of arrival at the reception desk, and the patient’s appointment time (if relevant). The label also included a brief explanation of the study for patients. The adhesive backing allowed the label to be peeled off and attached to the Nurse Card (N1) (Appendix 2-5). An instruction sheet for reception staff was supplied (Appendix 2-6).

(b) Green Nurse Card (Card N1 - Appendix 2-5):
Each participating nurse was supplied with pads of cards which were pre-coded with a practice number and a unique nurse number, and the nurse was asked to
tick the relevant information categories on the front and back of the card. These categories were derived from the researcher’s personal experience working as a practice nurse, and from the activities listed by McIntosh (1975) in her observation time study of the domiciliary nurse, and were based on a list of procedures considered to be ‘every day’ activities for most practice nurses. Space was provided on the card for the nurses to enter any activity undertaken but not included, which they considered relevant. The nurses were supplied with ‘Guide Notes for Participating Nurses’ to aid completion of the Nurse Card (Appendix 2-7).

**Front of Card**

The nurse was asked to stick the reception label to the top of the nurse card and, using a clock synchronised with the clock at reception, record the time of the patient's entry to the treatment room. If the patient-nurse contact was the result of a direct referral from the general practitioner, there was no reception label. In the space provided for the reception label, the nurse was requested to enter the time that the referral was initiated. Space was provided on the front of the card to record the sex of the patient, date of birth and whether this was a first visit for this problem, a return appointment, or an urgent or ‘emergency’ consultation.

The nurses were also asked to record up to two presenting problems. The rationale behind this was that the patient may present with a problem that had a relevant underlying chronic disease component. The nurses were asked to record the presenting problem as either a recognised diagnostic category if appropriate or alternatively, to simply write down the patient’s own words. Examples included, ‘sore toe’, ‘earache’, “need my ‘pill’ renewed”. These were then categorised and coded using The Classification and Analysis of General Practice Data (RCGP 1986).
Nurses were asked to tick an appropriate box for who initiated the visit for that particular day, not necessarily who initiated it originally if it was a return appointment. The level of general practitioner involvement in the consultation, if any, required one box to be ticked. At the bottom of the card the nurses were asked to enter by means of a tally mark, the number of interruptions they experienced before and during the consultation.

Back of Card
This consisted of four main categories of activities, which were divided into vaccination/immunisation, diagnostic tests, treatment procedures and other activities. Within these main categories specific items were listed and the nurses were asked to ‘tick’ all relevant boxes if appropriate to the patient. ‘Treatment room work’ was defined under the headings on the card as diagnostic tests and treatment, ‘clinics’ included child immunisation, and clinic activity was included in the ‘other activities’ section, for example antenatal and postnatal care. These categories were further clarified by the nurses in their Green End-of-Day Card (Card N3 - Appendix 2-8), described below.

There were five categories at the end of the Green Nurse Card (Card N1) concerning information about discharge or the necessity for return and the nurses were asked to tick only one of these. These are described as follows:

Discharged: by agreement with the patient he/she is not required to be seen again by the nurse for that condition.
Fixed Return: the patient is given a definite appointment to return to nurse or doctor.
Return SOS: it is not necessary to see the patient again, but if the condition does not settle he/she is invited to return for a further consultation.

Finally, the nurse was asked to record the time of the patient’s departure.
c) Green End-of-Day Card (Card N5 - Appendix 2-8):

At the end of each study day the nurses recorded, by means of ticking the appropriately headed box, how much time they had spent on routine treatment sessions, clinics, administration, meetings and other activities. This they were asked to enter to the nearest half hour and was designed to give an overall picture of their working day. Space was allowed on the form for entry of any activity not included, or for comments the nurse wished to make. This information was put together with the details given on the green Nurse Card to build a picture of the activities undertaken. An instruction sheet for completion of this card was given - 'Guide Notes for Completion of End of Day Card' (Appendix 2-9).

**Summary: Reception Card and Green Nurse Card**

On arrival at reception a small self-adhesive label was given to each patient attending with an appointment to see the nurse. On the front of the label the receptionist was asked to enter the day, the date, the time of arrival at the reception desk, and the patient’s appointment time (if relevant). Each participating nurse was asked to complete a Nurse Card for each patient contact, and tick relevant information categories on the front and back of the card. The card was pre-coded with a practice number and a unique nurse number.

At the end of each study day the nurses recorded how much time they had spent on routine treatment sessions, clinics, administration, meetings and other activities. This information was put together with the details provided on the Nurse Card to construct a representation of the activities undertaken.
Pilot of Workload Instruments

A pilot study is described as a ‘mini-study’ by Treece and Treece (1986) because it mimics all the steps in data collection and analysis except that the numbers are scaled down. It is recommended that the instruments should also be pre-tested on subjects similar to those being used in the main study. Fox (1982) observed that no piece of research can be any better than the instruments used to collect the data.

Although described in different ways, various authors including Fox (1982), Cormack (1984), Wilson (1985), Treece and Treece (1986), Seaman (1987), state that one of the required objectives in research is reliability, which requires that the same result will be obtained by another researcher replicating the project. Fox (1982) considered reliability to be the most important attribute that every instrument should possess. Seaman (1987) described reliability as:

\[
\text{the extent to which a specified procedure, such as measurement, yields consistent observation of the same facts from one time to another and from one situation to the other.}
\]

(p. 322)

The second important characteristic of an instrument is validity, in that the instrument measures what it purports to measure, and several authors including Fox (1982), Bush (1985), Seaman (1987), Moser and Kalton (1989), stated that validity is dependent upon, but independent of, reliability. Its dependence is based on reliability being a precondition for validity, but conversely it is independent in the sense that perfect reliability only conveys that perfect validity is feasible. It does not describe the extent to which validity has been achieved. Moser and Kalton (1989) cautioned that a reliable scale is not necessarily valid, because it could be measuring something other than what it was designed to measure.
The workload instruments for the Practice Nurse Study (a), (b) and (c) were pre-tested for feasibility in one general practice setting, and by two attached nurses, during the first week of February 1990. The delays in recruitment however, resulted in a lack of time to adequately test their reliability and validity. In an attempt to assure reliability of the coding categories for the workload data, detailed written instructions were given with each instrument.

The nurses were visited prior to commencement of the study and interpretation of each category was discussed and agreed in order to ensure that coding was consistent and that inter-rater reliability was as accurate as possible. Cormack (1989) pointed out however, that the researcher should be aware that errors of omission can occur throughout the course of the study which are difficult to control. Reliability and validity of the ‘enablement’ scores used in the Patient Satisfaction Questionnaires is reported by Porter (1997).

The pilot study was conducted to find out:

- whether the content of the research instruments was acceptable to the participants;
- how long it would take to complete the various research instruments;
- whether instructions on completion of the research instruments was clear to those concerned;
- whether the data were easy to compile and analyse; and finally
- whether the results had potential utility for practice nurses.

There were no problems reported by the participants in the handling of the research instruments and entering of information was reported to be fairly quick and easy once the method was understood. The activities listed on the Green Nurse Card (Card N1-Appendix 2-5) were considered adequate for the purpose by the
participating nurses and it was not necessary to include any additional items. Reception and nursing staff reported that the information sheets provided for completion of the various instruments were useful, especially for reference (Appendices 2-6, 2-7, 2-9). The pilot study produced 225 valid Nurse Cards (Card N2), containing workflow and workload data, and each nurse completed an End-of-Day Card (Card N3) for each working day.

Ethical Considerations

There is no mandatory requirement that research proposals should be scrutinised by a Research Ethics Committee, and there are no legal sanctions if research is carried out without the approval of such a committee (Tierney 1995). As far as nursing research is concerned however, nurses are expected to conform to the Code of Professional Conduct for the Nurse, Midwife and Health Visitor (UKCC 1992a), which states that the interests of patients must be safeguarded and that public trust and confidence must be justified.

The content of the study was examined by the Professor and Head of Department of General Practice, who was at that time Chair of the Local Research Ethics Committee, and, after discussion, ethical approval was not requested for any of the research instruments used in the study. Confidentiality was assured because no names or addresses of patients were used, and participating nurses were distinguished by a personal code number and practice identifier known only to the researcher. Each patient questionnaire carried an explanation about the content of the study, and with informed choice they could decide whether or not to participate. The only identification on all questionnaires for patients and health
professionals was that of the participating practice, and the cumulative number of the questionnaire itself.

At the time of the Practice Nurse Study, guidance about whether projects should be subjected to ethical review was erratic. Improved and more formalised guidelines were subsequently produced in various areas of the United Kingdom, including Scotland (SOHHD 1992). If the study was to be repeated, ethical approval would be sought because of the involvement of patients and the use of the facilities provided in the general practice setting.

Questionnaires: Views of Patients and Health Professionals

A number of questionnaires were designed. The aims of these were to measure patient satisfaction with practice nurse consultations, and to assess their views of the changing role of community nurses. The views of general practitioners and practice and community nurses were sought about future developments in primary care nursing in an attempt to identify areas of common interest and of possible misunderstanding.

1. Patient satisfaction and health outcome questionnaire (Peach) (Appendix 2-10)

2. Questionnaire on patients' views of the role of community nurses (White) (Appendix 2-11)

3. Questionnaires on practice nurses', community nurses' and general practitioners' perceptions of future developments in primary care nursing:
   - Practice Nurse Questionnaire (Green) (Appendix 2-12)
   - Health Visitor Questionnaire (Pink) (Appendix 2-13)
   - District Nurse Questionnaire (Yellow) (Appendix 2-14)
   - General Practitioner Questionnaire (Blue) (Appendix 2-15)
The questionnaires were colour coded for ease of administration and recognition and to make them more attractive to the respondent. Seaman (1987) pointed out that lighter colours have been found to elicit a higher percentage of returns, and pale shades were chosen. Nevertheless, none of the respondents commented on the colours of the questionnaires, and there is no way of knowing the effects on non-responders. Considerable time was spent on determining the order of questions and these required some revision after pilot work to put them in a more logical order and make them as interesting and relevant as possible. Decisions about the sequence of questions on the questionnaires followed the generally accepted rule (Seaman 1987) that questions should progress from the general to the specific.

Demographic data was placed at the front of the Patient Satisfaction Questionnaire (Appendix 2-10) because it seemed more appropriate, there being only two simple questions. All the other questionnaires had demographic information at the end. Placing of demographic data is a matter of choice, but Seaman (1987) and Oppenheim (1993) suggest that it should be put at the end, because this type of information is routine and dull and might discourage the respondent from reading further. Care was taken to formulate the questions in as clear and unambiguous manner as possible, to make for easy reading and comprehension. The questionnaires are described below:

1. Patient Satisfaction and Health Outcome Questionnaire

Design

This questionnaire was implemented in 1991, in Part B of the study, and was designed to measure patient opinion and satisfaction with consultations with
practice employed and attached nurses. A detachable covering sheet explained the purpose of the questionnaire (Appendix 2-16). The questionnaire itself was presented on a double-sided A4 sheet of peach-coloured paper and consisted of two initial demographic questions asking for the date of birth and sex of the respondent. The two demographic questions were followed by 13 closed questions, and allowed three lines for any comments respondents wished to make at the end. The questions consisted of fixed alternative closed-ended questions, three point rating scales and Likert-type responses.

Each questionnaire was given a four digit code, and a record was kept of the questionnaire numbers given to each nurse. Closed questions were pre-coded for ease of data entry, but there was space at the foot of the questionnaire for an open-ended response to the question asking if there were any comments. As suggested by Treece and Treece (1986), responses to these open-ended comments were put together in categories in an ASCII file (American Standard Code for Information Interchange) on personal computer (PC) for ease of handling because of the difficulty of classification.

**Content**

The first question asked if the patient had consulted the nurse before, and was followed by five general administrative questions about how the patient gained access to the nurse, including information on waiting times. In questions seven and eight respondents were asked if the consultation with the nurse had been interrupted, and if so, how they felt about it. There followed four questions relating to patients' opinions about their consultation with the nurse - questions 10, 11 and 12 concerning satisfaction, whether the nurse was interested in what
the patient had to say, and asking whether they would come and see the nurse again. Question 13 asked how ‘enabled’ the patient felt following their visit to the nurse. This question contained six response categories relating to the patient’s psycho-social well-being which had previously been used in the study of 85 general practitioners in Lothian (Howie et al. 1989; 1991).

Pilot and Administration

A pilot of 25 questionnaires conducted in April 1991 did not reveal any problems with the wording and the content of questions, and the questionnaire was adopted. The nurses agreed to hand out questionnaires to patients as they were leaving the treatment room during the months of May and June. The 33 nurses were given a supply of 100 questionnaires, making a total of 3300 potential returns. Each questionnaire carried a detachable front sheet on which appeared the name and address of Edinburgh University Department of General Practice, with an explanation of the purpose of the questionnaire and assurance of its anonymity (Appendix 2-16).

The nurses were asked to give questionnaires to patients over the age of 16 years. They were given the option to exclude any patients whom they considered would be unable to complete one. A number of reasons for this were specified. These included patients who did not have spectacles with them (reception staff and nurses were instructed not to help with completion of questionnaires), patients known to be unable to read or write or those whom the nurses considered in their judgement, would be distressed by being asked to complete a questionnaire. The decisions made by the nurses in this way were based, where appropriate, on knowledge of the patients concerned. The option to exclude patients in this way
was given because it was appreciated that the nurses were working under time constraints during consultations. The time spent by nurses in completing a patient record as well as explaining to the patient the purpose of the questionnaire could be extended unnecessarily in cases where the patient was considered unable or reluctant to complete a questionnaire.

Respondents were asked to complete the double-sided questionnaire in the waiting room before departure, and to put the completed questionnaire in a labelled box provided at reception. Those who did not wish to take part were asked to put the unanswered questionnaire in the box anyway.

Response Rates: Patient Satisfaction and Health Outcome Questionnaire

The response rate was modest and ranged from four questionnaire returns from one nurse, to 94 from another. Several nurses reported being too busy to be able to complete their workload cards and to hand out questionnaires as well. Overall, there were 1930 valid questionnaires out of a potential 3300 (58%) within four weeks. It would appear that the response rate reflected more that the nurses were unable or unwilling to hand out questionnaires, rather than a non-compliance in completing them by patients.

Summary: Patient Satisfaction and Health Outcome Questionnaire

This questionnaire was designed to measure patient opinion and satisfaction with consultations with the practice employed and attached nurses. The questions consisted of fixed alternative closed-ended questions, three point rating scales and Likert-type responses. There was space provided at the foot of the questionnaire for an open-ended response to the question asking if there were any comments.
Each questionnaire was given a four digit code, and a record kept of the questionnaire numbers given to each nurse. During May and June 1991, the 33 nurses were given a supply of 100 questionnaires and the nurses agreed to hand them out to patients over the age of 16 years, on leaving the treatment room. Respondents were asked to complete the questionnaire in the waiting room before departure. There were 1930 valid questionnaires out of a potential 3300 (58%) within four weeks.

2. *Questionnaire on Patients’ Views of the Role of Community Nurses*

This questionnaire attempted to assess patients’ views of the changing role of community nurses, and whom they would prefer to consult about particular issues within the general practice setting.

*Design*

The questionnaire was designed as an A4 size booklet of two double-sided pages and contained twenty questions. Several different types of responses were applied. These consisted of Likert-type responses, checklist answers and multiple-choice questions, with the addition of short open-ended questions asking the respondent to specify any ‘other’ reason not given from the choice offered in five of these closed questions.

A four digit code was stamped on the top right-hand corner of each questionnaire, the first two numbers being the practice identifier followed by the numbers 01 to 50. For example, Practice 9 was coded 0901 to 0950. Fifty questionnaires were estimated to be a manageable number for the reception staff in each practice to
administer. This would yield a potential 1100 returns from the 22 practices who had participated in the study.

Content

- The first two questions asked whether respondents had used the services of a community nurse recently, and whether they would rather be seen by a male or female nurse.
- A question on prescribing of specific items by nurses was followed by a checklist question asking whether patients would rather see a doctor or a nurse.
- Question five asked for an opinion on whether practice nurses should do home visits, and question six was a fixed alternative question asking respondents why they might choose to see the practice nurse instead of the doctor.
- Questions seven to eleven asked some questions about the practice with which respondents' were registered, and the services it offered.
- Questions 12 to 16 asked respondents to indicate which health professional they would choose to do different things, such as screening and immunisations for example.
- Question 17 listed twelve items involving health care and social issues, and asked respondents to indicate who, in their opinion, would be the 'best person' to consult if they wanted advice or information about any of them.
- Question 18 was a multiple-choice question which asked in what circumstances patients would accept an invitation to have a 'health check-up' in their practice.
- Question 19 asked respondents to indicate from a given list, with the addition of an 'other' category, who they would consult for health advice apart from their doctor.
- Finally, question 20 asked whether respondents knew that changes had taken place in family doctor services during the last year [1990].

As well as data on age, sex and marital status, demographic details included home and car ownership, number and ages of children in the household and whether
the respondent was a carer for anyone in the household. Age, illness and disability was a particular interest of one of the study's grantees, which merited the inclusion of this last question.

Administration

In December 1991 the 22 participating practices were contacted and reception staff were asked if they would be willing to hand out questionnaires to the first 50 patients of the practice over the age of 16 years who presented to the reception desk for 'any reason'. Some of the reasons for attending might include making an appointment for a doctor or nurse, or to collect a prescription. Receptionists in the 22 practices agreed to hand out questionnaires.

A covering letter was included with the questionnaire, letting the respondent know the purpose of the study and expressing the hope that the results of the research would be of benefit to patients and health professionals. Seaman (1987) indicated that appeals to the altruistic nature of respondents is one of the best inducements to get replies. A reply paid envelope was attached to the questionnaire to allow the patient to complete it at home.

Response Rates

It has been found that questionnaires involving the postal service have the poorest method of response and response rates as low as 10% are not unknown. Several authors regard a 50% response as adequate (Seaman 1987; Treece and Treece 1986; Moser and Kalton 1989). A recent pilot study by Poulton (1996) reports a 46% response rate to questionnaires measuring satisfaction with community nurses and general practitioners.
A total of 495 out of a potential 1100 questionnaires (45%) were returned after reminders to reception staff in the practices. Staff in two practices had forgotten to hand out any questionnaires at all and a number handed out a few and then forgot to hand out any more. When all the unused research instruments were returned at the end of the study, it was found that there were 231 unused questionnaires.

Summary: Questionnaire on Patients’ Views of the Role of Community Nurses

The questionnaire contained twenty closed questions which consisted of Likert-type responses, checklist answers and multiple-choice questions. In addition, there were short open-ended questions asking the respondent to specify any ‘other’ reason not given from the choice offered in five of the closed questions. In December 1991 it was agreed with the 22 participating practices that they would hand out questionnaires to the first 50 patients of the practice over the age of 16 years who presented to the reception desk for any reason at all. A reply paid envelope was attached to the questionnaire to allow the patient to complete it at home. This represented a potential 1100 returns.

At the end of the study however, there were 231 unused questionnaires returned from the participating practices, representing 21% of the original sample of 1100. If the numbers are re-calculated then the total returns of 495 questionnaires out of 869, represents a 57% response rate. There were wide variations in numbers of questionnaires returned across the 22 practices, ranging from the lowest at seven to the highest at 37. Practice codes on the unused questionnaires identified their origin, so this finding was consistent with non-compliance from certain practices rather than a lack of response from patients.
Summary of Questionnaire Returns

1100 questionnaires distributed to 22 practices
869 questionnaires handed out = 79% of total
231 questionnaires returned unused from practices = 21% of total
495 valid questionnaires returned out of 869 = 57%

Feedback to Nurses

Early in 1992 after completion of the study, the results of the Patient Satisfaction and Health Outcome Questionnaire and the questionnaire on Patients’ Views of the Role of Community Nurses were sent back to the nurses who took part in the study, along with an anonymous transcript of the patient comments. It was hoped that these results would be shared with other members of the practice staff. Indeed a number of general practitioners who read the accounts remarked that they had expected the patients to be satisfied with nurse consultations, because patient satisfaction with the nurses was frequently mentioned to the doctors in the participating practices.

3. Questionnaire on Practice Nurses’, Community Nurses’ and General Practitioners’ Perceptions of Future Developments in Primary Care Nursing.

• Practice Nurse Questionnaire (Green) (Appendix 2-12)
• Health Visitor Questionnaire (Pink) (Appendix 2-13)
• District Nurse Questionnaire (Yellow) (Appendix 2-14)
• General Practitioner Questionnaire (Blue) (Appendix 2-15)

These questionnaires attempted to identify areas of common interest, potential disagreement, and any overlap of roles. In addition, it was hoped that the results would provide an impression of how educational and training opportunities for primary care nurses were developing. The questionnaires were designed for
distribution at the end of 1991 when the workload part of the study was completed.

Design

The questionnaires consisted of four sides of A4 paper colour coded as indicated. There were seven pages containing 42 questions, with five demographic questions on the final page. These consisted of fixed alternative closed-ended questions, three point rating scales and Likert-type responses, but contained several open-ended questions that required the respondent to explain further or summarise a particular viewpoint. Oppenheim (1993) suggests that open coding allows respondents the freedom to comment in their own words about a question, and to do so in as much detail as space permits. The questionnaires were identifiable only by a two digit practice code, to allow matching of doctor and nurse responses where questions might be identical.

The questionnaires for nurses were alike except where this has been noted, with the substitution of the word ‘client’ instead of ‘patient’ in the health visitor questionnaire, and the job title of the nurse as appropriate for each question in each questionnaire. Oppenheim (1993) suggests that politeness is important and that researchers should try to look at things from the respondents’ point of view, never forgetting that the respondent is doing us a favour by taking the trouble to answer the questions. It was, therefore, considered important that the questionnaire designed for each professional group should use their job title where necessary for each question asked.
The questionnaire for completion by general practitioners was the same as that for the nurses for the first 19 questions. The questions on 'access' and 'practice meetings' focused on the doctors' opinions of whether nurses shared similar access and involvement in the practice as did the general practitioners. The section on 'continuing education' specifically asked general practitioners about continuing education for practice employed nurses.

These self-administered questionnaires did not have a formal pilot, but they were distributed to a number of nurse colleagues and to general practitioners and social scientists within the Department of General Practice. On the basis of their comments, the final version was produced.

**Content**

The first 23 questions addressed attitudes to the introduction of the New GP Contract before and after its implementation. Opinions on morale and working relationships among different members of the primary health care team were sought. Respondents were also asked their views on whether the changes brought about by the New GP Contract were beneficial for staff and patients.

- Questions 24 to 27 concerned practice meetings and contained identical questions for the nurse questionnaires. The nurses were asked whether they were invited to practice meetings and whether they attended them. The general practitioners were asked whether the nurses were invited and whether they, the general practitioners, participated in meetings.
Questions 28 to 31 asked respondents to indicate who, in their opinion, should undertake various clinical and administrative tasks within the primary care team.

There followed four questions relating to extended roles and prescribing by community nurses (questions 32 to 35).

Question 36 asked respondents whether they thought health visiting had a nursing component. A number of health visitor colleagues and general practitioners had suggested to the researcher that health visiting was becoming more like social work, and the nursing component was being marginalised. This question was included to test these opinions.

Question 37 asked the nurses whether they would recommend their particular field of nursing expertise as being an interesting area of work, and the general practitioners were asked whether they would recommend general practice as a career.

The nurses’ questionnaires had seven questions (questions 38 to 44) about continuing education for nurses working in primary care, and the general practitioners’ questionnaire had five questions (questions 38 to 42) specifically about the employment and continuing education of practice employed nurses.

Demographic details were placed at the end of the questionnaires and were identical for all respondents, with the addition of one question on the nurses’ questionnaire which asked for information on professional qualifications.
Recruitment

In October 1991, the practice managers (or senior receptionists as appropriate), in the 22 participating practices were telephoned and asked if they could supply the names and job titles of community nurses working within, or attached to, the practice. The questionnaire had the support of the Directors of Nursing Services in Lothian and West Lothian. On the basis of the information supplied, all practice employed and Health Board attached treatment room nurses, health visitors, district nurses and general practitioners in the participating practices were sent a questionnaire. A personal covering letter was included (Appendix 2-17), explaining the purpose of the questionnaire, and asking for their co-operation in its completion. Respondents were informed that any information would remain confidential and would only be used for statistical purposes. A stamped, addressed envelope was included for their reply.

Response Rates

There was a moderate response rate within six weeks. Out of 144 general practitioners, 72 responded (50%); 35 out of 56 health visitors (63%); 27 out of 42 district nurses (64%) and 34 out of 54 practice employed and attached nurses (63%). The latter included nurses who worked in the practices but who were not involved in the study. This represented an overall response rate of 57% (n=168). No reminders were issued because, although the letters were addressed to individuals, the questionnaires themselves were anonymous and the only identifier was a practice code. The response rate from nurses was low in comparison to the Peter (1993) study in Glasgow, which had an 86% response after reminders were sent out. A study by Ross et al. (1994) reported a return of 620 completed questionnaires from nurses, a 69% response rate.
Summary: Practice Nurses’, Community Nurses’ and General Practitioners’ Questionnaires

These questionnaires attempted to identify areas of common interest, potential disagreement and any overlap of roles, as well as an impression of how educational and training opportunities for primary care nurses were developing. The questionnaires were designed for distribution at the end of 1991 when the workload part of the study was completed. They consisted of seven pages containing 42 questions, with five demographic questions on the final page. As well as fixed alternative closed-ended questions, three point rating scales and Likert-type responses, the questionnaires contained several open-ended questions. Seventy-two out of 144 general practitioners responded (50%); 35 out of 56 health visitors (63%); 27 out of 42 district nurses (64%) and 34 out of 54 practice employed and attached nurses (63%). The latter included nurses who worked in the practices but who were not involved in the study. This represented an overall response rate of 57% (n=168).

Interim Feedback to Nurses

Based on the data from the first round of recording, a mid-way report was prepared for the nurses giving them some limited information. This was in an attempt to stimulate continuing interest in the study but not to alter their behaviour prior to the second round of recording. During April and May 1991, I visited the 34 nurses who had participated in Part A of the study. This was done to provide them with selected feedback from the data collection which had finished in August 1990, and to encourage the nurses to participate for a second time. Particular care was taken not to influence any change in the behaviour of the nurses prior to the second recording period.
On-going entry and analysis of the nurse workload data took place between October 1990 and March 1991 for Part A of the study, and between September and December 1991 for Part B. The questionnaires were coded and entered on computer by the end of February, 1992. Manual checking and ordering of data prior to entry on to personal computer was uncomplicated. Input of data was undertaken using the QUATTRO PRO (Quattro, 1987) spreadsheet package.

This was followed by data ‘cleaning’, which involved finding errors by running frequencies for scores on each variable and inspecting the results for anything that was obviously incorrect. The manual data was then re-checked and corrections made if necessary. This is a laborious process, but is very important. As Wilson (1985) noted, this can mean the difference between an otherwise fine study and disaster. All the data were analysed using the Statistical Package for the Social Sciences (SPSS 1988) in line with the research aims. Descriptive statistics, including measures of central tendency (mean, mode and median) and measures of distribution (standard deviation, variance, and range) were used to present the data in a way that produced a picture of the nurses’ working week.
Fieldwork

In addition to a visit during April and May 1991 to all the nurses who had participated in the first round of recording, informal contact with the practice nurses took place throughout the two years of the study period.

Methods of Collecting and Storing Information

Informal contact with the practice nurses took the form of occasional visits and telephone calls to the practices. Several practice nurses instigated telephone calls or sent unsolicited short 'progress reports'. I considered it important to show ongoing interest in, and to build a knowledge base about, the participating nurses and their working environment in an attempt to make the data more meaningful. This seemed particularly important because the data collection process itself took place over relatively short time scales. As soon as possible after contact with a nurse participant, the content of the conversation was written down, coded with the nurse and practice code identifier, and stored in a loose-leaf book kept for the purpose.

Although the data from the main body of the study were largely quantitative, the details provided by the nurses in the 'Comments' section of their End-of-Day Cards (Card N3 - Appendix 2-8) along with conversations at various times, provided interesting information and helped to build a profile of their working patterns and their attitudes to other members of the primary health care team.

Strauss and Corbin (1990) suggest that, in addition to literature sources, professional and personal experiences are valuable sources of theoretical sensitivity. These professional and personal experiences provide a background of
information that ‘sensitise’ the researcher to what is going on in the situation being studied.

[Professional experience] even, if implicit, is taken into the research situation and helps you to understand events and actions seen and heard, and to do so more quickly than if you did not bring this background into the research.

(p. 42)

Professional knowledge can provide valuable insight that can be drawn upon in the research. Strauss and Corbin caution however, against allowing such experience to block the analytical process because sometimes, certain factors can be considered obvious and not worthy of closer examination. Likewise, with personal experience, they suggest that there is a danger of assuming that everyone else’s personal experience has been similar to one’s own, and this was a factor that required particular attention in my case. Having previously worked as a practice nurse for many years I had to be careful that my ideas about the role did not bias my judgement in support of nurses who expressed similar views to those I held myself.

Acknowledgement of Contribution to Study

At the end of the study, all the nurses who had participated in the study were sent a personal letter and a bouquet of flowers to thank them for taking part. In addition, a letter of thanks was sent to the practice staff thanking them for their help.
Summary

In this chapter the background to the research study, its aims, design and methods have been described. In designing this piece of research my experience as a practice nurse was particularly useful, because I was quickly able to identify common characteristics of normal practice nurse workload to be included in the data gathering process. I was also in a position to hypothesise an 'average' working day for a practice nurse, which made the design of the other research instruments easier, and resulted in few amendments having to be made.

Experience of working with other health professionals in general practice made the process of questionnaire design interesting because many of the questions were derived from listening to colleagues and in discussion with them about current areas of concern and effects on working practices. An attempt was made to present the study in such a way that its application would be of interest to, and accepted by, not only the nurses, but also the doctors, and be seen as relevant to nursing practice.

In the next chapter the results of the workload part of the Practice Nurse Study are presented.
Chapter Five

PRESENTATION AND INTERPRETATION OF THE DATA ON PRACTICE NURSE WORKLOAD

Work expands so as to fill the time available for its completion and the thing to be done swells in importance and complexity in a direct ratio with the time to be spent. Parkinson's First Law.

C. Northcote Parkinson.

Introduction

In this chapter the results and an interpretation of the data contained in the workload element of the Practice Nurse Study are presented. The data are largely descriptive, using simple frequencies, measures of central tendency and cross-tabulation. All data were, as previously stated in Chapter Four, coded and analysed using the Statistical Package for the Social Sciences (SPSS) (SPSS 1988) and significance between categorical variables determined by the chi square statistic. Although all responses had a number of missing values, statistics presented are based on valid percentages and are detailed in Appendix 1.

Reporting the Data

Data on Workload, Working Practices and Workflow

The results of the data in relation to the first four aims of the study will be reported in this chapter, beginning with the personal characteristics and an
occupational profile of the participating nurses. At this point it is worth restating that the data on workload relates to a total of 6675 nurse-patient consultations in 1990, and a total of 6050 nurse-patient consultations in 1991. Of the 6675 nurse-patient consultations in 1990, 4296 patients (64%) were seen by practice employed nurses and 2379 (36%) by attached nurses. In 1991, out of the 6050 nurse-patient consultations, 3913 patients (65%) were seen by practice employed nurses and 2137 (35%) by attached nurses.

Table 5-1 Total patients seen during both recording periods

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Practice</td>
<td>64.4</td>
<td>4296</td>
</tr>
<tr>
<td>Health Board</td>
<td>35.6</td>
<td>2379</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>6675</td>
</tr>
</tbody>
</table>

Personal Characteristics of the Participating Nurses

Thirty four nurses participated in the study in 1990 and 33 nurses took part in 1991. Twenty six nurses remained 'constant' over the two years, but a few changes took place in the numbers of participating nurses between the two recording periods. In only one set of analyses do these changes affect the resulting figures and these will be detailed in the text. All the nurses participating in the workload part of the study were female and they each worked for only one practice.

Number of Nurses Working in the Practice

Nine of the participating nurses worked alone in the treatment room of the practice, seven practice employed and two attached nurses. The remaining nurses worked with one or two other nurses, and in two practices there were three other
nurses. None of the nurses worked for single-handed general practitioners. In the practices where the nurses worked alone there were between three and five general practitioners.

Age Range, Experience and Marital Status of the Nurses

The age groups of the nurses are shown in Table 5-2. The average age of all the nurses was 50, ranging from 29 to 54 years. Attached nurses were slightly younger on average.

Table 5-2 Age groups of participating nurses

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Nurse employed by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Practice Health Board</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>20-29</td>
<td>0.0</td>
</tr>
<tr>
<td>30-39</td>
<td>30.0</td>
</tr>
<tr>
<td>40-49</td>
<td>33.3</td>
</tr>
<tr>
<td>50-59</td>
<td>10.0</td>
</tr>
<tr>
<td>60+</td>
<td>0.0</td>
</tr>
<tr>
<td>Valid Total</td>
<td>73.3</td>
</tr>
</tbody>
</table>

Experience ranged from two to 20 years, but 65% (n=20) of nurses had worked as a practice nurse for between two and five years (Table 5-3). In the first year of the study one attached nurse was unmarried and in the second year there were two nurses unmarried (one attached and one practice employed nurse).
Table 5-3 Length of time worked as a practice nurse

<table>
<thead>
<tr>
<th>Time</th>
<th>2-5 years</th>
<th>6-10 years</th>
<th>11-20 years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prac</td>
<td>HB</td>
<td>Prac</td>
<td>HB</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30-39</td>
<td>8</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>40-49</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total - n</td>
<td>16</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total - %</td>
<td>51.6</td>
<td>12.9</td>
<td>9.6</td>
<td>16.1</td>
</tr>
</tbody>
</table>

Profile of Qualifications and Grades

Thirty two out of the thirty four nurses held UKCC registration as a Registered General Nurse. Two were Enrolled Nurses (General), one practice employed and one attached nurse. Many of the participating nurses possessed a wide spectrum of additional qualifications. These are illustrated in Table 5-4 according to employment status.

As stated earlier, for the purpose of the study, nurses described as having a dual appointment were those who worked in the practice treatment room for a number of hours for the Health Board and were paid by the general practitioner to spend some extra time in the practice, usually doing specifically delegated screening or clinic sessions.
Table 5.4 Profile of professional and other qualifications

<table>
<thead>
<tr>
<th>PROFESSIONAL AND OTHER QUALIFICATIONS</th>
<th>Practice employed</th>
<th>Health Board employed</th>
<th>Dual appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic qualifications:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered general nurse</td>
<td>8</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Enrolled nurse (general)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other qualifications:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered mental nurse</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Registered sick children's nurse</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Registered midwife</td>
<td>2</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Registered health visitor</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>District nurse qualification</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Family Planning Certificate</td>
<td>5</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Practice Nurse Certificate</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>BA/BSc Nursing</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Other degree</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Multiple coding

Practice nurses in Lothian are employed according to clinical grading guidelines from the Scottish Office, Home and Health Department (SHHD 1988). For example, grade C applies to second level registration, the enrolled nurse. Levels D and above apply to nurses with first level registration. Lothian has a smaller percentage of D, E, G and H grade practice nurses than that reported by Atkin et al. (1993) in England and Wales, but a higher percentage of F grade nurses (McBeath 1994). All the attached and 12 of the practice employed nurses in the study were allocated a grade 'F'. Ten practice employed nurses were grade 'G' and one was grade 'H'. These grades are reimbursed by Primary Care Services, but may not reflect the actual grade paid by the employing general practitioner. The grading structure is designed to assist practices in employing appropriate skills, knowledge and experience for the job specification.
The Nurses' Week

Information on how the nurses spent their working day was obtained from the Green End-of-Day Card (Card N3 - Appendix 2-8). The nurses in the study worked a variety of days and hours. This ranged from two to five days and from eight to 38 hours per week. Nine of the nurses described themselves as working full-time and 24 reported that they worked part-time.

The attached nurses worked an average of 25 hours per week both years, and the practice employed nurses an average of 20 hours in 1990, increasing to 21 hours in 1991. Eight nurses increased their hours in the second year, two attached nurses and six practice employed nurses (one of the practice employed nurses being paid for an extra 4.5 hours by the Health Board). Two practice employed nurses reduced their hours during the study; one from 20 to 19.5 and the other from 19.5 to 14 hours. The employment status of the nurses and the hours that they worked each week are shown in Table 1-1 in Appendix 1.

Nurse Activities

Because of the variety of nurses' hours, the total available hours for all nurses were calculated and then the percentage of time doing different activities. These are illustrated in Table 5-5. Over the two years of recording both attached and practice employed nurses undertook less treatment room work. In terms of practice employed nurses the level fell by 11% in contrast to 4% for attached nurses (Table 5-5).
Table 5-5 Time spent doing different activities as a percentage

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment room work</td>
<td>62</td>
<td>51</td>
<td>64</td>
<td>60</td>
</tr>
<tr>
<td>Routine clinics</td>
<td>2</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Special clinics</td>
<td>4</td>
<td>12</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Administration</td>
<td>16</td>
<td>15</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Meetings</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Breaks</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>2</td>
</tr>
</tbody>
</table>

Notes:
1. Dual appointment: 2 nurses
2. Dual appointment: 3 nurses

The time spent doing different activities was then translated into hours per whole-time equivalent (WTE) (37.5 hours) per week (Table 5-6).

Table 5-6 Time spent doing different activities by WTE (Hours per whole-time equivalent (WTE 37.5 hours) per week)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment room work</td>
<td>23.25</td>
<td>19.0</td>
<td>24.0</td>
<td>22.5</td>
</tr>
<tr>
<td>Routine clinics</td>
<td>0.75</td>
<td>3.5</td>
<td>0.75</td>
<td>4.25</td>
</tr>
<tr>
<td>Special clinics</td>
<td>1.5</td>
<td>4.5</td>
<td>2.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Administration</td>
<td>6.0</td>
<td>5.5</td>
<td>5.0</td>
<td>4.25</td>
</tr>
<tr>
<td>Meetings</td>
<td>0.5</td>
<td>0.75</td>
<td>0.75</td>
<td>1.0</td>
</tr>
<tr>
<td>Breaks</td>
<td>2.75</td>
<td>2.25</td>
<td>2.5</td>
<td>2.25</td>
</tr>
<tr>
<td>Other</td>
<td>2.75</td>
<td>2.0</td>
<td>2.5</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Clinics

Clinics described as ‘routine’ included antenatal, postnatal and child welfare/immunisation clinics. Designated ‘special’ clinics included family
planning/well woman, hypertension, asthma, minor surgery and any others the nurses were involved in. Both groups of nurses reported an increase in time spent on routine and special clinics in the second year (Tables 5-5 and 5-6).

In Table 5-6 it can be seen that for practice employed nurses the proportion of time spent in routine clinics increased from three quarters of an hour in 1990, to three and a half hours per week in 1991 (WTE), and special clinics from one and a half hours in 1990 to four and a half hours in 1991 (WTE).

For attached nurses, routine clinics increased from three quarters of an hour per week in the first year, to four and a quarter hours per week in 1991. Special clinics increased marginally by half an hour in the second year, from two hours to two and a half hours per week (WTE).

**Administration**

The nurses spent on average one hour a day (WTE) on administrative duties. This included filling in laboratory request forms, writing up case notes, making and receiving telephone calls, tidying surgeries, stocking doctors' bags and ordering drugs and supplies.

Over the two recording periods both groups of nurses recorded a slight fall in time spent on administration of about one per cent, although individual nurses did record a slight increase in the second year. This was almost exclusively in the practice employed group where eight nurses recorded an average increase in administration of 4%, ranging from 0.5 to 9%. One nurse holding a dual
appointment increased time spent on administration by 5%. None of the attached nurses increased administration time.

**Practice Meetings and Breaks**

There was a marginal increase for both groups in the number of meetings attended in the second year and a slight decrease in time spent on breaks. In an instrument measuring half-hour slots, breaks were difficult to quantify. Sometimes nurses only took a ten minute break but ticked a half-hour slot on their End-of-Day sheets (Card N3) and wrote in 'ten minutes' beside it.

**Other Activities**

'Other' activities covered anything that was different from the nurse's usual routine. In the first year nurses recorded preparation for 'new' clinics which were just starting, for example: wart clinics, well woman, coil fitting, diabetes and asthma clinics. The number of entries in the 'Other' category fell slightly in the second year because in 1991 these clinics were recorded in the 'Special Clinic' section. For both years, in the 'Other' category, two practice employed nurses recorded home visits and three summarised and selected out old and duplicated medical records.

The remaining workload information was obtained from the Green Nurse Card (Card N1 - Appendix 2-8).
Nurse-Patient Contacts

As illustrated in Figure 5-1 during both periods of study the greatest proportion of patients seen by both practice employed and attached nurses were directly referred from the general practitioner. The proportion of general practitioner referrals fell in the second year for practice nurses but increased for attached nurses. For both groups of nurses the majority of these referrals were for screening and prophylactic procedures during the two recording periods. In the second year practice employed nurses initiated more of their own appointments (9%) and saw 11% fewer referrals. This trend was reversed for the attached nurses who received 10% more referrals from the general practitioner in the second year and initiated 3% less of their own appointments.

Figure 5-1 Nurse-patient contacts - visit initiated by:

(cross reference Table 1-2, chi squares 1-3 & 1-4 in Appendix 1)
In 1990 and 1991, the largest proportion of patients seen by practice-employed and attached nurses were both males and females between the ages of 16 and 44 (Table 5-7).

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Practice-employed nurses</th>
<th>Health Board employed nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>47</td>
<td>58</td>
</tr>
<tr>
<td>5-15</td>
<td>112</td>
<td>82</td>
</tr>
<tr>
<td>16-44</td>
<td>408</td>
<td>913</td>
</tr>
<tr>
<td>45-64</td>
<td>395</td>
<td>574</td>
</tr>
<tr>
<td>65+</td>
<td>329</td>
<td>565</td>
</tr>
<tr>
<td>Total</td>
<td>1291</td>
<td>2192</td>
</tr>
</tbody>
</table>

* Figures

**Level of General Practitioner Involvement in Consultations**

Doctors were involved in significantly fewer consultations (25%) in 1991 compared to 40% in 1990. Although both groups of nurses were working more independently, practice employed nurses reported fewer joint appointments with the general practitioner and asked for help less often in 1991.

Advice/discussion (indirect) described instances where nurses and doctors communicated by leaving each other notes or leaving messages with reception staff. This means of communication was reported as lower in the second year for all nurses (Figure 5-2).
Consultation Times, Waiting Times and Patient Flow

As described in Chapter Four, in order to calculate nurse consultation times and patient waiting times, the arrival time and, if relevant, the appointment time of the patient was noted by the reception staff on a clock synchronised with a second clock in the nurse’s treatment room. When the patient entered the treatment room, the nurse noted the time that the patient came in, and at the end of the consultation, the nurse recorded the time of the patient’s departure.

In addition, the nurse recorded on a Nurse Card the time of any referral from the general practitioner, even if she was in the middle of a consultation with another patient. When the first patient left the treatment room and the referred patient came in, the time was recorded on the card.
To represent how the nurses managed their appointments and referrals, flow charts of an average recording day for two nurses are illustrated in Figures 5-3 & 5-4.

It was found that generally, patients tended to arrive early. If this was the case, and the nurse was not consulting, she would take the patient as soon as they arrived. Alternatively, if the patient was late for their appointment with the nurse, and a referral was initiated by the general practitioner in the meantime, the nurse would ‘fit’ the referral in before the next patient arrived. Where there were no ‘gaps’ available between appointments the nurse had to estimate how long the process of care would take and balance appointments and referrals to ensure the shortest possible waiting time for patients.
Figure 8.3 Flow chart of an average recording day - Nurse 1
Figure 5.4 Flow chart of an average recording day - Nurse 2
The average consultation time for all nurses in the study was ten minutes. For practice employed nurses it was ten minutes and attached nurses, nine minutes. This remained constant during the recording periods over the two years (Table 5-8).

*Table 5-8 Mean consultation times: Practice-employed and attached nurses*

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean cons. time (mins)</td>
<td>10.3</td>
<td>10.4</td>
</tr>
<tr>
<td>S.D.</td>
<td>16.48</td>
<td>10.12</td>
</tr>
<tr>
<td>Entire population</td>
<td>Mins</td>
<td>S.D.</td>
</tr>
<tr>
<td>1990</td>
<td>9.9</td>
<td>14.98</td>
</tr>
<tr>
<td>1991</td>
<td>10.0</td>
<td>11.21</td>
</tr>
</tbody>
</table>

*The test used is the t-test for mean times.*

1990. Mean consultation time. <0.04 probability.

1991. Mean consultation time <0.001 probability

There was little overall change in waiting times during both recording periods. In 1990 and 1991, patients seeing the practice employed nurses waited longer to be taken into the treatment room from the time of their appointment than those seeing the attached nurses (Table 5-9).
Table 5-9 Mean waiting times: Practice-employed and attached nurses

<table>
<thead>
<tr>
<th>Mean waiting times</th>
<th>Practice employed</th>
<th>HB Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment to time into treatment room (mins)</td>
<td>7.1</td>
<td>6.2</td>
</tr>
<tr>
<td>S.D.</td>
<td>22.43</td>
<td>13.33</td>
</tr>
<tr>
<td>Entire population</td>
<td>Mins</td>
<td>S.D.</td>
</tr>
<tr>
<td>1990</td>
<td>6.5</td>
<td>25.15</td>
</tr>
<tr>
<td>1991</td>
<td>6.0</td>
<td>17.04</td>
</tr>
<tr>
<td>Arrival to time into treatment room (mins)</td>
<td>12.2</td>
<td>12.5</td>
</tr>
<tr>
<td>S.D.</td>
<td>19.75</td>
<td>12.74</td>
</tr>
<tr>
<td>Entire population</td>
<td>Mins</td>
<td>S.D.</td>
</tr>
<tr>
<td>1990</td>
<td>11.7</td>
<td>17.82</td>
</tr>
<tr>
<td>1991</td>
<td>11.7</td>
<td>13.78</td>
</tr>
</tbody>
</table>

The test used is the t-test for mean times.

1990 Waiting time from appointment to time into treatment room. <0.01 probability.
1991 Waiting time from arrival to time into treatment room. <0.002 probability.

'Three Style'

In an attempt to identify any changes in consulting rate over the two periods of recording, nurse consulting speed was divided into three groups - those consulting at less than nine minutes (quicker nurses), those with a consulting speed of between nine and 11 minutes (intermediate) and a third group at 12 minutes and over (slower nurses). This variable was titled 'nurse style' and is illustrated in Table 5-10.

Table 5-10 Nurse consultations by 'Nurse style'
(cross reference Tables 1-8 & 1-9 chi squares in Appendix 1)

<table>
<thead>
<tr>
<th>Consulting Speed:</th>
<th>Practice</th>
<th>HB Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 9 mins</td>
<td>34.5</td>
<td>28.3</td>
</tr>
<tr>
<td>9 - 11 mins</td>
<td>40.9</td>
<td>42.0</td>
</tr>
<tr>
<td>12+ mins</td>
<td>24.5</td>
<td>29.7</td>
</tr>
</tbody>
</table>
There was a decrease in the faster style for both groups of nurses in the second year and an increase in intermediate style. This increase was more evident in the attached nurses group (18%) than that of the employed nurses (1%). There was a 5% increase of practice employed nurses with a slower style, and no attached nurses in this category in the second year. It was found that a slower style was more likely to be associated with screening procedures and other activities involving advice and counselling, such as those undertaken by practice employed nurses. A faster style was more likely to be associated with simple diagnostic tests and treatments such as those undertaken by attached nurses.

Overall there were fewer nurses in both the practice and attached groups with a 'faster' style during 1991 and an increase in 'intermediate' style. There were two more practice employed nurses with a 'slower' style in 1991 but no attached nurses remained in this category in the second year. In the second year five nurses out of 33 crossed from one category to another, all of them practice employed nurses. Two nurses moved from the slower category - one to the fast and one to the intermediate category, one moved from intermediate to slow and two from fast to intermediate.

**Disposition (Disposal)**

Practice employed nurses completed discharge for more patients than did attached nurses both years, but in the second year they brought back more patients to themselves and referred fewer back to the doctors. In contrast, the attached nurses discharged fewer patients in the second year, and referred more back to the doctors (Figure 5-5).
This correlates with the variable 'Disposition by Nurse Style' (Figure 5-6) where it can be seen that nurses with a 'slower' style completely discharged more patients both years, increasingly asking patients to return only if necessary. In contrast, the 'intermediate' group brought back more patients to themselves and the doctors in the second year. In addition, the nurses with a 'slower' style asked fewer patients to return to the general practitioners in the second year, whereas the nurses in the 'faster' group discharged less and asked more patients to return to both themselves and the doctors.
Figure 5-6 Disposition by nurse style (all nurses) 1990 & 1991
(Cross reference Table 1-13, in Appendix 1)

**Interruptions to Nurse Consultations**

The practice nurses were frequently interrupted by receptionists, general practitioners and sometimes other colleagues who entered the treatment room, often without knocking or asking permission to enter. Use of an internal communication system or the telephone were another frequent source of interruptions for some nurses. These interruptions were usually reported to be by reception staff who wanted advice about which health professional a patient who was requesting an appointment should see. Some interruptions were reported to be to check the length of an appointment for a specific procedure. On some occasions nurses were asked to speak on the telephone to patients, again to give advice or give results of blood or urine tests.

Nurses reported between one and seven interruptions during a single nurse-patient contact in the treatment room in 26% of all consultations in 1990 and in 17% of consultations in 1991. These interruptions were by telephone or in
person. In 1990, 13% of interruptions occurred before consultations and in 1991 the level fell to 10%. Interruptions to nurse consultations were higher for attached nurses than for practice employed nurses during both years of recording although the levels fell for both groups in 1991.

*Figure 5-7 Interruptions as a percentage of consultations*

(Cross reference Table 1-14 & chi squares Table 1-15 & 1-16 in Appendix 1)

![Graph showing interruptions as a percentage of consultations](image)

Nurses with an 'intermediate' consulting style of between nine and 11 minutes had the most interruptions both years (Figure 5-8). Nurses consulting with a 'faster' style were the least interrupted group in 1990. In 1991, those with a 'slower' style were least interrupted, and practice employed nurses were the only ones in this group in the second year of recording.
Figure 5-8 Interruptions as a percentage of consultations by 'nurse style'

(Cross reference Table 1-17 & chi squares 1-18 in Appendix 1)

Problems Presenting to the Nurse

Nurses recorded details of the reason for the patient’s visit as 'problems presenting to the nurse' and these were categorised and coded using The Classification and Analysis of General Practice Data (RCGP 1986).

First Presenting Problem

The category 'First Presenting Problem' was defined as the main problem or reason for the patient’s visit that day. Table 5-11 shows that during 1990 both groups of nurses spent most of their patient contact time undertaking screening procedures. This covered areas such as taking cervical smears, screening for diabetes, hypertension, respiratory, metabolic and endocrine diseases. In 1991 the same category shows that both groups of nurses still spent most of their patient contact time doing screening. This covered the same areas as the previous year with the
addition of screening for blood disorders which had not been recorded by any of the nurses in 1990.

Table 5-11 Problems presenting to the nurse as a percentage of consultations - First presenting problem

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice</th>
<th></th>
<th>Health Board</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections and parasitic</td>
<td>2.5</td>
<td>3.2</td>
<td>1.9</td>
<td>2.7</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>0.6</td>
<td>0.8</td>
<td>0.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Endocrine, nutritional &amp; metabolic</td>
<td>3.0</td>
<td>10.1</td>
<td>3.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Blood and blood-forming organs</td>
<td>2.1</td>
<td>3.0</td>
<td>2.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Mental disorders &amp; nervous system</td>
<td>0.6</td>
<td>1.9</td>
<td>1.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Social, marital &amp; family problems</td>
<td>1.1</td>
<td>0.7</td>
<td>1.0</td>
<td>0.8</td>
</tr>
<tr>
<td>Eye and ear</td>
<td>4.9</td>
<td>4.7</td>
<td>4.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Cardio-, cerebro- &amp; periphero-vascular</td>
<td>3.3</td>
<td>4.6</td>
<td>2.9</td>
<td>3.9</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>2.1</td>
<td>3.8</td>
<td>0.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Digestive system</td>
<td>0.5</td>
<td>0.4</td>
<td>0.7</td>
<td>0.9</td>
</tr>
<tr>
<td>Genito-urinary</td>
<td>1.7</td>
<td>1.6</td>
<td>3.7</td>
<td>5.4</td>
</tr>
<tr>
<td>Skin &amp; subcutaneous tissue</td>
<td>5.5</td>
<td>4.6</td>
<td>6.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Musculoskeletal system &amp; connective tissue</td>
<td>3.0</td>
<td>2.7</td>
<td>3.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Ill-defined conditions</td>
<td>3.1</td>
<td>2.4</td>
<td>4.5</td>
<td>6.3</td>
</tr>
<tr>
<td>Results of investigations</td>
<td>1.0</td>
<td>0.8</td>
<td>1.5</td>
<td>1.2</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>8.2</td>
<td>7.1</td>
<td>11.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Special surveillance</td>
<td>2.2</td>
<td>1.1</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td>Prophylactic procedures</td>
<td>13.7</td>
<td>10.4</td>
<td>8.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Reproductive &amp; child health</td>
<td>4.8</td>
<td>2.9</td>
<td>7.3</td>
<td>5.3</td>
</tr>
<tr>
<td>Screening procedures</td>
<td>24.1</td>
<td>25.8</td>
<td>20.4</td>
<td>15.3</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>10.1</td>
<td>7.2</td>
<td>11.2</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Second Presenting Problem

A second presenting problem was defined as a secondary problem or a previously diagnosed condition from which the patient was suffering. In the case of chronic disease management, this may have been relevant to the consultation. For example, the patient may have been attending for a dressing to an infected toe, but it would be important for the nurse to be aware that the patient also suffered from
diabetes. In consultations where a 'Second Presenting Problem' was recorded in 1990, screening procedures were again the highest category for both groups (Table 5-12). In 1991 in consultations where a 'Second Presenting Problem' was recorded, screening remained the highest category for practice nurses, but was overtaken by 'Surgical Procedures' for attached nurses. This consisted of removal of sutures, wart removal and trimming of ingrown toenails.

Table 5-12 Problems presenting to the nurse as percentage of consultations - Second presenting problem

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CLASSIFICATION OF DISEASE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections and parasitic</td>
<td>2.2</td>
<td>1.9</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>0.8</td>
<td>0.6</td>
<td>0.4</td>
<td>0.0</td>
</tr>
<tr>
<td>Endocrine, nutritional &amp; metabolic</td>
<td>5.7</td>
<td>9.3</td>
<td>3.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Blood and blood-forming organs</td>
<td>3.0</td>
<td>0.9</td>
<td>3.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Mental disorders &amp; nervous system</td>
<td>5.0</td>
<td>5.5</td>
<td>8.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Social, marital &amp; family problems</td>
<td>4.2</td>
<td>2.8</td>
<td>2.5</td>
<td>3.0</td>
</tr>
<tr>
<td>Eye and ear</td>
<td>2.8</td>
<td>2.5</td>
<td>1.7</td>
<td>1.0</td>
</tr>
<tr>
<td>Cardio-, cerebro- &amp; periphero-vascular</td>
<td>7.6</td>
<td>10.0</td>
<td>5.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>1.6</td>
<td>2.8</td>
<td>2.5</td>
<td>0.7</td>
</tr>
<tr>
<td>Digestive system</td>
<td>1.0</td>
<td>0.8</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Genito-urinary</td>
<td>2.2</td>
<td>1.7</td>
<td>2.9</td>
<td>3.4</td>
</tr>
<tr>
<td>Skin &amp; subcutaneous tissue</td>
<td>3.8</td>
<td>3.0</td>
<td>2.5</td>
<td>4.0</td>
</tr>
<tr>
<td>Musculoskeletal system &amp; connective tissue</td>
<td>4.6</td>
<td>2.5</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Ill-defined conditions</td>
<td>5.5</td>
<td>4.0</td>
<td>5.9</td>
<td>8.1</td>
</tr>
<tr>
<td>Results of investigations</td>
<td>1.9</td>
<td>3.2</td>
<td>1.7</td>
<td>1.3</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>3.4</td>
<td>2.3</td>
<td>6.7</td>
<td>4.0</td>
</tr>
<tr>
<td>Special surveillance</td>
<td>2.6</td>
<td>0.9</td>
<td>1.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Prophylactic procedures</td>
<td>10.1</td>
<td>9.3</td>
<td>4.6</td>
<td>6.7</td>
</tr>
<tr>
<td>Reproductive &amp; child health</td>
<td>3.4</td>
<td>4.5</td>
<td>6.3</td>
<td>15.2</td>
</tr>
<tr>
<td>Screening procedures</td>
<td>20.2</td>
<td>24.1</td>
<td>24.3</td>
<td>12.4</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>6.5</td>
<td>7.2</td>
<td>9.7</td>
<td>17.5</td>
</tr>
</tbody>
</table>
Items of Service

Items of service were expressed as a percentage of consultations because patients were often seen for several things during one consultation.

Immunisation/Vaccination

Practice employed nurses undertook relatively more of these procedures than their attached nurse colleagues during both recording periods. In the second year attached nurses gave fewer travel immunisations, while practice employed nurses recorded relatively fewer routine childhood immunisations and those of patients in the special risk group.

Diagnostic Tests

In the area of diagnostic tests, venepuncture was the highest recorded item of service as a percentage of consultations both years, although overall it fell slightly in 1991. Attached nurses took more venepunctures than their practice nurse colleagues both years (p<0.001). Practice employed nurses recorded 23% of consultations where venepunctures were performed in 1991 (a fall of 5% from 1990) and attached nurses a level of 33% (an increase of 4% from 1990). Consultations where a venepuncture only was performed took an average of six minutes over both recording periods. Percentages of diagnostic tests which were part of clinic work (weight, blood pressure, urine testing), increased for practice nurses, while decreasing for attached nurses.
**Treatment Procedures and Chaperoning**

Attached nurses recorded more treatment procedures than their practice nurse colleagues during both recording periods. While practice employed nurses syringed more ears both years, the attached nurses undertook more dressings, removal of sutures and ear, nose, throat and eye treatment. Both groups of nurses chaperoned fewer patients in 1991.

**Prescribing**

Although only a small element of the nurses’ work, the process of writing out and getting prescriptions signed for patients took up a considerable amount of nurse time. The mean time in minutes for all nurses, excluding interruptions, was 11 minutes in 1990 and 16 minutes in 1991. Practice employed nurses were less involved in this process in the second year.

**Therapeutic Listening**

Nurses were asked to note occasions when listening to patients' concerns or worries was a key feature of the consultation, whether or not it was the original reason for the visit (Table 5-13).

Time spent listening to patient problems increased by 7% overall during the second recording period (p<0.001). Practice employed nurses reported a higher level of therapeutic listening than the attached nurses in 1990, 11% in contrast to 8% (p<0.001). This increased to 17% in 1991 (p<0.001).
Attached nurses increased their level of therapeutic listening to 19% in the second year (p<0.001), a level higher than that of the employed nurses. This result was found to be due to very high levels of therapeutic listening by two attached nurses recruited to the study in the second year. The figures were re-examined because the limitations of the small numbers may have had the effect of skewing the data. When the results for nurses who had remained constant over the two recording periods were compared (and new nurses recruited to the study were excluded), practice employed nurses remained the group with the higher level of therapeutic listening (Table 5-14).

Table 5-14 Therapeutic listening recorded by nurses who were 'constant' over two year recording period

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>10.3</td>
<td>17.1</td>
</tr>
<tr>
<td>Health Board</td>
<td>6.1</td>
<td>9.6</td>
</tr>
</tbody>
</table>

(Results expressed as a percentage of consultations)

**Screening and Health Education**

Three per cent of all nurse consultations in 1990 involved a new registration screening, taking 12 minutes to perform. By the following year new registration screening had increased to 7% of all consultations and the time taken to 23 minutes. In the second year, relatively more screening procedures (15%), were undertaken by practice employed nurses as a result of the introduction of the New
GP Contract. During 1991 their attached nurse colleagues reported no change in screening procedures undertaken (2% both years).

Practice employed nurses also reported an increase in health education advice, from 19% in 1990 to 35% in 1991. The greatest increases were that of dietary advice (9%, p<0.001), and advice on exercise (4%, p<0.001). There was relatively little variation in health promotion activities by attached nurses overall (1% less in 1991), but they reported fewer occasions of giving advice on exercise in the second year.

**Other Activities**

This covered anything that was different from the nurse's usual routine. In the first year several nurses recorded preparation for clinics new to the practice, for example: wart clinics, well woman, coil fitting, diabetes and asthma clinics. The number of entries in the 'Other' category fell slightly in the second year because in 1991 these clinics were recorded as 'Special' clinics. During both recording periods, two practice employed nurses detailed home visits and three reported the summarising and selecting out of duplicate medical records, in the 'Other' category.

The items of service undertaken by practice employed and attached nurses during 1990 and 1991 are shown in Table 5-15.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VACCINATION/ IMMUNISATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>child (0-5)</td>
<td>2.4</td>
<td>0.2</td>
<td>1.1</td>
<td>0.9</td>
</tr>
<tr>
<td>special group at risk</td>
<td>7.1</td>
<td>3.3</td>
<td>5.1</td>
<td>3.3</td>
</tr>
<tr>
<td>overseas traveller</td>
<td>4.0</td>
<td>3.5</td>
<td>4.5</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC TESTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>weight</td>
<td>9.3</td>
<td>10.7</td>
<td>22.8</td>
<td>7.2</td>
</tr>
<tr>
<td>recording of blood pressure</td>
<td>15.8</td>
<td>9.6</td>
<td>19.8</td>
<td>5.9</td>
</tr>
<tr>
<td>urine collection/ testing</td>
<td>11.0</td>
<td>15.0</td>
<td>14.6</td>
<td>9.4</td>
</tr>
<tr>
<td>swab/ specimen taking for bact. exam</td>
<td>2.6</td>
<td>2.5</td>
<td>1.9</td>
<td>4.9</td>
</tr>
<tr>
<td>venepuncture</td>
<td>27.1</td>
<td>29.7</td>
<td>22.3</td>
<td>33.4</td>
</tr>
<tr>
<td>cervical smear taking</td>
<td>5.5</td>
<td>3.5</td>
<td>6.0</td>
<td>3.7</td>
</tr>
<tr>
<td>ECG recording</td>
<td>0.6</td>
<td>1.2</td>
<td>0.7</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>TREATMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dressing (all types)</td>
<td>22.0</td>
<td>25.5</td>
<td>17.4</td>
<td>25.6</td>
</tr>
<tr>
<td>therapeutic injection</td>
<td>4.9</td>
<td>7.6</td>
<td>5.2</td>
<td>7.7</td>
</tr>
<tr>
<td>ear syringing</td>
<td>6.2</td>
<td>4.9</td>
<td>5.7</td>
<td>3.4</td>
</tr>
<tr>
<td>suture insertion/removal</td>
<td>3.3</td>
<td>4.5</td>
<td>2.5</td>
<td>4.5</td>
</tr>
<tr>
<td>ENT/ eye treatment</td>
<td>1.1</td>
<td>1.2</td>
<td>0.5</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>OTHER ACTIVITIES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ante-natal care</td>
<td>2.4</td>
<td>2.8</td>
<td>1.4</td>
<td>2.6</td>
</tr>
<tr>
<td>post-natal care</td>
<td>0.4</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>contraception</td>
<td>2.1</td>
<td>2.6</td>
<td>2.0</td>
<td>3.4</td>
</tr>
<tr>
<td>chaperoning</td>
<td>1.8</td>
<td>2.3</td>
<td>0.8</td>
<td>2.2</td>
</tr>
<tr>
<td>writing prescription</td>
<td>3.7</td>
<td>0.8</td>
<td>1.8</td>
<td>1.1</td>
</tr>
<tr>
<td>therapeutic listening</td>
<td>11.4</td>
<td>7.7</td>
<td>16.7</td>
<td>19.2</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>new registration</td>
<td>2.5</td>
<td>0.6</td>
<td>6.5</td>
<td>0.5</td>
</tr>
<tr>
<td>child health check (0-5)</td>
<td>0.1</td>
<td>0.0</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td>elderly person</td>
<td>0.6</td>
<td>0.1</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>other</td>
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<td>1.2</td>
<td>12.8</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Health education/advice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>4.8</td>
<td>14.8</td>
<td>5.3</td>
</tr>
<tr>
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<td>0.9</td>
<td>2.4</td>
<td>0.9</td>
</tr>
<tr>
<td>stress</td>
<td>1.8</td>
<td>0.9</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>exercise</td>
<td>2.3</td>
<td>4.0</td>
<td>6.6</td>
<td>2.8</td>
</tr>
<tr>
<td>smoking</td>
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<td>1.4</td>
<td>2.7</td>
<td>2.1</td>
</tr>
<tr>
<td>other</td>
<td>4.5</td>
<td>7.2</td>
<td>6.1</td>
<td>6.0</td>
</tr>
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</table>

In consultations where individual procedures were undertaken and there were no interruptions, an attempt was made to estimate the time taken to do these. This is
illustrated in Table 5-16 which records the mean time in minutes spent on single
items of service (excluding interruptions).

Table 5-16 Single items of service undertaken by practice employed and attached nurses - mean time (mins) excluding interruptions

<table>
<thead>
<tr>
<th>Service Description</th>
<th>1990</th>
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</tr>
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<tbody>
<tr>
<td>VACCINATION/ IMMUNISATION</td>
<td></td>
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<td>5.4</td>
<td>6.5</td>
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<tr>
<td>special group at risk</td>
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<tr>
<td>overseas traveller</td>
<td>9.3</td>
<td>9.6</td>
</tr>
<tr>
<td>DIAGNOSTIC TESTS</td>
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<td></td>
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<tr>
<td>weight</td>
<td>3.8</td>
<td>2.8</td>
</tr>
<tr>
<td>recording of blood pressure</td>
<td>6.3</td>
<td>5.1</td>
</tr>
<tr>
<td>urine collection/ testing</td>
<td>4.8</td>
<td>5.4</td>
</tr>
<tr>
<td>swab/ specimen taking for bact. exam</td>
<td>6.2</td>
<td>9.3</td>
</tr>
<tr>
<td>venepuncture</td>
<td>6.3</td>
<td>6.5</td>
</tr>
<tr>
<td>cervical smear taking</td>
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</tr>
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<td>ECG recording</td>
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<td>16.9</td>
</tr>
<tr>
<td>TREATMENT</td>
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<tr>
<td>dressing (all types)</td>
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<td>9.5</td>
</tr>
<tr>
<td>therapeutic injection</td>
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<td>6.2</td>
</tr>
<tr>
<td>ear syringing</td>
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<td>8.1</td>
</tr>
<tr>
<td>suture insertion/removal</td>
<td>10.8</td>
<td>6.7</td>
</tr>
<tr>
<td>ENT/ eye treatment</td>
<td>6.1</td>
<td>6.5</td>
</tr>
<tr>
<td>OTHER ACTIVITIES</td>
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<tr>
<td>ante-natal care</td>
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</tr>
<tr>
<td>post-natal care</td>
<td>7.5</td>
<td>17.0</td>
</tr>
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<td>contraception</td>
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<td>13.2</td>
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<tr>
<td>writing prescription</td>
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<td>therapeutic listening</td>
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<td>new registration</td>
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<td>elderly person</td>
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<tr>
<td>alcohol</td>
<td>-</td>
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</tr>
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<td>stress</td>
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</tr>
<tr>
<td>exercise</td>
<td>5.5</td>
<td>6.8</td>
</tr>
<tr>
<td>smoking</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>other</td>
<td>6.9</td>
<td>9.1</td>
</tr>
</tbody>
</table>
Additional Material

In addition to the workload data, field notes were taken at intervals during the course of the study, which were the results of occasional telephone calls and informal visits to the nurses. This material is considered here and is followed by a discussion of the findings from the workload and fieldwork data.

Fieldwork: A Reflection on Informal Discussions with Practice Nurses

Introduction

As described in Chapter Four, informal contact with the practice nurses took place throughout the two years of the study period. I made occasional visits and telephone calls to the practices, and also received telephone calls and occasionally, unsolicited short progress reports from some of the practice nurses.

The Working Environment

Although all the nurses in the study worked in treatment rooms provided by the practice, some of these were larger and better equipped than others. Two participating practices provided a computer for the nurses in the treatment room. The three nurses concerned recorded appointment times, patient attendance and some data for practice statistics, for example cervical smears and immunisations. In practices which employed more than one nurse, the nurses had to work from one treatment room and it was sometimes necessary to take a patient into a consulting room if the treatment room was occupied. On occasions, when doctors were consulting, there was no alternative room for the nurses to use and this
increased waiting times for patients who were referred or had an appointment with the nurse.

The nurses also reported that doctors who were running late with surgeries would often refer patients to the nurse’s room to undress prior to examination. This would allow the doctor time to ‘catch up’, but resulted in blocking the treatment room for considerable periods of time.

I tell reception that I have a patient ready, and we wait and wait. Then when I check to see what’s happening, it turns out he’s taken another patient in. The reception staff are quite apologetic, but they say that the doctor told them to send the next person in. It’s quite embarrassing trying to keep the patient happy.

(Attached nurse)

Sometimes I’ve seen me wait for nearly half an hour with someone on the couch, and I’m stuck because I can’t take another patient somewhere else in case he [the GP] comes through and I’m supposed to chaperone.

(Practice employed nurse)

Prescribing

Nurses have been initiating prescriptions in general practice for some considerable time although this is not yet legitimised, and the nurses in this study reported that they commonly did so for oral contraceptives, antibiotics, and preparations for the ear, eye and nose.

An on-going problem was that of getting access to doctors while they were consulting to ask them to make out or sign a prescription for a patient seeing the nurse. In addition, patients sometimes ‘short-circuited’ the system by requesting a repeat prescription from the nurse ‘while I’m here’. The nurses reported that it was difficult to refuse these requests, particularly if the patient was elderly or had travelled from a distance to get to the surgery. This placed an extra burden on the
nurse’s time, having to write out these prescriptions. Receptionists were understandably reluctant to undertake this in the middle of a busy surgery.

- You can’t really ask the receptionists to do it, but you can’t really say ‘no’ to the patient either. You’re the one who’s got the patient in front of you and it’s difficult to say ‘you’ll have to come back’. You just have to try to educate them what to do next time, but it doesn’t always work.

- Sometimes you stand outside the [consulting room] door for ages waiting for the patient to come out, so you can grab the doctor. If you leave the prescription with reception, the doctor sometimes takes another patient in and your patient has to wait even longer.

(Practice employed nurses’ comments)

 Protocols

None of the nurses in the study reported working to protocols, although several said that they used guidelines issued by various drug companies for immunisation of children and patients in ‘at risk’ groups. It was suggested that the general practitioners ‘did not approve’ of protocols and considered that they were a waste of time. One nurse in the study commented:

- I asked the GPs about us making up protocols in a loose-leaf book, but they said it wasn’t necessary. I think it was [lack of interest] because it would take a bit of work and they can’t be bothered, and in all fairness they are a bit pushed. I’m going to do it anyway when I have time though, and then get them to check it, it’s the only way.

[Practice employed nurse]

On occasions the nurses felt vulnerable when asked to undertake certain tasks with a medicalised focus, particularly when the request was made in the presence of a patient. On closer questioning of the nurses however, it did appear that many of the practices did have loosely defined ‘practice policies’ about the management of certain conditions (urinary tract infection, for example) although these were not always committed to paper. It was a finding of The Georgian Research Society
(1991), that most general practitioners consider protocols as being relevant to only a few conditions, and Ross and Bower (1992) also reported that nurses had difficulty getting consensus about protocols.

**Administration**

Practice employed nurses generally worked more autonomously, and undertook responsibility for follow-up of patients for cervical screening and annual blood tests for pernicious anaemia for example. They also initiated recall for patients who defaulted for child immunisation procedures and pregnant women who had missed antenatal appointments at the surgery. None of the attached nurses in the study did this, a similar finding to that of Cater and Hawthorn (1988).

All the nurses were involved in some form of cleaning duties. These included tidying and re-stocking consulting rooms and doctors' bags, and their own treatment rooms. Most of the practice employed nurses ordered drugs and equipment for the practice on a Form EC10, which was signed by a general practitioner.

**Practice Employed Nurses’ Views About Other Nursing Staff**

A number of practice employed nurses who worked full-time, expressed the view that it was sometimes difficult working with another nurse in the practice who was employed for only a few hours per day, or who came in two or three times a week. Nurses employed in this fragmented way were reported to be less interested in any innovations that were proposed by their colleagues, and were described as being 'happy to just do the job and leave on time'.
• I can understand it, she's got a young family and she doesn't want any hassle.

• I think the GPs forget she's in on a Tuesday, I have to keep reminding them to give her some work. Then they [the GPs] say, 'Oh, you tell her what I want'. Then I feel as if I'm ordering her around.

• She's a really nice girl, and don't get me wrong, she works hard, but she just doesn't want to do any more than she's doing now. I just get a bit fed up, because I'm the one who wants to go on courses, or to start a new type of clinic, and she's just not interested. She does her job, and off she goes, and yet we both get paid on the same scale.

[Practice employed nurses, referring to practice employed nurse colleagues].

The seven nurses so identified freely acknowledged that it was difficult to feel committed to teamwork within the practice because there was no continuity for them. They said that commitment to home and family meant that they did not have the same time available to attend continuing education events, so they felt more confident if they restricted their activities.

The nurses described the day-to-day changes in relation to episodes of patient care which made it difficult to keep up to date. Criticism of the lack of information that was passed on to them was minimal however, because they said they appreciated that the staff could not update them on all events that had taken place in their absence. They were philosophical about their role within the practice, and considered themselves to be regarded as a 'pair of hands' on occasions.

There was a similar feeling among some practice employed nurses that nurses attached to the practice did not want to get involved at more than a superficial level. They perceived attached nurses as perhaps not feeling part of the team to the same extent as they did, and a few practice employed nurses reported that their attached colleagues had actually voiced these concerns themselves.
• I sometimes think they [attached nurses] hide behind the fact they're not employed by the practice, and they just say 'I'm not allowed to do that'.

[Practice employed nurse]

• I don't think the GPs like to ask them [attached nurses] to do other things because they [the GPs] are frightened of the community nursing hierarchy.

[Practice employed nurse]

• I find it easier to do it [venepuncture] myself, because she [attached nurse] is only allowed to attempt it once and if she doesn't get into the vein, she can't try again.

[Practice employed nurse]

In contrast to this last comment, several practice employed nurses reported that attached nurses were very willing to take the delegated work they were given from the general practitioners, such as venepunctures and dressings. This allowed practice employed nurses the flexibility to expand their role by undertaking more health promotion clinics.

• She's quite happy taking all the referrals from the GPs, because they are quick things and the patients are in and out. She doesn't get stuck with people like I do, because she hasn't been here that long so they don't hang about for a chat like they would with me.

• We get on really well, because she's a 'doer' and likes the 'quickies' and I like to listen to patients' problems and do New Patient Screening and things.

[Practice employed nurses talking about attached nurse colleagues].

Views of Attached Nurses

In practices where attached nurses worked as the sole nurse or with other attached nurses, they reported feeling less isolated than attached nurses who worked in practices where there was an employed nurse. Nevertheless, attached nurses who worked with practice employed colleagues reported having good personal and working relationships with them. There were occasions however, when practice
issues were not discussed with them, and their practice employed colleagues were privy to more information than they, the attached nurses, were given.

Several attached nurses said that being employees of the Health Board sometimes affected their relationships with practice staff, and they did not always feel part of the nucleus of the team. They perceived that the doctors did not have the same rapport with them as attached staff, as they did with practice employed nurses. This was thought to be relative to the good or bad relationships the general practitioners had with Health Board nurse management, and the degree of autonomy ‘allowed’ to the attached nurses by their nursing officers.

- I think the GPs think we are some kind of moles, sent to spy on them! I mean - they’re all really nice, but they seem to see us as different and don’t tell us some things.

- I don’t mind doing bloods and dressings, but I sometimes think the doctors think I can’t do anything else. Sometimes it’s a bit irritating - the doctors just send a patient through for a blood, but they don’t speak to me about it and I’m expected to guess what blood test it is.

- I’ve worked in the practice for five years, and they [the doctors] employed a nurse themselves in August, so she’s only been here less than six months. Yet, everyone in the practice was taken out to a hotel for a Christmas meal, except the health visitor and I - we weren’t invited. Presumably, because we’re not employed in the practice. We were really hurt.

Indeed, practice employed nurses reported having a more satisfactory working relationship with the general practitioners than did their attached colleagues.

- I feel that I work alongside the GPs and they all trust me to do what I think is best.

- The GPs will seek me out to tell me something rather than tell [name]. You’d think she wasn’t capable of understanding, or that I’m her boss or something.

(Practice Nurses)
Attached nurses reported occasions when there was a reluctance by reception staff to offer the same support to attached staff as they did to the practice employed nurses. The attached nurses perceived this to be a similar attitude of 'distrust' of their place within the practice team to that implied by the doctors.

- *Sometimes the receptionists say they are too busy to get notes out for me, but they do it for the other [practice employed] nurse.*

- *One of the receptionists told me when I first came that I would have to file my own notes when I'd finished with them. It was ages before I discovered that I didn't need to do it.*

Four of the attached nurses who worked as the sole nurse in a practice were more positive about their relationships within the team. They were involved in informal direct contact with general practitioners and other colleagues, and attended team meetings where information and knowledge were freely shared. This they considered to be of direct benefit to patient management and care, and a good learning experience.

**Role Clarification**

Nine of the practice nurses (five practice employed and four attached nurses) who worked full-time, reported that they worked according to a 'treatment room' model in the mornings, and in a more expanded role in the afternoons. In the mornings for example, they did venepunctures and dressings delegated from the doctors, and in the afternoons they worked more independently undertaking clinic work. This involved disease management and giving health education advice. The nurses reported finding themselves increasingly comfortable with the more expanded role, and found it difficult to revert to the more traditional model of doctor's assistant. The reason for this was reported to be because they had to work
quickly in the mornings, and they did not have the same opportunity to give advice to patients and listen to their problems.

Although fewer practice employed nurses worked full-time, they were generally more proactive in their desire to expand their role to that of a nurse practitioner. They appreciated that they would require to build on their existing nursing skills and undertake further academic study. They welcomed opportunities to provide more nurse-led care, and commented on the flexibility of their role in providing ease of access for patients and time to listen to their problems.

_The patients know that they can come to me with things that they say are 'silly', but you know that whatever it is, it's worrying them, and they don't want to bother the doctor._

_I sometimes know there's a problem without the patient saying anything. I know them so well._

Discussion of the Findings from the Workload and Fieldwork Data

During 1990 and 1991 data were gathered on the workload and working patterns of practice employed and attached nurses. Changes in workload and working practices of these nurses, before and immediately after the introduction of the New GP Contract, were described. This discussion contains an elaboration of the main findings and exploration of these in relation to the research questions, the informal discussions with the nurses themselves and other literature on practice nursing.
Recruitment

Recruitment proved an unexpected stumbling block due to the considerable difficulty encountered when trying to draw a representative sample of Lothian attached and practice employed nurses. In the first place, there was no complete list of nurses available from which to draw a sample, and there was not enough time from the funding of the project to the implementation of the New GP Contract to write to all practices in Lothian in order to derive a complete list. This lack of basic information on the number of attached and practice employed nurses has been a problem for other researchers (NBS 1992; Peter, 1993; Atkin et al. 1993).

Secondly, most general practitioners and practice nurses were anticipating a significant increase in administrative and clinical workload as a result of the impending New GP Contract and many were naturally reluctant to add to this by agreeing to participate in this research project. Thirdly, Lothian Health Board's policy in regard to the appointment of attached nurses changed twice over the duration of the study. Despite these difficulties, the response from most of the nurses and practices who were approached was positive. Further, an official list of nurses was still unavailable by the end of the project, so the representativeness of the sample could not be checked.

Changes in the Sample of Nurses

In addition, there were minor changes in the composition of the sample of nurses over the two time periods, but apart from the variable of therapeutic listening, these changes did not appear to have had a significant effect on the shifting trends in nurse activity. Given the variety of hours worked, the lack of specific job
descriptions and the range of activities performed, there probably is no such thing as a representative sample.

**Personal Characteristics and Occupational Profile**

The nurses participating in this study were in a slightly higher age range than that reported elsewhere (Peter 1993; Atkin et al. 1993; Ross et al. 1994). In this Lothian sample, 75% of nurses had been in post between two and five years. This contrasts with the findings of Peter, that 68% of practice employed nurses in Glasgow had been in post for less than one year, and that of Ross et al. who reported that 38% of nurses had been in their present post for two to five years. Atkin and colleagues reported that although 67% of nurses in the census of practice employed nurses in England and Wales had worked as practice nurses for less than five years, only 9% had been in post for less than one year. Although it would appear that this Lothian sample is different in terms of age and experience from that of Peter, and Ross et al., it is more comparable to the recent census of practice nurses in England and Wales (Atkin et al. 1993).

The hours worked by practice employed nurses in this study is comparable to the findings of Reedy et al. (1980b) and Atkin et al. who reported that nurses worked an average of 23 hours a week. In this Lothian study attached nurses worked more hours and days than their practice employed colleagues, who worked on a more irregular basis and for as few as four hours a day for two days a week. In informal discussions with several practice employed nurses who worked full-time, they expressed the view that their practice employed colleagues who worked part time were not interested in innovation and change, and that they were more at ease
undertaking simple task-oriented procedures. The nurses so identified, agreed that this was the case.

Although attached nurses worked longer hours on average, they were perceived by some practice employed nurses to have less commitment to the concept of the team. Six attached nurses acknowledged that they did not feel fully accepted as part of the team, but denied that they did not have a serious commitment to it.

**Workload and Working Patterns**

The statutory requirements imposed on general practitioners by the New GP Contract, and the need to develop screening programmes for their practice population, has resulted in the delegation of activities such as health promotion and chronic disease management, to the practice nurse. As illustrated in Tables 5-5 and 5-6, by the second recording period both attached and practice employed nurses had experienced a reduction in the time spent on routine treatment room work and an increase in clinic activity.

This was more significant for practice employed nurses who saw a greater reduction in routine treatment room work and a larger proportion of time spent in clinic work than the attached nurses, particularly in the area of special clinics. Attached nurses spent less of their time in routine treatment room work but significantly increased their involvement in routine clinics and, to a lesser extent, special clinics. Practice employed nurses undertook more preventive procedures than their attached nurse colleagues during both periods of recording and attached nurses saw relatively more patients for treatment procedures.
Although the largest proportion of patients seen by both groups of nurses during both periods of recording was by general practitioner referral, doctors were less involved in the content of nurse consultations in the second year, and had fewer joint appointments with the nurses.

*Consultations and Items of Service*

The average consultation time for both health board attached and practice employed nurses remained constant at ten minutes over both recording periods. If consultation times were related to nurse ‘style’ however, nurses with a 'faster' style undertook relatively more of the simple diagnostic procedures such as venepuncture, weight and urine collection while those in the 'intermediate' style category gave advice to and vaccinated people for travel abroad, spent time on therapeutic listening and performed dressings. Nurses with a 'slower' style were more likely to have consultations involving cervical smear taking, electrocardiograph (ECG) recording and screening procedures, and to spend time listening to patients. In the second year, only practice employed nurses remained in the group with the slower style. This perhaps reflected a degree of independent working not permitted to attached nurses.

The correlation between length of consultation and its content is to be expected. Longer consultations were associated with more health promotion/illness prevention procedures as defined by the New GP Contract and shorter consultations with simple diagnostic procedures. It is also possible that nurses who are working faster, seeing more referrals and doing more of the simple tasks for the general practitioner, such as venepunctures, are then bringing the patients back to see the doctor for results of tests.
There appears to be an association between consultation length and items of service performed. In consultations where individual procedures were undertaken and there were no interruptions, an attempt was made to estimate the time taken to do these. In this study giving injections ranged from 5.3 to 6.2 minutes over the two recording periods. These are very similar findings to that of McIntosh and Richardson (1976), in their observational study of surgery attendances to the nurse. They reported that when individual procedures were timed with a stopwatch, injections took 5.8 minutes.

In the McIntosh and Richardson study however, dressings took an average of 11 minutes to perform. Nurses in this study took an average of nine minutes to do a dressing, but in this case the nurses were not being observed and measurement of the time spent on an individual activity was based on recording the time the patient entered and left the treatment room. Such self-recording methods do not reflect time spent on possible preparation before the patient enters the treatment room. Advances have been made in skin care applications since the McIntosh and Richardson study in 1976 and this makes dressing procedures easier and possibly, quicker, for nurses to do.

If so-called traditional roles are analogous here with the performance of quickly completed, delegated tasks in short consultations, then these would appear to be undertaken by attached nurses. Practice employed nurses on the other hand, were involved in a more innovative role. They were undertaking more diagnostic activities, screening and health education activities in the second year. Practice employed nurses also spent more time on therapeutic listening, initiated more of their own appointments and had fewer referrals in general than their attached colleagues.
Administration

Administration is reported as being a not inconsiderable part of the work of the practice nurse (Drury and Kuennsberg 1970; Reedy 1972; Ross et al. 1992; Atkin et al. 1993, McBeath 1994; Hibble 1995). At the present time these administrative duties are less likely to be of the kind involving reception work as reported by Drury and Kuennsberg, when 85% of a sample of nurses in 140 practices regularly did this. Nevertheless, McBeath reports that one in three practice employed nurses (38%) are still involved in reception duties, although the majority only carry out this function on an occasional basis.

Overall, the amount of time spent on administrative activities has altered little since the work study of district nursing staff in 1976 (McIntosh and Richardson 1976) which found that attached nurses regularly spent 60-90 minutes a day on practice duties involving administrative and clerical work. General administrative duties occupied on average one hour a day (WTE) for all the nurses in the study, for both years. This mainly involved clerical duties, such as completing forms, call and recall of patients. It also included the re-stocking of consulting rooms and doctors' bags, the ordering of supplies and some cleaning. In the circumstances surrounding the difficulties of recruitment of nurses to the study, and their concerns about the anticipated 'extra' administration involved with the introduction of the New GP Contract, it is surprising that there has been such little change in administrative activity.

The Value of Therapeutic Listening

Therapeutic listening was a feature of longer consultations and was higher for practice employed nurses. All the nurses in the study, and particularly the
practice employed nurses, increased their levels of therapeutic listening in the second year. Therapeutic listening is an important aspect of the consultation and the practice nurse is ideally placed to provide an holistic perspective to this form of communication. Drury et al. (1988) reported that communication is considered by patients to be the most important skill in a primary health care provider.

There is still a stereotype of the caring female role, and nurses are perceived as having more time and being easier to talk to than a doctor (Stilwell 1988b). Nurses will listen to problems that patients consider a doctor might think trivial, and the nurse can act as the patient's advocate to the doctor or another agency if necessary. The interface between listening and giving advice is particularly valuable because it can also facilitate the individual's desire for more information about their health and prevention of disease. Patients in the study who made comments at the end of the Patient Satisfaction Questionnaire, described the practice nurse as being easier to talk to than the doctor about problems that they considered the doctor would find unimportant and time-consuming.

**Interruptions to Nurse Consultations**

In the part of the study involving practice nurse workload, 39% of consultations involved a direct referral from the doctor. The referrals that resulted in an interruption occurred where doctors telephoned through to the treatment room, used an 'Intercom' system, or came in to the nurse to explain the nature of that referral or another referral about to take place.

The reduction in the level of interruptions during the second recording period was possibly a consequence of giving the nurses a mid-way report on some of the
findings from the first part of the study, which included interruption data. The nurses reported concern that the level of interruptions they had experienced was so high, and the intervention caused them to make an effort to reduce interruptions in the second year. Intervention was not part of the study design, but the effects were, hopefully, beneficial for nurses and patients.

The nurses who reported the highest number of interruptions in the first recording period had a marked reduction in interruption levels in the second year. In 1991, the changes in interruption rate could also reflect that the nurses were working more autonomously, making more of their own appointments and undertaking more of the health promotion and illness prevention procedures specified in the New GP Contract.

Doctors in the participating practices who commented on the findings, disclaimed responsibility for more than an occasional interruption. Certainly, in discussion with the nurses several of the interruptions were reported to be by reception staff who were unsure how to deal with patient problems and asked for advice from the nurse. In some cases receptionists asked the nurse to make a decision about whether a patient requiring an appointment should be seen by the doctor or the nurse. The nurses reported that they regularly had to make decisions of this kind because the receptionists did not want to interrupt the doctor.

Other nursing colleagues were reported to be responsible for interrupting consultations. Interruptions by other community nurses usually consisted of district nurses coming in to collect supplies, or health visitors borrowing equipment for clinics, or collecting leaflets from treatment rooms that held the main store cupboard. Similarly, doctors working in practices where the treatment
room housed the drug cupboard came in while the nurses were consulting, to re-stock their medical bags or to ask the nurses to do so. A practical solution to this particular problem could perhaps be found if surgeries had sufficient space to locate supplies in another area.

In Chapter Three the importance of being with a patient, listening and recognising valuable non-verbal cues was discussed and was described as an ability of experienced nurses in their contact with patients (Benner 1984). Ten per cent of nurse consultations in the first year and 17% in the second year of the study involved some kind of therapeutic listening, making any interruption a distraction. In discussion with the nurses, many reported that persons coming in to the treatment room while they were consulting did not knock at the door and, having come in, did not identify themselves to the patient. In several cases the nurses reported having a delicate conversation with a patient, and the interruption disturbed the flow of the consultation to such an extent that it was impossible to recover the rapport that had existed until the moment of interruption.

Since this study was undertaken the role of the practice nurse has expanded from that of relieving doctors of time-consuming practical tasks and acting under their supervision and direction. Nevertheless, many practice nurses are still undertaking a wide range of procedures such as described in this study, as well as expanding their role into disease management and health promotion activities (Ross et al. 1994; Hibble 1995; Jeffreys et al. 1995). Nurses are increasingly becoming the first point of contact for patients in general practice and are taking more decisions about their care (Drury et al. 1988; Marsh et al. 1995). As practice nurses expand their role and develop a greater degree of autonomy in
their working environment, it is perhaps less likely that nurses and doctors will be interrupted by each other.

**Role Development**

Although practice employment implies a degree of management control by general practitioner employers, there is a measure of flexibility within general practice that allows practice nurses to work more independently than their attached nurse colleagues who function within a more bureaucratic organisation. This flexibility may permit the more innovative nurse to expand her role in areas such as disease management and health promotion. There are, of course, concerns over the degree of autonomy that nurses should have, but it is auspicious that support for more independent practice has been underpinned by the Scope of Professional Practice (UKCC 1992b), which declares in the Position Statement that practice must:

...be sensitive, relevant and responsive to the needs of individual patients and clients and have the capacity to adjust, where and when appropriate, to changing circumstances.

It would appear from this study that practice employment offers more opportunity for independent assessment of patients and their problems. The changes reported in the second year of this study could reflect that nurses were working more autonomously, and the practice employed nurses in particular, were making more of their own appointments and undertaking more of the health promotion/illness prevention procedures specified in the New GP Contract. This study also found that a number of nurses were employed to undertake task-orientated procedures delegated by the general practitioner, and this finding is supported by the work of
Atkin et al. (1993) who suggest that a small proportion of nurses are employed to undertake very specific roles within the practice.

The changes reported in 1991 could reflect the findings that practice employed nurses were working more autonomously, making more of their own appointments and undertaking more of the health promotion and illness prevention procedures specified in the New GP Contract. Overall, practice nurses are becoming more involved in anticipatory care and health promotion activities in response to the aims of the New GP Contract, and such consultations require privacy in order to develop a satisfactory nurse-patient relationship.

The workload and working patterns of practice nurses cannot be examined without reference to the consumer. In the next chapter the perceptions of patients about their care and their satisfaction with services provided by the practice are explored using material from the results of two questionnaires. The first questionnaire concerned patient satisfaction with practice nurse consultations and the second surveyed patient opinion on the changing role of practice nurses and community nurses.
Chapter Six

SATISFACTION AND THE CHANGING ROLE: THE PATIENTS’ PERSPECTIVE

Where there is much desire to learn, there of necessity will be much arguing, much writing, many opinions; for opinion in good men is but knowledge in the making.
‘Areopagitica’. John Milton (1608 - 1674)

Introduction

In this chapter the place of practice nursing within the primary health care team is examined in the context of the findings from two patient questionnaires. In addition, where it seems appropriate, the material is related to the workload data on practice nurses previously reported. The opinions of patients about the processes of care provided by the nurses is explored. Interpersonal communication skills, such as explaining, listening and negotiating change in lifestyle where appropriate, is investigated, particularly in response to patients’ comments from open-ended questions. Incidences of traditional, and more innovative practice are considered in the context of patient responses.

The first questionnaire focused specifically on patient satisfaction with consultations with the practice nurse. The work of practice nurses cannot however, be examined in isolation from other members of the primary health care team and, for this reason, the second questionnaire explored patients’ views of the changing role of practice nurses, health visitors, district nurses and general
practitioners. Patients were asked about a number of issues surrounding the services offered by their practice, including disease management, health promotion and screening and who was the health professional of choice to provide these services. The questionnaires were designed to address Aim 5 of the Practice Nurse Study, which was:

To measure patient satisfaction with consultations with practice nurses, and to assess patients' views of the changing role of practice nurses and community nurses.

Data from these two questionnaires are only reported here if the content is considered relevant to this discourse. Tables express valid totals, because in some cases all questions were not answered and some questions allowed for multiple coding. All quotations from respondents are reported verbatim.

Patient Satisfaction and Health Outcome

Summary Reference to Methods

As described in Chapter Four, all 33 nurses participating in the second part of the study agreed to hand out questionnaires to patients as they were leaving the treatment room. The nurses were asked to give questionnaires to patients over the age of 16 years, and were given the option to exclude any patients for reasons already specified. Respondents were asked to complete the questionnaire or (if they did not want to complete it) to put the blank questionnaire in the box provided, before leaving the practice premises.
Response Rates

Out of a potential 3300 questionnaires, there were 1930 valid responses (58%) within four weeks (Table 6-1). When the unused questionnaires were returned and the valid questionnaires analysed, it was found that there were returns from only 26 out of the 33 nurses. On questioning, seven nurses from six practices agreed that they had not handed out any questionnaires due to pressure of work. This non-compliance was disappointing because the nurses in all the practices had been contacted at intervals during the period that questionnaires were to be administered, to give them encouragement and to ask if there were any problems. None were reported at the time.

Table 6-1 Valid questionnaire returns

<table>
<thead>
<tr>
<th>Number of participating nurses in practice</th>
<th>Questionnaire returns</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>2</td>
<td>183</td>
</tr>
<tr>
<td>2</td>
<td>161</td>
</tr>
<tr>
<td>1</td>
<td>83</td>
</tr>
<tr>
<td>1</td>
<td>38</td>
</tr>
<tr>
<td>1</td>
<td>62</td>
</tr>
<tr>
<td>1</td>
<td>86</td>
</tr>
<tr>
<td>2</td>
<td>120</td>
</tr>
<tr>
<td>2</td>
<td>117</td>
</tr>
<tr>
<td>5</td>
<td>333</td>
</tr>
<tr>
<td>2</td>
<td>118</td>
</tr>
<tr>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>1</td>
<td>88</td>
</tr>
<tr>
<td>1</td>
<td>94</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>235</td>
</tr>
<tr>
<td>2</td>
<td>178</td>
</tr>
</tbody>
</table>

TOTAL= 28

Total practices = 16 out of 22

Characteristics of Respondents

Nearly three quarters of the 1930 respondents were female (67%), and the largest number of respondents were over 60 years of age. A breakdown of age group and sex of respondents is illustrated in Table 6-2.
Table 6-2 Age group and sex of respondents

<table>
<thead>
<tr>
<th>Age group</th>
<th>Male</th>
<th></th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>7.6</td>
<td>40</td>
<td>3.8</td>
</tr>
<tr>
<td>20-29 years</td>
<td>13.4</td>
<td>70</td>
<td>19.3</td>
</tr>
<tr>
<td>30-39 years</td>
<td>15.1</td>
<td>79</td>
<td>20.7</td>
</tr>
<tr>
<td>40-49 years</td>
<td>17.4</td>
<td>91</td>
<td>13.4</td>
</tr>
<tr>
<td>50-59 years</td>
<td>15.3</td>
<td>80</td>
<td>15.0</td>
</tr>
<tr>
<td>over 60 years</td>
<td>31.2</td>
<td>163</td>
<td>27.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>523</td>
<td>1092</td>
<td></td>
</tr>
</tbody>
</table>

Valid total = 1615

Nurse-Patient Contacts

Respondents were asked if they had consulted the practice nurse before and 74% (n=1317) said that they had done so. Significantly more female respondents (70% n=839) than males (30% n=367) had consulted the practice nurse before ($x^2=11.2$, df 2, $p <0.01$).

Patients were also asked how they had made contact with the nurse that day. This is shown alongside the workload data for 1991, in Table 6-3.

Table 6-3 Nurse/patient contacts

<table>
<thead>
<tr>
<th>Visit initiated by:</th>
<th>Nurse workload data</th>
<th>Patient questionnaire data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Nurse</td>
<td>28.0</td>
<td>1605</td>
</tr>
<tr>
<td>Patient self-referral</td>
<td>24.0</td>
<td>1352</td>
</tr>
<tr>
<td>Referral from GP</td>
<td>38.0</td>
<td>2139</td>
</tr>
<tr>
<td>Other</td>
<td>10.0</td>
<td>579</td>
</tr>
<tr>
<td>Valid total</td>
<td>100.0</td>
<td>5675</td>
</tr>
</tbody>
</table>

Thirty eight per cent of respondents reported being referred directly to the nurse by the general practitioner that day, a similar finding to that reported by the workload data. Fifty five per cent of respondents said they had made an
appointment in contrast to the 24% reported by the workload data. Other means of contact were reported as 7% by respondents and 10% by the workload data.

There are possible reasons for the differences in self-referral rates. It is conceivable that, apart from patient self-referral, nurse initiated contacts originally arose from general practitioner referral, as well as from appointments made for patients by the nurses themselves. As described in the section on Research Instruments in Chapter Four, the nurses were instructed to tick the appropriate box for who initiated the visit for that particular day, not who initiated it originally if it was a return appointment.

Respondents who had an appointment with the practice nurse were asked if the general practitioner had been involved in the consultation at any point, and 30% of respondents reported doctor involvement in their consultation. This is comparable with the workload data where doctors were involved in 25% of consultations in 1991, in contrast to 40% in 1990.

**Waiting Times**

*Patients with an Appointment to See the Nurse*

Thirty five per cent of patients (n=668) who had an appointment with the practice nurse reported that they were seen on time. Twenty-seven per cent of patients said they had to wait, but 39% of this number said they were seen within five minutes of arrival and 66% were seen within ten minutes (Figure 6-1).
The mean waiting time reported by patients with an appointment to see the nurse was 12 minutes. The recorded waiting times in the workload data for 1991 however, do not support the impressions of waiting times reported by patients. The data illustrate that the mean waiting time (from appointment to time taken in to treatment room) for all appointments made with practice nurses was six minutes (Table 6-4). Twelve per cent (n=62) of patients considered that they waited too long in the waiting room for their appointment with the nurse.

<table>
<thead>
<tr>
<th>Table 6-4 Mean waiting times (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APPOINTMENT TO TIME INTO TREATMENT ROOM</strong></td>
</tr>
<tr>
<td>Reported by patients</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>s.d.</td>
</tr>
<tr>
<td>11.7</td>
</tr>
<tr>
<td>9.5</td>
</tr>
<tr>
<td>n= 525</td>
</tr>
</tbody>
</table>

The test used is the t-test for mean times <0.001 probability.
Patients Referred from the Doctor

Although 18% of respondents (n=347) reported being seen immediately as a result of a direct referral from the doctor, it would appear that of the 18% who had to wait, 52% perceived that they had to wait at least five minutes (Table 6-4). The mean waiting time for patients who were referred to the nurse was reported to be ten minutes (Figure 6-1). In this instance respondents perceived their waiting time to be shorter than the workload data suggest. It is interesting that respondents had a different impression with regard to how long they waited for nurse appointments in contrast to referrals from the general practitioner. Little discontent was expressed however, only 18 patients out of 685 (3%) felt that they had to wait too long. Only 5% of all patients referred to the nurse felt that they had been referred because the doctor was in a hurry.

Interruptions to Patient-Nurse Consultations

Twenty-seven per cent of patients were aware of an interruption to their consultation with the nurse. Twelve per cent of interruptions (n=187) were as a result of the nurse having to answer the telephone and 15% (n=184) were as a consequence of someone entering the treatment room. Although interruptions during consultations reported by the nurses in the second year had fallen by 9% (from 26% to 17%), the nurses still found these interruptions distracting. Ten per cent more interruptions were reported by the patient questionnaire than by the workload data, and yet only 4% of patients (n=55) reported these disturbances as distracting.

The numbers were too small to calculate any association between patients who reported the consultation as distracting and having enough time to talk to the
practice nurse. There was also no significant association between telephone interruptions and patient satisfaction. There was a significant difference however, in relation to satisfaction, and consultations interrupted by persons coming in to the treatment room. Eighty two per cent of patients (n=150) were satisfied with their consultation in spite of the interruption ($x^2=38, df=6, p<0.001$).

*Patient Satisfaction with Consultations*

Eighty-five per cent of patients (n=1491) reported that they were ‘very satisfied’ or ‘satisfied’ with their consultation with the nurse, 2% (n=30) were ambivalent and 13% (n=229) reported dissatisfaction. Ninety-nine per cent of patients (n=1710) reported that the nurse was ‘very’ or ‘quite’ interested in what they had to say, and 96% (n=1680) said that they had enough time to talk to the nurse and that they would definitely make an appointment to see her again. The doctor was perceived to have slightly less time, 14% of respondents saying they did not have enough time to talk to the doctor.

The 13% of respondents who reported dissatisfaction were selected out from the data and 87% (n=218) were found to have responded positively to the question asking if the nurse was interested in what they had to say. They also reported (97%, n=219) that they would make another appointment to see the nurse. These findings will be elaborated upon in the Discussion.

*Health Outcome*

In response to the questions on health outcome, patients were fairly evenly divided on whether their visit to the nurse had enabled them to cope in certain areas, or
whether they felt the same, or less able to cope (Figure 6-2). Fifty-two per cent of patients reported feeling more able to keep themselves healthy. As a result of their visit to the nurse 50% of patients felt that they were more able to help themselves.

Figure 6-2 Health outcome

(Cross reference Table 1-22 in Appendix 1)

The two variables on being ‘able to keep yourself healthy’ and ‘being able to help yourself’ were examined by age group of respondent. In respect of the variable ‘able to keep yourself healthy’ it was found that 66% of those over 60 years of age were most enabled ($\chi^2=51.1$, df 10, $p<0.001$). The variable ‘being able to help yourself’ showed that the most enabled group were again those over 60 years of age (57%, n=120) ($\chi^2=33.5$, df 10, $p<0.001$). There were no significant differences on analysis by sex of respondent.

**Responses to Open-Ended Questions**

Twenty per cent of patients (n = 378 of 1930) responded to the open-ended questions at the end of the questionnaire. Some of the most frequently employed comments representing 50 or more similar adjectives, were grouped into
categories. These included descriptions of the attitude of the nurses towards patients, how patients depicted the personality of the nurses and accounts of how the nurses went about their work. Comments about the manner of the nurses frequently included adjectives such as ‘understanding’, ‘efficient’, ‘caring’ and ‘helpful’.

- I have always found the nurse very kind, helpful, friendly and reassuring for myself and my family. I feel more confident knowing she is there to help whenever needed.
- I've always been very satisfied by the treatment and manner of the nurse. Its almost a pleasure to come!
- Nurse is a very pleasant, calm and caring person - a pleasure to consult.
- I found the nurse extremely helpful and understanding.

Respondents described the service provided by the nursing staff as ‘excellent’ and ‘efficient’.

- Attend nurse on a regular basis for PTR checks and have always found her very proficient.
- Always find nurses extremely competent and friendly.
- Stitches removed efficiently and speedily by a caring nurse.
- Excellent service - very thorough - she pays attention to my needs and feelings.
- Very efficient service.

Patients observed that the nurses put them at their ease, had time to listen and made them feel that there was time to talk. In addition, there was a view expressed that the nurse could be approached with problems or worries that patients considered too trivial or embarrassing to discuss with a doctor.

- Nurse took time to talk and made me feel very comfortable.
- Very relaxed with nurse as she explained things very thoroughly.
- Found nurse very pleasant and a good listener.
- Able to talk better to nurse than doctor - nurse more understanding.
- Always found nurse charming and willing to listen - never felt hurried in any way.
- I was very nervous but nurse was very friendly and patient and put me at ease - I would visit her again.
• I would never go and see the doctor with my corn, but it keeps me awake at night and it may be nothing to them, but it is really sore. I know Sister won’t laugh at me, she’s so understanding.

• When I was in getting my ‘pill’, I asked her about what to do about bee and wasp stings. I wouldn’t bother the doctor about that, but I was worried if it happened to him [the baby].

There was evidence from statements made that 21 respondents suffered from chronic illness, and that the nurses contributed to the patient’s feeling of well-being in dealing with the more holistic areas of their health and ability to cope with life.

• Sometimes I worry when I have to wait because of my schizophrenia, but she has such a lovely, gentle approach that I go away feeling better.

• Have been attending the surgery for last two years for ulcer on sole of foot, also am badly affected with arthritis - at moment feel quite suicidal but on leaving surgery felt much better for seeing nurse and able to cope.

• She always gives my neck a wee massage when she changes my collar for my sponditis [spondylitis].

• I never thought I would look forward to getting these dressings for my psoriasis changed, but her hands are so gentle.

Seventeen respondents said that they appreciated seeing a nurse instead of a doctor because it involved less waiting time. In addition, they felt that certain problems were better dealt with by a nurse.

• Able to see nurse directly without need to see doctor first, very time saving.

• Nurses’ work is extremely valuable in relieving overworked doctors of patients with minor ailments.

• I think there are dividends from seeing other staff apart from the GP.
  (a) you accept a scolding from the nurse without affecting your relationship with the doctor
  (b) you feel free to ask clarification or advice without taking up the doctor’s time or having to take in too much information at once
  (c) it’s an efficient use of everybody’s time.

• Sister knows more about giving the ‘pill’ than the doctor.

• Routine ear syringe, successful. Easier for nurse than doctor.
In 32 cases, the practice staff in general were praised, and the following were typical of comments made:

- All the staff at the practice do their utmost to be helpful.
- Always get the best attention from doctors and nurses.

There were comments in relation to enablement from 27 respondents, and these included:

- Visit will help me to get better.
- Confident I am in good hands and healing ones at that.
- Attended nurse for a year and she has helped me a great deal.
- She makes you want to take another step forward.

There were no complaints about the processes of care given by the nurses. None of the 13% of patients who ticked the box indicating they were dissatisfied with their visit to the nurse made negative comments. Indeed, there were 69 positive comments and these included adjectives such as ‘kind’, ‘helpful’, and ‘caring’, which suggested a misreading of the question.

Respondents who commented favourably overall did, occasionally, include some expression of dissatisfaction in the comments section of the questionnaire in relation to organisational issues within practices:

- Had to take time more time off work to see nurse another day for blood test because doctor wouldn’t take it.
- Waited three-quarters of an hour for an antenatal appointment.
- Waiting time for results to come through.
- Waiting to see a doctor! No complaints about seeing sister, she is more helpful than any doctor I have seen.

The patients’ perceptions of the nurses will be elaborated upon in the discussion.
Discussion

This discussion will explore the implications of the findings from the patient Satisfaction and Health Outcome Questionnaire and examine the limitations of its administration and content. In addition, it will consider the issues contained within the data in the wider context of other material relating to patient satisfaction with practice nurses and nurse practitioners.

The New GP Contract (DoH 1989a) requires health authorities (in England and Wales) and health boards (in Scotland) to undertake surveys of patient satisfaction with the services provided by general practitioners. Most of these recent consultation satisfaction surveys however, relate to doctor-patient contacts and do not extend to satisfaction with other members of the primary health care team (Poulton 1996). There has also been a general tendency for patients to report that they are satisfied with consultations with general practitioners (Cartwright and Anderson 1981; Hopton et al. 1993).

Response Rates

A response rate of 58% (n=1930) would appear modest for a directly administered questionnaire although the pilot study previously referred to, and conducted by Poulton (1996), reports a 46% response rate to a directly administered questionnaire. It is generally accepted nevertheless, that response rates for postal questionnaires are lower than those for directly administered questionnaires (Moser and Kalton 1982).

It would seem from the number of unused questionnaires returned from certain nurses that there was more non-compliance from the participating nurses in
handing out the forms, rather than a lack of response from patients in completing them. As previously reported in Chapter Four, several nurses said that they were too busy to complete their workload cards and to hand out questionnaires to patients. Although there is no direct evidence to support the difficulties reported by the nurses, this highlights the limitations of administering a questionnaire in this way in conjunction with the completion of other study instruments. Although each questionnaire was accompanied by an explanatory front sheet, the nurses were obliged firstly, to ask the patient if they were willing to participate and secondly, to outline the purpose of the survey. This added extra time on to the end of each consultation, and it in some cases nurses reported that they either forgot to, or elected not to, hand out a questionnaire.

Validity and Reliability

There are many instruments to measure patient satisfaction, but there is no consensus about which dimensions of care should be evaluated. There are at present, few valid and reliable instruments in the United Kingdom to measure patient satisfaction with general practice, although Baker (1990; 1991) designed two scales, one to look at patient satisfaction with general practitioner consultations and a second to measure satisfaction with services provided in the practice. Neither, however, assess satisfaction with the services provided by practice nurses. More recently, Grogan et al. (1995) undertook a study to test the reliability and validity of a patient satisfaction questionnaire that included practice nurses and satisfaction with the surgery services, and found that it was adequate for the purpose. Items in the sub-scale in respect of practice nurses included information giving, listening and reassurance.
As Moser and Kalton (1989) suggested, the reliability and validity of a scale are always specific to a particular population, time and purpose, not to uniform attributes. There may be a difficulty with responses due to levels of understanding or education, and the wording of questions may affect acquiescence. Moser and Kalton also pointed out that the researcher has to decide what degree of reliability and validity he or she, will consider acceptable. As described in Chapter Four, due to time constraints, the instrument used to measure patient satisfaction in this study was only piloted for efficiency of questionnaire design prior to administration in the main study.

There is no way of checking the reliability of the method of distribution of questionnaires in the study other than by repeating their distribution with the same or different subjects, as suggested by Howie (1989). It would be advisable, however, in replicating the study if participants had only one research instrument to deal with at a time. In addition, the study was undertaken at a time of change and the personnel within the participating practices were struggling to adapt to new methods of administration being introduced as a result of the New GP Contract. Furthermore, for practice nurses this resulted in a redefinition for many of them of the range and diversity of roles undertaken. This may have had some bearing on their levels of compliance in administering the research instrument.

Access

Patients have access to practice nurses in a variety of ways. They can come by appointment to see the nurse, they can be directly referred by the general practitioner or they can present to the surgery as an ‘emergency’. Practice nurses have an indeterminate workload each day, because the number and nature of
referrals from general practitioners cannot be planned ahead. This results in the practice nurses having to fit in referrals from the general practitioner between patients who have made appointments to see them. The nurse has to make a judgement as to how long each consultation will take and fit patients in accordingly. In spite of this, the practice nurses recorded very low patient waiting times in the study of their workload, yet there is a contention that appointment systems in general practice can be a principal cause of dissatisfaction (Grogan et al. 1995). Although patients perceived that they had to wait longer than the workload data reported, only 9% of respondents overall felt that they had to wait too long to see the nurse.

Comments in the Patient Satisfaction and Health Outcome questionnaire suggested that patients considered the general practitioners to be under greater time pressure than the nurses. These findings are supported by Touche Ross (1994) who reported that nurse practitioner services had the attraction to patients of flexibility in format. For example, drop-in sessions, and frequent independence from the regular appointment system. In another study by Marriott (1981) it was reported that the attendance rate for the population registered with the doctors was 964 per 1000 per year. Open access to the practice nurse resulted in the nurse being the person of first contact in half of the surgery attendances. Three quarters of this number were treated without referral to a doctor. Over half of the patients in the Practice Nurse Study reported that they had initiated their visit to the nurse, and similar to Marriott's study, three quarters reported that they were treated without a doctor being involved in the consultation.
Patients' Attitudes to Interruptions

Thirty eight per cent of respondents reported that they had been referred to the nurse by the general practitioner that day, reflecting a similar 39% of referrals reported in the practice nurse workload part of the study. A number of these referrals resulted in an interruption by telephone through to the treatment room, the use of an 'Intercom' system, or the doctor coming in to the room. In addition, there were interruptions from reception staff and other nursing colleagues.

Although the nurses in the study all worked within an appointment system, they did offer flexibility and would often see patients without appointments who just 'turned up' at the reception desk and asked to be seen. It is therefore possible that some of the interruptions generated by reception staff were in response to these requests from patients to be seen by the nurse without a pre-booked appointment. Nurses also generally provide longer appointments than general practitioners (Salisbury and Tettersell 1988; Touche Ross 1994), which may reflect the perception of patients that nurses have more time to listen and explain.

In the second year of the study the nurses reported a total of 30.2 interruptions per 100 consultations (n=1729), and 11 nurses (33%) were interrupted more than ten times in 100 consultations. In spite of the nurses' concern only a quarter of patient respondents were aware of an interruption to their consultation with the nurse, and of these, only 4% found it a distraction. Firstly, this perhaps reflects the public image that it is the doctor's prerogative to give the nurse instructions and it is the duty of the nurse to carry them out. Thus, any interruption to the nurse's consultation by the general practitioner may not be perceived as an interruption by the patient, but simply the doctor using the power of delegation.
Secondly, the perception of nurses as understanding, sympathetic and accessible is perhaps the reason why other members of the primary health care team, such as reception staff and other nursing colleagues, are more likely to disturb a nurse-patient consultation than a doctor-patient consultation. While it is recognised that communication between doctors and nurses working together in general practice is very important, perhaps the nature of the communication deserves closer attention. Some doctors never experience interruptions at all and most doctors do not experience interruptions on the scale that nurses do. Nevertheless, doctors that do get interrupted report these interruptions as stressful. It has also been reported that doctors feel more stressed when there is no nurse on duty in the practice (SHHD 1990). Nurses also report that frequent interruptions are stressful and, if this is the case, it may affect the quality of care they provide.

It is accepted that many practices do negotiate methods of working together as a team to meet the needs of the staff concerned, and of the practice population that they serve (Allen et al. 1991). In some practices however, the structure of the nurse's employment is still relatively uncoordinated, with no specific role definition, and the number and type of tasks delegated by the general practitioner allows the nurse little control and direction in her work. This perhaps unwitting, lack of respect for the level of professional status of the nurse could be reflected in the number of interruptions experienced.

**Patient Satisfaction**

Eighty five per cent of patients reported satisfaction with their consultation with the nurse. A 13% response of dissatisfaction with the visit however, seemed high in proportion to the other positive responses about the consultation, and in
comparison with other studies. Salisbury and Tettersell (1988) reported high levels of patient satisfaction with nurse practitioners (96%), as did Touche Ross (1994) who reported a level of 98% for practice nurses.

It would seem that there was a misunderstanding in the reading of the question relating to satisfaction with the consultation. The negative responses were very small numbers spread across all participating practices and could have been a result of a misreading of the scale, which started with 'very dissatisfied' and ended with 'very satisfied'. Although it had face validity, this was a potential limitation in the design of the questionnaire, there being only one other question that started with a negative response, the question that followed. Examination of the responses to this second question however, showed that it did not appear to produce the same problem. The rationale behind reversing the scores was to try to avoid a tendency in respondents to reply in a consistent manner without reading the contents of the questions carefully. In view of the mismatch of the question in comparison to other variables, it was considered important that this should be investigated further.

When the 13% of patients with negative responses were selected out from the data these patients were found to have replied positively to the closed questions asking firstly, if the nurse was interested in what they had to say and secondly, if they would make an appointment to see her again. Furthermore, a number of these respondents made positive comments:

- Quick and efficient.
- Extremely efficient and courteous attention.
- She is always interested and is so gentle and caring, she is lovely.
Patient Perceptions of the Consultation with the Nurse

Ninety six per cent of patients felt that they had adequate time to talk to the nurse. This could be related to the average length of all nurse consultations (ten minutes) in the Practice Nurse Study. In addition, 99% of respondents reported that the nurse was interested in what they had to say. The latter is a higher figure than the 83% for practice nurses and 88% for nurse practitioners in the general practitioner sites reported by Touche Ross (1994 in the South East Thames Regional Health Authority (SETRHA) pilot project. The evaluation of the SETRHA pilot project studied the role and workload of 20 nurse practitioners in various sites over a two year period, and included patient satisfaction with their care in comparison with other sources of care.

Although patients in the Practice Nurse Study reported that the nurses were willing to spend time with them, they also drew attention to the ability of the nurses to work ‘quickly’ and ‘efficiently’. On exploration of comments relating to ‘efficiency’, these appeared to be related to procedures, such as the removal of sutures, and diagnostic tests. The benefits of therapeutic ‘touch’ were described more often by those who appeared to suffer from chronic disease and who required regular dressings. Respondents reported making clear distinctions about when to see a doctor and when to see a nurse. On occasions when they had any doubt about the appropriateness of whom to consult however, they considered that the nurse would be the person of choice, particularly if the problem was considered embarrassing or too minor for a consultation with the doctor. Respondents also felt that it was sometimes easier to get an appointment with a nurse than a doctor.
Ninety six per cent of patients in the study would consult the nurse again, a result mirrored by that of Salisbury and Tettersell who reported a 97% response to this question. Both results are higher than that reported by Drury et al. (1988) in relation to nurse practitioners, where just over half the patients who had consulted the nurse practitioner would do so again. These studies by Salisbury and Tettersell and Drury et al., however, had smaller samples of patients who completed satisfaction questionnaires than that in the Practice Nurse Study. In the case of the Salisbury and Tettersell study, there were 73 valid returns, and in that of Drury et al., there were 126. Another problem with these studies, apart from the sample sizes, is that the responses are based on the work of one nurse practitioner in each case, who may not have been representative of nurse practitioners in general.

**Health Outcome**

The results from the questions on health outcome were equivocal. Nevertheless, the nurses scored higher than the general practitioners in the Lothian general practitioner study (Howie et al. 1989; 1991) in reassuring patients in an holistic way about their health, their ability to keep themselves healthy and to cope with life generally. Elderly patients were most enabled by their consultations in these categories. Although these two studies are not comparable, having a different case mix and having been conducted at different times, the more holistic findings in the Practice Nurse Study are sustained by patients' comments about the willingness of the nurses to listen to their problems and how they felt better after their consultation. Reedy (1972) described the role of counselling and listening valued by patients, and their ability to put patients at ease. Stilwell (1988b); Drury et al. (1988); Touche Ross (1994) and the Derbyshire nurse practitioner project
(Chambers 1994) among others, reported that patients value the listening and explanatory skills offered by nurses.

**Communication**

Patients reported that the nurses were easy to talk to, did not make them feel hurried, and communication skills were rated highly. These findings were similarly described by Martin (1987) who suggested that patients see practice nurses as more accessible and easier to talk to than the general practitioner. Patients in the study observed that as well as providing a traditional, caring role, the nurses offered health education and family planning advice, and undertook disease management. Comments included the value of attending the practice nurse with ‘minor’ chronic pain such as a corn, or problems that patients considered too trivial or embarrassing to discuss with the doctor. Observations related to therapeutic touch and therapeutic listening, which were features of consultations involving chronic illness. Patients in the study also observed that the nurses were kind, caring, gentle, and understanding. This attitude to nurses confirms the findings of Anderson (1973) and Webb and Hope (1995) that the public expect nurses to have a warm and friendly style, and to provide sympathy.

**Summary**

Respondents in this study were satisfied with consultations with practice nurses and would be willing to consult the nurses again. Patients perceived the nurses as efficient in the way they carried out their work, but this did not detract from their approachability. This was particularly related to what were described as ‘minor’ or ‘embarrassing’ problems that patients felt were too insignificant to take to the doctor. Nevertheless, these ‘minor’ problems caused the patients varying degrees
of distress and they appreciated that the nurses were interested in these problems and were able to give reassurance. A number of respondents who said that they suffered from chronic illness commented that visiting the nurse improved their feeling of well-being. Patients also felt that some problems did not require the involvement of a doctor.

Exploration of the literature suggested that additional research into patient opinions of specific elements of nursing care provision in primary care might paint a more accurate picture of the needs of patients in this setting, and provide information on how to enhance their well-being. In an attempt to explore these issues further, the next section examines the results of the postal questionnaire which solicited patients’ views on the role of practice nurses and community nurses. This is followed by a discussion of the findings from the data.

Patients’ Views of the Changing Role of Practice Nurses and Community Nurses

Response Rates

As stated in Chapter Four, it had been agreed with the 22 participating practices that the first 50 patients over 16 years of age to present at the reception desk for any reason were to be handed a questionnaire by the receptionist which was to be returned by post. There were 495 questionnaires returned out of 869, representing a 57% response rate.
Characteristics of Respondents

Seventy four per cent of respondents were female and 26% were male. The greatest number of male respondents were over 50 years of age and the majority of female respondents were in the 30 to 39, and over 60 age groups (Figure 6-3). Although the numbers were smaller than those in the patient satisfaction questionnaire, the distribution was similar.

Figure 6-3 Age group and sex - all respondents (percentage)

(Cross reference Table 1-23 in Appendix 1)

Availability of Nursing Staff in the Practice

Respondents were asked whether their practice provided the services of specific nursing staff. Their responses are shown in Figure 6-4. It is of note that all practices in the study had at least one practice employed nurse, district nurse and health visitor. It is possible however, that patients would be generally less aware
of the presence of district nurses and health visitors as they are not always on the practice premises for the same length of time during the day as practice nurses.

Figure 6-4 Knowledge of availability of nursing staff in the practice

(Cross reference Table 1-24 in Appendix 1)

![Bar chart showing knowledge of availability of nursing staff in the practice](image)

Fifty eight per cent of respondents (n=282) said they had used the services of the practice nurse within the last 12 months, 8% (n=39) had seen the district nurse and 13% (n=60) had used the services of the health visitor. The characteristics of respondents were little changed when the data were re-analysed to include only patients who reported that they had used the services of the practice nurse within the last 12 months (Figure 6-5). Similarly, 74% of respondents were female and 26% were male. In this case the age of male respondents had risen to over 60 years of age but the majority of female respondents were still in the 30 to 39, and over 60 age groups. Of the community nurses, one third of respondents who had seen the district nurse were over the age of 60 years, whereas the majority of the health visitors' clients were aged between 20 and 39 years of age.
Preference for Male or Female Nurse

Concerning nurses in general, 56% of all respondents expressed no preference whether they saw a female or male nurse, 42% said that they would rather see a female, and only 2% reported a preference for a male nurse. When the data were re-examined to determine whether males would rather see a male nurse and females would rather see a female nurse, it was found that 81% of male patients expressed no preference, but 51% of female patients would prefer to see a female nurse. Patients over the age of 60 years were more likely to express no preference about whom they consulted.
**Prescribing**

In response to a question on nurse prescribing of medicines and dressings without having to ask a doctor, the majority of respondents who felt that all practice and community nurses should be able to prescribe certain items were in the over 60 age group, followed by the 30 to 39 age group. Overall, 60% of patients felt that the practice nurse should be able to prescribe, and 56% felt that the district nurse should be able to do so. There was less support for health visitor prescribing, only 33% of patients feeling this was appropriate. Figure 6-6 illustrates positive responses to a question asking about nurse prescribing of specific items. From the choice of items, respondents considered that the prescribing of ointment for a skin condition was the most acceptable for all the nurses, and prescribing of antibiotics the least acceptable.

*Figure 6-6 Positive responses to nurse prescribing for specific conditions*

(Cross reference Table 1-26 in Appendix 1)

Overall, nurse prescribing received greater approval from both male and female patients over 60 years of age. The exception to this was in the prescribing of oral
contraceptives, where more female patients in the 30-39 age group reported that all the nurses should be able to do so. In addition, more female patients aged between 30 and 39 years of age thought practice nurses should be able to prescribe ointments for skin conditions.

The data were further analysed to look at attitudes to prescribing by respondents who had used the services of practice nurses, health visitors or district nurses within the past 12 months. The only significant association was between patients who had consulted the practice nurse within the last 12 months and the prescribing of an inhaler for someone with asthma ($x^2=18.4, df=4, p.<0.001$).

**Attitudes to Home Visits by Practice Nurses**

Patients were asked if they would mind if the practice nurse came when they requested a home visit. Although a quarter of respondents said that if they requested a home visit a doctor should *always* attend, the remainder qualified their responses and were willing to consider the option of home visiting by practice nurses. Two thirds of respondents considered that it would depend on the reason for the visit. Eight per cent of respondents felt that if the nurse came, she could report any problems back to the doctor and 6% said they would not mind whether the doctor or practice nurse came (Table 6-5). It was reported in the workload data that only two practice employed nurses did home visits.

<table>
<thead>
<tr>
<th>If you requested a home visit and the Practice Nurse came, would you mind?</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, I think the doctor should always come</td>
<td>24.9</td>
<td>117</td>
</tr>
<tr>
<td>No, I think the nurse could report any problems back to the doctor</td>
<td>8.3</td>
<td>39</td>
</tr>
<tr>
<td>I think it would depend on the reason for the visit</td>
<td>61.2</td>
<td>287</td>
</tr>
<tr>
<td>I would not mind whether the doctor or nurse came</td>
<td>5.5</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>99.9</td>
<td>469</td>
</tr>
</tbody>
</table>
Patient Choice: Practice Nurse Rather Than Doctor?

Respondents were asked if there were occasions when they would choose to see the practice nurse rather than the doctor. Forty eight per cent of patients (n=231) said that they would do so 'often' or 'sometimes', 36% (n=172) said 'not very often' and 16% (n=79) said they would never see the practice nurse in preference to the doctor. Male and female respondents over 50 years of age reported being more likely to choose the practice nurse in preference to the doctor (Figure 6-7).

Figure 6-7 Patient choice: Practice nurse rather than doctor

(Cross reference Table 1-27 in Appendix 1)

Specific Reasons for Choosing to See the Practice Nurse

When patients were asked if they might choose to see the practice nurse rather than the doctor for one of the reasons specified in Table 6-6, the most popular reasons were that the practice nurse could deal with problems that did not need a doctor (88%), and that the nurse could call the general practitioner through to the treatment room if necessary (84%). A third of patients responded positively to the other suggestions for choosing the nurse.
The same questions were analysed looking at the responses of patients who had consulted the practice nurse within the last 12 months and, although the results were not statistically significant, there was an increase of 4% in respondents who thought the nurse listened to them compared to the overall total of respondents (Table 6-6).

Table 6-6 Reasons for choosing the practice nurse rather than the doctor

<table>
<thead>
<tr>
<th>Reasons for choosing the practice nurse rather than the doctor</th>
<th>All respondents</th>
<th>Respondents who had consulted the practice nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>You can get an appointment sooner</td>
<td>40.1</td>
<td>151</td>
</tr>
<tr>
<td>You don’t have to wait as long in the waiting room</td>
<td>32.6</td>
<td>118</td>
</tr>
<tr>
<td>The nurse will give you more of her time</td>
<td>34.6</td>
<td>123</td>
</tr>
<tr>
<td>You don’t feel embarrassed trying to explain things to a nurse</td>
<td>32.0</td>
<td>118</td>
</tr>
<tr>
<td>The nurse listens to you</td>
<td>39.3</td>
<td>132</td>
</tr>
<tr>
<td>You can see the nurse about problems that don’t need a doctor</td>
<td>88.4</td>
<td>382</td>
</tr>
<tr>
<td>The nurse can call the GP through if she thinks it necessary</td>
<td>84.2</td>
<td>368</td>
</tr>
<tr>
<td>Any other reason</td>
<td>10.3</td>
<td>16</td>
</tr>
</tbody>
</table>

If respondents considered that none of the reasons given were applicable, the variable ‘any other reason’ asked them to specify when they might choose to see the nurse rather than the doctor. The following were a consensus from the 16 responses received, although nearly all did include some of the items in the list:

- She is really nice and understanding as I have a groin problem and she can talk and I don’t get embarrassed and she tells my GP and I get better treatment because of her.
- More likely to understand female problems.
- She understands what you’re on about, and she speaks to you as if you’re not daft!
- If something minor GPs’ time could be saved.
Services Offered by the Practice

Knowledge of Service Provision

All the participating practices offered the range of services listed in the questionnaire. Patients were fairly well informed about the main services that they thought their practice offered. These included the services of nurses, maternity services, baby clinics and the availability of cervical smear tests, but they were less sure about other areas such as asthma, diabetes, family planning and well-person clinics (Table 6-7). Female respondents had a greater overall knowledge of services provided, except for well-man clinics and diabetes clinics where male respondents were marginally better informed.

Table 6-7 Positive responses to knowledge of services offered by the practice (by sex of respondent)

<table>
<thead>
<tr>
<th>Services</th>
<th>All respondents</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Maternity care</td>
<td>70.0</td>
<td>318</td>
<td>76.6</td>
</tr>
<tr>
<td>Baby clinics</td>
<td>72.4</td>
<td>336</td>
<td>77.0</td>
</tr>
<tr>
<td>Family planning</td>
<td>39.9</td>
<td>175</td>
<td>43.2</td>
</tr>
<tr>
<td>Cervical smear tests</td>
<td>77.9</td>
<td>360</td>
<td>85.5</td>
</tr>
<tr>
<td>Breast examinations</td>
<td>46.0</td>
<td>207</td>
<td>49.1</td>
</tr>
<tr>
<td>Well man clinics</td>
<td>27.2</td>
<td>119</td>
<td>26.0</td>
</tr>
<tr>
<td>Well woman clinics</td>
<td>51.0</td>
<td>230</td>
<td>55.1</td>
</tr>
<tr>
<td>Asthma clinics</td>
<td>18.1</td>
<td>80</td>
<td>19.4</td>
</tr>
<tr>
<td>Diabetic clinics</td>
<td>11.4</td>
<td>48</td>
<td>10.8</td>
</tr>
<tr>
<td>Other services</td>
<td>12.7</td>
<td>26</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Uncertainty About Availability of Services

There was more uncertainty expressed about availability of services than there were definite responses that services were not available at all. Analysis of ‘don’t know’ responses by sex of respondent is shown in Table 6-8.
Table 6-8 'Don’t know' responses to knowledge of services offered by the practice (by sex of respondent)

<table>
<thead>
<tr>
<th>Services</th>
<th>All respondents</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Maternity care</td>
<td>28.4</td>
<td>129</td>
<td>22.5</td>
</tr>
<tr>
<td>Baby clinics</td>
<td>25.0</td>
<td>116</td>
<td>20.8</td>
</tr>
<tr>
<td>Family planning</td>
<td>54.0</td>
<td>237</td>
<td>50.0</td>
</tr>
<tr>
<td>Cervical smear tests</td>
<td>21.4</td>
<td>99</td>
<td>13.9</td>
</tr>
<tr>
<td>Breast examinations</td>
<td>50.7</td>
<td>228</td>
<td>47.5</td>
</tr>
<tr>
<td>Well man clinics</td>
<td>68.6</td>
<td>300</td>
<td>69.8</td>
</tr>
<tr>
<td>Well woman clinics</td>
<td>45.5</td>
<td>205</td>
<td>41.2</td>
</tr>
<tr>
<td>Asthma clinics</td>
<td>75.3</td>
<td>333</td>
<td>73.2</td>
</tr>
<tr>
<td>Diabetic clinics</td>
<td>82.2</td>
<td>346</td>
<td>81.8</td>
</tr>
<tr>
<td>Other services</td>
<td>71.1</td>
<td>145</td>
<td>68.9</td>
</tr>
</tbody>
</table>

A further breakdown of these responses revealed that 24% of female respondents between 20 and 29 years of age did not know if maternity and baby clinic services were provided in their practice, and 14% of the same age group did not know if they could have cervical smears taken. Half the female respondents did not know if family planning services were offered by the practice, and 59% of that number (n=92) were aged between 16 and 49 years of age. There was little knowledge of the availability of breast examination, and nearly half the women (46% n=71) aged between 30 and 59 years of age did not know if this service was provided.

Two thirds of male respondents were unaware if well-man clinics were available, 37% (n=26) of whom were aged between 30 and 59 years of age. Of the 46% of respondents who did not know if their practice provided well-woman clinics, 42% of these were female and lack of knowledge about this service was evenly spread across age groups.
Open-Ended Question

There were 26 responses to an open-ended question asking if the practice offered any other services not mentioned. These responses included the availability of advice about drug dependency problems, stress management and diet. Sixteen respondents said that their practice provided wart clinics, four mentioned sports medicine clinics and eight, minor surgery. In the workload data from the study the nurses also reported running wart clinics and helping with minor surgery. Practice employed nurses in particular increased time spent on giving diet and exercise advice. Knowledge of the other services mentioned by patients may be as a result of personal experience, advertising within the practices or assumption of what might be available. Nevertheless, 79% (n=382) of all respondents stated that they were 'satisfied' or 'very satisfied' with the services that their practice offered at the present time.

Time Spent Listening to Patients

Half of the respondents (n=213) thought that the general practitioner was the health professional who had more time to listen, a view particularly expressed by those in the older age group. A quarter of all respondents (n=102) thought it was the practice nurse, again more respondents were aged over 60 years of age. According to the workload data, time spent listening to patients' problems by practice nurses increased overall by 7% in the second year of the study.

Health visitors were considered to have more time to listen by 18% of respondents, mainly in the 20 to 40 age group. Five per cent (n=21) thought district nurses had more time to listen and 3% (n=14) mentioned reception staff. Respondents in the age group of 30 to 39 years, and those over 60 years of age considered that
nursing members of the primary care team, more than anyone else, had more time
to listen (Table 6-9).

Table 6-9 Who has more time to listen? - By age group of respondents

<table>
<thead>
<tr>
<th>Age group</th>
<th>Practice nurse</th>
<th>Health visitor</th>
<th>General practitioner</th>
<th>District nurse</th>
<th>Reception staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>2.2</td>
<td>2</td>
<td>3.0</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>20-29 years</td>
<td>17.2</td>
<td>16</td>
<td>37.9</td>
<td>25</td>
<td>10.0</td>
</tr>
<tr>
<td>30-39 years</td>
<td>12.9</td>
<td>12</td>
<td>34.8</td>
<td>23</td>
<td>18.9</td>
</tr>
<tr>
<td>40-49 years</td>
<td>14.0</td>
<td>13</td>
<td>9.1</td>
<td>6</td>
<td>17.4</td>
</tr>
<tr>
<td>50-59 years</td>
<td>17.2</td>
<td>16</td>
<td>6.1</td>
<td>4</td>
<td>12.9</td>
</tr>
<tr>
<td>Over 60 yrs</td>
<td>36.6</td>
<td>34</td>
<td>9.1</td>
<td>6</td>
<td>40.3</td>
</tr>
</tbody>
</table>

Valid total n=390

**Items of Service Provision: Choice of Health Professional**

When asked if ‘health checks’ could be done by nurses, 69% (n=315) of patients thought that they could be done by practice nurses, 56% (n=214) by district nurses and 37% (n=135) reported that health visitors could do so.

Respondents were asked which health professional they would choose to do different things in general practice (Figure 6-8). Patients felt that general practitioners (44%) and practice nurses (31%) should immunise children, only 6% considering that health visitors should do so. The practice nurse was the health professional of choice to take cervical smears, and patients would choose the general practitioner (46%) and the practice nurse (34%) to do breast examinations. In the workload part of the study practice nurses recorded that they spent 10% of their time taking cervical smears.
Respondents were evenly divided in their opinion about whether general practitioners or health visitors should check the health and development of children under the age of five. Sixty-two per cent felt that general practitioners should do 'check-ups' on people over 75 years of age, only 6% feeling that this was an area for the health visitor. Nearly 15% of respondents however, had no opinion who should undertake this form of screening.

**Information and Advice**

Respondents were asked whom they considered would be the best person to consult for information and advice about particular health and social topics (Table 6-10).
Table 6-10 Sources of information or advice

<table>
<thead>
<tr>
<th>Item of service</th>
<th>Practice nurse</th>
<th>Health visitor</th>
<th>General practitioner</th>
<th>District nurse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>diet</td>
<td>41.3</td>
<td>187</td>
<td>19.0</td>
<td>86</td>
<td>37.3</td>
</tr>
<tr>
<td>blood pressure</td>
<td>23.4</td>
<td>108</td>
<td>0.2</td>
<td>4</td>
<td>72.7</td>
</tr>
<tr>
<td>heart disease</td>
<td>4.1</td>
<td>19</td>
<td>2.8</td>
<td>13</td>
<td>92.4</td>
</tr>
<tr>
<td>alcohol control</td>
<td>13.8</td>
<td>61</td>
<td>11.7</td>
<td>52</td>
<td>72.2</td>
</tr>
<tr>
<td>management of stress</td>
<td>14.7</td>
<td>66</td>
<td>11.6</td>
<td>52</td>
<td>70.5</td>
</tr>
<tr>
<td>exercise</td>
<td>44.8</td>
<td>198</td>
<td>18.1</td>
<td>80</td>
<td>34.2</td>
</tr>
<tr>
<td>giving up smoking</td>
<td>28.6</td>
<td>125</td>
<td>19.2</td>
<td>84</td>
<td>50.3</td>
</tr>
<tr>
<td>how to cope with a sick person in your family</td>
<td>18.3</td>
<td>81</td>
<td>27.1</td>
<td>120</td>
<td>35.7</td>
</tr>
<tr>
<td>bereavement</td>
<td>12.5</td>
<td>55</td>
<td>29.8</td>
<td>131</td>
<td>49.7</td>
</tr>
<tr>
<td>a problem with your marriage</td>
<td>11.8</td>
<td>49</td>
<td>39.7</td>
<td>165</td>
<td>45.0</td>
</tr>
<tr>
<td>a child misbehaving at school</td>
<td>13.3</td>
<td>56</td>
<td>52.1</td>
<td>220</td>
<td>31.0</td>
</tr>
<tr>
<td>someone in your family taking drugs</td>
<td>6.5</td>
<td>29</td>
<td>18.4</td>
<td>82</td>
<td>73.1</td>
</tr>
</tbody>
</table>

The practice nurse was considered the best person to talk with for advice or information about diet or exercise by nearly half the respondents, and the general practitioner was the next choice. Apart from the general practitioner, the practice nurse was the next person of choice to consult about blood pressure advice, heart disease, the management of stress and alcohol control.

Although half the respondents said they would consult the general practitioner for advice on giving up smoking, a third would consult the practice nurse or the health visitor. Advice on coping with a sick person in the family would more likely be directed at the general practitioner (36%), but 27% would consult the health visitor and 19% would seek advice from the practice or district nurse.

Bereavement counselling and advice on marital problems would mainly be sought from the general practitioner or the health visitor. The health visitor (52%) was
the person of first choice to consult about a child misbehaving at school. Seventy three per cent of patients would seek advice from the doctor about someone in the family taking drugs, although 18% would talk to the health visitor about the problem.

To summarise therefore, the general practitioner would appear to be the health professional of choice for all items listed except for advice on diet and exercise, where the practice nurse would be more likely to be consulted. The practice nurse was second choice for advice on blood pressure, heart disease, alcohol control, management of stress and advice on giving up smoking. The health visitor came second to the general practitioner as a source of advice on coping with a sick member of the family, bereavement, marital problems, a family member taking drugs, or for advice on a child misbehaving at school.

**Health Check-Ups**

Respondents were asked under what circumstances they would accept an invitation to have a health check up, one of the provisions under the terms of the New GP Contract. This question allowed respondents to tick all applicable answers. The most popular responses were that respondents would be happy to come to the surgery at an agreed appointment time (98%, n = 446), accept if they were coming to the surgery anyway (96%, n = 160), and accept if it could be done at home (94%, n = 110). There were no significant differences in age groups of patients who would have accepted to have a check-up at home.
Eighteen respondents gave reasons for accepting or refusing an offer of a check up, and their comments included the following:

- I am Mr. Healthy. I have never had a sore head, I have never taken a pill in my life, I drink but I have never had a hang-over, I don't know how long since seeing my doctor, in fact I should get a rebate from the NHS but I can't say that for most people.
  
  (Male, aged 62 years)

- I wouldn't need to, because I receive a lot of treatment so I get check-ups all the time.
  
  (Female, aged 52 years)

- I would accept if I was coming to the surgery anyway, just to see what it involves. Again, I have no idea which areas of my health would be investigated in a health check, but think in general that personal 'MOTs' on people with no specific problems are probably a waste of everyone's time. Feel health checks are most likely to be valuable for very young children, very old people and people with chronic ailments.
  
  (Male, aged 39 years)

- I'd accept if it could be done at home. Cartilage in knee problem - arthritis in joints.
  
  (Male aged 27 years)

- Accept, but feel vaguely worried that they considered it necessary.
  
  (Female, aged 35 years)

- Would come if the appointment could be made after work rather than lose time off work.
  
  (Female, aged 54 years).

Health Advice from Sources other than the General Practitioner

It was anticipated that the general practitioner would be the health professional of choice for certain items of service, so a general question on health advice was asked which excluded doctors. Apart from the doctor, 55% of patients (n=231) said they would definitely consult the practice nurse rather than any other source, for health advice. Thirty-three per cent of patients (n=109) would consult the
district nurse, 35% (n=114) the health visitor, and 54% (n=194) reported that they would 'perhaps' consult the chemist.

In reply to an open-ended question asking if patients would use any other sources for health advice, there were 22 responses. The most popular were, that it would depend on the nature of the problem, and that medical textbooks would be consulted. Other comments on sources of information included health leaflets, or request for referral to a consultant in the appropriate specialty. Individual responses included consultation with a spiritualist healer, a yoga teacher, or charities with expert knowledge such as the Eczema Society or the Brittle Bone Society.

Finally, 55% (n=272) of respondents stated that they were aware that there had been changes made in family doctor services during 1990.

Discussion

The perceptions of patients from this sample (n= 495) were analysed in an attempt to address issues which were considered to be relevant during a time of considerable change within primary care. A number of these issues were articulated in relation to the patient satisfaction data, but are also given attention here. For example, patients' reasons for choosing to see a nurse rather than a doctor. This, and other topics will be discussed further.
Response Rates

The pressure on reception staff in dealing with patients, either at the reception desk or on the telephone, as well as coping with demands from general practitioners and other members of the primary health care team, can be quite considerable. Although practice managers and senior receptionists were approached individually in all participating practices, and they expressed their willingness to hand out questionnaires, this acquiescence was perhaps not reflected in actuality. The administration of the questionnaires also took place in early December at a time when public interest is more focused on sending Christmas greetings than completing questionnaires.

Nurses and Service Provision

Fifty eight per cent (n=282) of respondents had used the services of the practice nurse within the last year and over half expressed no preference whether the nurse was male or female. In other areas however, it is interesting that older patients have been reported to be more particular. In a study to assess the acceptability to patients of the use of patients' first names by doctors and doctors' first names by patients, 475 patients consulting 30 general practitioners in five practice settings were asked to complete a questionnaire (McKinstry 1990). Most of the patients either liked (n=223) or did not mind (n=175) being called by their first names. Seventy seven patients disliked it, most of whom (n=29) were over 65 years of age. Sixty eight per cent (n=324) of patients said they would not like to call the doctor by his or her first name.
Prescribing

Respondents were more in favour of nurse prescribing by practice nurses and district nurses than they were by health visitors. The responses however, may partly be reflected in the fact that 58% of respondents had actually used the services of the practice nurse in contrast to the 8% who had seen the district nurse and 13% who had seen the health visitor. It may also be related to a perception of the more ‘practical’ nature of the roles of practice and district nurses, in contrast to the advisory role of the health visitor.

The RCN has spent more than ten years working towards the introduction of legislation for nurses to be able to prescribe certain products (RCN 1995). At the present time the legislation has been passed through Parliament (Great Britain Parliament 1992), and from October 1994 has been piloted in eight sites throughout the country (Jones 1994). The pilot was restricted to nurses with a district nurse or health visitor qualification who prescribe from a limited formulary. The recommendations for district nurses to prescribe from a limited list were suggested some time ago by the Community Nursing Review (DHSS 1986a), particularly in relation to the timing and dosage of drugs for pain relief in patients receiving terminal care.

Nurse or Doctor?

Forty eight per cent of the respondents in this study said that there were occasions when they would choose to see the practice nurse rather than the general practitioner. This is not unusual. In a study of patient choice in family planning (Murray and Paxton 1993), two hundred consecutive women who attended the nurse or doctor in a general medical practice for purposes including family
planning advice or supplies, were invited to complete a questionnaire before leaving the practice premises. From a 70% response rate (n=140), 61% of respondents said they would choose to see the nurse for an initial consultation for a coil fitting and 69% would choose to see the nurse to have a cap fitted. The nurse was also the first choice for return family planning consultations and examinations for oral contraception, coil and cap checks, cervical smears and breast examinations.

In comparison, Drury et al. (1988) in the study of the work of the nurse practitioner, reported that 48% of patients felt that there were occasions when they would only turn to the doctor. The respondents who would chose to see the nurse said they would do so because they felt that the nurse could deal with problems that do not need a doctor’s skills or because the nurse can call on the doctor’s help if required. Although over half of the respondents had no preference whether the nurse was male or female, patient comments support the caring, gentle role usually associated with the female character, and is one which fulfils the more traditional role.

When asked about the reasons for consulting the nurse practitioner instead of the general practitioner, Salisbury and Tettersell (1988) and Drury et al. (1988) reported that patients mentioned not wanting to ‘bother’ the doctor and ‘not needing’ a doctor. The implementation of the New GP Contract and the concomitant increase in the employment of practice nurses, has resulted in the delivery of a wide spectrum of nursing care to the patient. As the role of the practice nurse evolves to include more anticipatory care and chronic disease management, patients may choose to see the practice nurse for a variety of reasons.
Touche Ross (1994) reported that decisions about visiting the nurse practitioner were sometimes based on the ‘embarrassment factor’ of discussing certain subject matter with the doctor, who might also dismiss the problem as trivial. This finding was also reported by a third of patients in this study. For example, over 40% of respondents reported that practice nurses should take cervical smears. This is not just a task. If practice nurses are satisfactorily trained they should explain the reasons for the test, describe the procedure itself, inform about results and follow-up, and while doing so, attempt to relax the patient and reduce the embarrassment factor. Many doctors do not always have time in their consultations to provide such holistic care. Indeed, Wright (1995) suggests that traditional paternalistic medical practice is in marked contrast to that of the alternative professional example of partnership with patients that nursing offers. Such a relationship allows the patient to retain empowerment over his or her own health.

**Services Offered by the Practice**

Three quarters of all respondents were happy with the services offered by their practice at the time of the study. Overall, they were well informed about the services provided, and some respondents mentioned additional services not listed on the questionnaire. Female respondents were considerably better informed about all services listed, including services that were not specifically ‘female oriented’. The exception was ‘well-man’ clinics, where two thirds of men were aware of them in contrast to one third of women. Although generally reasonably well-informed, it was of concern that a quarter of female respondents under 30 years of age did not know if maternity and baby clinics were provided, or whether cervical smears could be done in the practice. In addition, half of the respondents
did not know about well-woman clinics and these respondents were almost exclusively female.

**Roles of Health Professionals**

The general practitioner was the preferred health professional to consult for most activities specified, with the exception of taking cervical smears. In this domain the practice nurse was the more popular choice, and was also the second choice to undertake breast examination. There is no way of knowing whether patients had access to a female doctor, and if not, whether this influenced their selection of health professional.

The listening skills of nurses that are particularly highlighted by patients (Reedy 1972; Drury *et al.* 1988; Salisbury and Tettersell 1988; Touche Ross 1994) are not supported in this study when the nurses are compared with doctors. Fifty per cent of patients considered that the doctor had more time to listen to them, although a quarter thought the practice nurse had more time. This is a slightly puzzling finding in view of the very positive and often selective comments that patients make about the holistic aspects of the nurse’s role. District nurses were considered to be under the greatest time pressure, only 5% of respondents believing that they had time to listen. Understandably perhaps, reception staff were perceived to have the least time of all.

Although a third of patients considered that the health visitor should check the health and development of the under five age group, only 6% considered that the health visitor should immunise children. Whether this opinion was grounded on
experience of the work of health visitors within individual practices, or was a subjective view, was not an issue addressed by the questionnaire.

Health visitors are trained to take an overall view of the family's health while undertaking child surveillance, and there is a danger that if this role is taken over by general practitioners it will have a medicalised focus (Cubbin et al. 1990). Over half of the respondents however, said that they would consult the health visitor about a child misbehaving at school, and 40% would seek advice about problems in their marriage. Although the general practitioner would be their first choice, patients would next choose to consult the health visitor about a sick person in the family or someone taking drugs. Similarly, the health visitor was the nurse of choice when seeking guidance about coping with bereavement. Only 6% of respondents felt that health visitors should check on the health and welfare of elderly clients, in contrast to two thirds of respondents who felt it was the responsibility of the general practitioner.

Health visitors are concerned that practice nurses may take over their role in health promotion and home visiting of elderly clients, and there is a danger that confusion will arise when families or individuals receive, sometimes inconsistent, advice from a variety of different health professionals. The New GP Contract stipulates that everyone over the age of 75 should be offered a visit at least once a year. Although not a specific target, neither health visitors nor district nurses have managed to achieve this over the years, mainly because of inadequate staffing levels and the resultant time constraints (Cubbin et al. 1990).

The role of practice nurses has expanded to include special responsibility for screening and health promotion, and patients in this study considered the practice
nurse to be the best person to talk with about diet and exercise. Apart from the doctor, the practice nurse was the nurse of choice to consult about blood pressure, alcohol control, stress management and giving up smoking. Other studies (Ross et al. 1994; Hibble 1995; Jeffreys et al. 1995) report that practice nurses are involved in these activities. Ross et al. (1994) report that 85% of practice nurses would like to expand their role in health promotion and counselling, and Hibble (1995) reports that practice nurses in 1992 were spending 10% of their total nursing time in health promotion, having recorded no such activity previously. Prior to the New GP Contract, Greenfield et al. (1987) reported that 15% of practice nurses wished to expand their role, and Cater and Hawthorn (1988) reported a level of 39% who wished to do so.

**Health Check-Ups**

Respondents were happy to accept an invitation to have a health check up, and most were willing to attend the surgery. Apart from the general practitioner, patients reported that they would rather consult the practice nurse in preference to any other source, for health advice.

It is of interest in this study, that district nurses scored lower for more variables than their other nurse colleagues. In a study by Poulton (1996) which used a questionnaire to measure satisfaction with community nurses (one nurse practitioner, district nurses, practice nurses and health visitors) in three fundholding practices of 11,000 patients or more, patient satisfaction was rated significantly higher for district and practice nurses than for general practitioners and health visitors. Poulton (1996) reports the number of consultations with each health professional, but apart from recording that there is one nurse practitioner,
the number of other participating nurses is not recorded. In addition, as data were only available for a small number of health professionals studied, Poulton cautions against making comparisons between groups of health professionals.

Conclusion

The range of sometimes conflicting, views of patients makes it difficult for practices to address the problem of improving the services they provide. Examination of the results from individual practices did not reveal any similarities in the data on particular issues that could be conveyed to the practices to inform them about patients' views. In the feedback of the results, a broad message to practices was the lack of knowledge of 'particular' services for 'particular' age and sex groups of the practice population.

What was valuable from the study was the generalist nature of information that covered what patients felt about their practices, the services they offered and the primary health care team who provided these services. Practice nurses were reported by patients to be undertaking a mix of traditional and expanded roles. Elderly patients appeared to particularly appreciate their contacts with the practice nurse, and more than a third of female patients would choose to have cervical smears and breast examinations done by the nurse in preference to the doctor. While these are 'extended' roles in terms of procedures, they also involve elements of more holistic care. Such 'procedures' include listening, examination and diagnostic skills, decision making and advice, and are more in keeping with an expanded role.
The majority of respondents said they were happy with the services provided by their practices and were appreciative of the caring attitude of doctors and nurses. They also appeared to show willingness to participate in health education programmes. The Community Nursing Review team (DHSS 1986a) heard the words ‘participation’ and ‘partnership’ frequently during discussions with consumers. This was emphasised by the consumers themselves as represented by the Association of Community Health Councils in England and Wales, when they advocated that:

*It is important to generate an ethos among nurses and other professionals which would lead them to regard patients or clients, families and friends, as partners in the caring exercise. Granted that many appear to welcome dependency and traditional nursing attitudes encourage it, involvement, personal responsibility and participation would seem to be more appropriate.*

(p.61)

In the next chapter the results and a discussion of the findings from a questionnaire is presented. This was administered to general practitioners, other practice nurses, and community nurses who worked in the same practices as the participating practice nurses. The questionnaire attempted to ascertain their views on the changes brought about by the introduction of the New GP Contract and how they perceived primary care nursing would develop in the future.
Chapter Seven

PRACTICE NURSES, COMMUNITY NURSES AND GENERAL PRACTITIONERS: SOME PERCEPTIONS OF FUTURE DEVELOPMENTS IN PRIMARY CARE NURSING

Opinion is ultimately determined by the feelings, and not by the intellect.
Herbert Spencer (1820 - 1903)

Introduction

In this chapter the personal views of practice nurses, community nurses and general practitioners are recounted in relation to their responses to a questionnaire. Although the numbers of responses are relatively small and the study was locally based, an attempt is made to relate their views to the wider context of the changes that were taking place in general practice as a result of the New GP Contract, including the comprehensive reforms that were reflecting the shift in health care in the NHS at the time.

As described in Chapter Four, all the respondents were invited to complete a questionnaire if they worked in, or were attached to, one of the participating practices. The questionnaires for all the nurses and the general practitioners (Questionnaires 2-8, 2-9, 2-10, 2-11 in Appendix 2) were alike for the first 19 questions. In the general practitioners' questionnaire the questions on 'access' and 'practice meetings' focused on the doctors' opinions of whether nurses had the
same amount of access and involvement in the practice as did the general practitioners. The section on ‘continuing education’ specifically asked general practitioners about continuing education for practice employed nurses.

These questionnaires were very detailed and for this reason, as described in the Methods section in Chapter Four, mainly consisted of a closed format. Nevertheless, it was hoped that the insertion of a number of strategically placed open-ended questions would allow respondents the opportunity to give their individual opinions about professional roles, and provide the means for them to communicate issues pertinent to the development of primary care nursing in the future. The content of the questionnaire addressed Aim 6 of the study, namely:

To identify practice nurses’, community nurses’, and general practitioners’ perceptions of future developments in primary care nursing so as to identify areas of common interest and of potential disagreement.

Response Rates

A total of 168 out of 296 respondents (57%) from 25 practices returned valid questionnaires. Of these, 34 out of 54 were practice employed and attached nurses (63%). The practice nurse respondents comprised not only the nurse participants but also practice nurses working in the practices who were not involved in the workload study. Twenty-one were practice employed nurses and 13 were attached nurses. There were 72 out of 144 (50%) general practitioner respondents, 35 out of 56 health visitors (63%), and 27 out of 42 district nurse respondents (64%). The actual numbers of responses are shown in Table 1-29 in Appendix 1, and the variation across practices may reflect the level of interest in, or awareness of, the study, by community nurses in particular. Individual responses to questions was quite variable.
Manpower Distribution

In an attempt to put the numbers of responses into context at a local level, some information on manpower distribution between 1990 and 1991 is included at this point, along with a demographic profile. A profile of professional and other qualifications of the nurses is also included.

Table 7.1 Manpower distribution (WTE) 1990 & 1991

<table>
<thead>
<tr>
<th>Total</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Scotland</td>
<td>615</td>
<td>1509</td>
<td>1211</td>
<td>3300</td>
</tr>
<tr>
<td>In Lothian</td>
<td>74</td>
<td>237</td>
<td>238</td>
<td>505</td>
</tr>
<tr>
<td>In participating practices</td>
<td>54</td>
<td>56</td>
<td>42</td>
<td>144</td>
</tr>
<tr>
<td>Total respondents</td>
<td>34</td>
<td>35</td>
<td>27</td>
<td>72</td>
</tr>
</tbody>
</table>

Practice Employed and Attached Nurses

In 1991, a survey conducted by the Scottish National Board for Nursing, Midwifery and Health Visiting (NBS 1992) suggested that there were 1030 practice nurses with different levels of qualifications employed by general practitioners, 186 of these working in Lothian. Unfortunately, these figures represent numbers of nurses and were not available by whole-time equivalents. National figures were unavailable for health board attached nurses to general practice, but there were 43 attached nurses working in the practices of general practice in Lothian in 1990-91.

Demographic and Occupational Profile

The 34 practice nurse respondents were female, and compared to the majority of health visitors and district nurses who worked full-time, 25 of the practice nurses worked part-time. The ages of the practice nurse respondents ranged from 29 to
54 years, with a mean of 40 years (S.D. 7.7). Although their experience ranged from two to 20 years, 10 of the 34 respondent practice nurses had worked as practice nurses for only two years. These ten nurses were all employed by general practitioners in the year prior to the introduction of the New GP Contract. Thirty one practice nurses had first level registration and three were enrolled nurses. Eight practice nurses had attended a Practice Nurse course. The profile of professional and other qualifications was similar in most respects to that of the practice nurse participants in the workload part of the study, as shown in Table 7-2.

Table 7-2 Profile of professional and other qualifications - Nurse respondents

<table>
<thead>
<tr>
<th>QUALIFICATIONS</th>
<th>PRACTICE NURSES</th>
<th>HEALTH VISITORS</th>
<th>DISTRICT NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Workload</td>
<td>Questionnaire</td>
<td></td>
</tr>
<tr>
<td>Registered general nurse</td>
<td>32</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Enrolled nurse (general)</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Registered mental nurse</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Registered sick children's nurse</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Registered midwife</td>
<td>14</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Registered health visitor</td>
<td>1</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>District nurse qualification</td>
<td>5</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Family Planning Certificate</td>
<td>15</td>
<td>15</td>
<td>27</td>
</tr>
<tr>
<td>Practice Nurse Certificate</td>
<td>6</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>BA/ B.Sc. Nursing</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Post-graduate degree</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other degree</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Number of nurses | 34 | 34 | 35 | 27

Note: Numbers do not add up because of multiple coding

Health Visitors

During the period 1990-91, whole-time equivalent (WTE) figures for health visitors in Scotland were 1509. This represented a 3% decrease in the figures for 1989-90. There were 237 health visitors employed in Lothian during 1990-91.
Demographic and Occupational Profile

There was one male health visitor, and the other 34 health visitor respondents were female. Twenty nine health visitors worked full-time and six worked part-time. Their ages ranged from 30 to 59 years, with a mean age of 42 years (S.D. 8.7). Experience as a health visitor ranged from two to 25 years, and the majority (29 respondents) had spent more than five years in the job. They were all registered general nurses and qualified health visitors, and several had additional qualifications (Table 7-2). Ten respondents were the only health visitor attached to the practice, eight worked with one other colleague and three worked with two other colleagues.

District Nurses

Registered district nurses (holding a district nursing certificate) numbered 1211 (WTE) in Scotland in 1990-91, which represented a decrease of 1% on the 1989-90 figures. Numbers employed in Lothian during 1990-91 were 238, similar to that of health visitors. A number of these district nurses may have undertaken some sessions in general practice practices, but information about this was unavailable.

Demographic and Occupational Profile

Twenty six of the 27 district nurse respondents were female. Twenty three worked full-time and four part-time. Their ages ranged from 20 to 63 years, with a mean age of 43 years (s.d. 10.3). Their work experience as district nurses was reported as being between four and 35 years. Twenty four nurses were Registered General Nurses, and 24 nurses reported having the District Nursing Certificate. Extra
qualifications are recorded in Table 7-2. Eleven district nurse respondents worked alone, six with one other, and one with three other district nurses.

**General Practitioners**

Information from the Information and Statistics Division (ISD, 1993; 1966) of the Common Service Agency for the Scottish Health Service suggests that, in 1990-91, there were in excess of 3,300 general practitioners providing general medical services in Scotland, and these figures had not changed substantially since 1985. In 1990-91, 505 of these general practitioners were working in Lothian. At that time these Lothian general practitioners were servicing a population of approximately 750,000 and the average list size was 1600. Twenty three general practitioners were single-handed and 482 worked in partnerships.

**Demographic and Occupational Profile**

The majority (68%), 49 out of the 72 respondent general practitioners were male and 23 (32%) were female. Forty seven male respondents and seven female respondents worked full time. Their ages ranged from 29 to 63 years, with a mean age of 40 years (S.D. 8.4). Four doctors (two male and two female) had worked in general practice for less than one year, but the remainder had been general practitioners for between two and 32 years. The age groups of all respondents who gave their date of birth on the questionnaires, are shown in Table 7-3. The majority of respondents were aged between thirty and forty years of age.

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>20-29 years</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>30-39 years</td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>40-49 years</td>
<td>12</td>
<td>9</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>50-59 years</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Over 60 years</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Valid total</td>
<td>30</td>
<td>29</td>
<td>23</td>
<td>54</td>
</tr>
</tbody>
</table>
Concerns Before and After the Introduction of the New General Practitioner Contract

The questionnaire was circulated towards the end of 1991, a year after the introduction of the New GP Contract. Respondents were asked to think back to how they felt about certain issues prior to the implementation of the Contract, and then to compare these views with how they felt at the present time (Figure 7-1). Their views will be examined in relation to the concerns expressed.

*Figure 7-1 Percentage of 'YES' responses to various concerns before and after the introduction of the new GP contract*

(Cross reference Table 1-30 in Appendix 1)

![Bar chart showing percentage of 'YES' responses to various concerns before and after the introduction of the new GP contract.]

**Attitudes to an Increasing Workload**

Respondents were asked to think back to 1990, and whether they had any concerns at the time about the New GP Contract increasing their workload. Seventy one per cent (n=111) of all respondents reported being concerned at the
time. This concern was greatest among general practitioners (86%), and practice nurses (68%).

Having worked in parallel with the New GP Contract for a year, respondents were asked how they felt at the present time about an increasing workload. Although anxieties had only increased overall by 4%, levels of concern among general practitioners and practice nurses had increased by 13 per cent. In contrast, expectations of an increasing workload had fallen for health visitors and district nurses.

When asked if their workload had actually increased since the introduction of the New GP Contract, 76% (n=120) of all respondents reported that it had increased. This was mainly reported by general practitioners (100%) and by 97% of practice nurses (Figure 7-1). A number of reasons were given for this increase in workload. These included involvement in screening clinics for specified subgroups of the population, reported by 78% of general practitioners and 68% of practice nurses, and 74% of practice nurses reported an increase in patient referrals. Sixty three per cent (n=17) of practice nurses who mentioned ‘other activities’ that they were involved in, commented on the extra time spent on administration.

- Time spent organising clinics and less time to speak to patients if they have any other problems.
- Doctors now take the Wart Clinic because ‘they’ get paid (as for minor surgery). We do the paperwork.
- Now do six health promotion clinics per week. Venepuncture now performed by doctors, dressings referred to DNs where applicable.

The reports and comments of the practice nurses were compared with the findings from the measurement of practice nurse workload, reported in Chapter Five. The
results from the workload part of the study indicate that there was a re-distribution of the nurses’ work, and that more time was spent in clinic activities. Practice employed nurses had fewer referrals overall in the second year, although they had significantly more referrals from reception staff (2%, $X^2=7.4$, df 1, $p<0.01$). In 1991, attached nurses had marginally fewer referrals from reception staff, although there was a slight increase from ‘other’ sources. Neither of these were significant.

The workload data however, does not support the impression practice employed nurses had about referrals from the general practitioners in the second year. Overall, there were fewer referrals from the general practitioners, although they increased for attached nurses while falling for practice employed nurses. Doctors were also involved in significantly fewer consultations (25%) in 1991, compared to 40% in 1990. All the nurse respondents perceived that they were spending more time on administration, and again, it is indicated by the workload data that there was a slight fall of 1% in time spent on administration generally.

No actual change in overall workload was reported by 61% of health visitors and 56% of district nurses, although 26% of health visitor respondents and 48% of district nurse respondents reported an increase in visits to elderly patients (Figure 7-1). Eight health visitors reported having to reduce home visiting time, because of increased time spent in clinics and extra administration. Comments included:

- Reduction in regular home visits.
- Have to spend more time with children, less time with the elderly.
- Less ‘routine’ visits to the elderly.
- Unable to visit families for supportive visits as regularly as I would like.
- Amount of paperwork and meetings have increased, giving less time to visit families at home.
Seven district nurses were unhappy that they were taking on some of the treatment procedures previously done by the practice nurses, who were now being delegated by general practitioners to do the 'health checks' on elderly patients over the age of 75 years in the home.

- 'Mobile' patients no longer seen at practice for treatments e.g. dressings. Patients now seen by DN service and have to be 'absorbed' into the case load.
- Not able to do as many 'over 75' health and social checks.

This shift of workload back to the district nursing service was also acknowledged by the practice nurses themselves. Practice nurses acknowledged referring patients to their district nurse colleagues because of the re-distribution of practice nurse workload and the amount of time being spent on clinic activities.

Increased visiting to elderly patients was reported by approximately half of the general practitioners. Thirty one per cent (n=22) of general practitioners reported an increase in various forms of administration and in working hours, and described this as resulting in a reduction in time spent with patients.

- Paperwork, computer work, letters etc. Have had to reduce practice area and ask remote patients to change doctors to save time on house calls. Quicker consultations to push through the patients.
- Administration, meetings and paperwork increased dramatically. My day has had to get longer.
- More time seeing well patients, less time treating ill ones.
- Increased practice administration, paperwork, computers, lists etc. Reduction in return visits to patients seen at home, discharged from hospital etc.

**Items of Service**

In an examination of organisation within primary care, specific items of service were investigated. All the nurses and general practitioners were asked to indicate from a given list, which items of service they were providing at the present time,
one year after the introduction of the New Contract. Their responses are shown in Figure 7-2.

Figure 7-2: Items of Service

(Cross reference Table 1-31 in Appendix 1)

As shown in Figure 7-2, immunisation of children was undertaken by 53% of practice nurses and 82% of general practitioners, but only four health visitors and one district nurse reported that they immunised children. Antenatal and postnatal care was undertaken by the majority of health visitors and general practitioners. Less than half of the practice nurses and only one district nurse reported involvement in this area.

The workload data shows an overall increase in immunisation of children by practice nurses in the second year, although practice employed nurses did 1% fewer and attached nurses, 1% more. Antenatal and postnatal care decreased for practice nurses in the second year. On examination of the data from the patients' questionnaire, respondents would choose the practice nurse and the doctor to immunise children in preference to the health visitor or the district nurse.
Screening of elderly patients was undertaken by most health visitors, district nurses and general practitioners, and by half of the practice nurses. All the general practitioner respondents reported undertaking family planning, as did half of the health visitors. Less than half of the practice nurses and only one district nurse reported this as an item of service. Screening of elderly patients increased marginally from 1% to 2% for practice employed nurses in the second year, but attached nurses did none at all and it was only recorded as being 0.1% of their workload in 1990.

A number of issues are of interest here. According to the self-reported qualifications of the practice nurses, nearly half were Registered Midwives and half held the Family Planning Certificate. Although not practising midwives, few practice nurses were involved in general practice-based antenatal care. In addition, patient choice of practice nurses as their preferred carer for family planning advice has been previously documented (Murray and Paxton 1993). It was also reported in the workload data that practice nurses increased the time spent in special clinics, which included family planning and well-woman clinics, by 4% in the second year. Although they were involved in antenatal and postnatal care, health visitors were not involved in immunisation of young children.

*Respondents’ Views on Whether They Should Undertake Certain Items of Service*

From a separate list of items of service members of the primary care team were asked whether they felt certain specified tasks *should* be part of their work (Figure 7-3).
Cervical Smears and Contraceptive Advice

Over three quarters of practice nurses and general practitioners felt that they should take cervical smears. The majority of general practitioners and health visitors, and 84% of practice nurses reported that it was part of their work to give contraceptive advice. Although the practice nurses in the workload part of the study increased the taking of cervical smears by 1% in the second year, giving contraceptive advice remained unchanged and involved 5% of all practice nurse consultations both years.

From the patient questionnaire data on their knowledge of services provided by the practice, discussed in Chapter Six, it was reported that less than half of all respondents (40%) knew whether family planning services were provided, and only half of the female respondents knew whether breast examination was
available. The practice nurse however, would be the health professional of choice to undertake cervical smears, 42% of respondents making this preference.

**Immunisation Of Children**

With regard to the immunisation of children, two thirds of general practitioners felt that this should be a doctor's responsibility, although 21% (n=15) of general practitioners thought practice nurses should immunise children. Over 70% of practice nurses respondents thought that they, as practice nurses, should immunise children, but only eight health visitors and one district nurse felt it was part of the health visitor or district nurse role. Fifty four per cent (n = 19) of health visitors however, thought child immunisation should be done by the general practitioner.

**Screening Of Elderly Patients**

Half of the general practitioner respondents (n=37 out of 68) felt that they should not be undertaking screening of elderly patients, and 24 of these 37 general practitioner respondents reported that it should be the work of the health visitor. The majority of health visitors and district nurses felt that it was a part of their duties, as did half of the practice nurses.

**Influenza Vaccination**

All the practice nurse respondents (n=33) considered that influenza vaccination should be part of their work, and two thirds of district nurses (n=17) considered that it was an item of service that district nurses should provide. Only one third of
general practitioners (n=22) thought it should be done by a doctor, and only 3 health visitors felt that it was an area for the health visitor.

Compiling Annual Reports and Designing Practice Leaflets

Two thirds of all respondents felt that they should contribute in the compiling of practice annual reports and in helping to design practice leaflets.

Quality of Patient Care

The possible effects of the impending New GP Contract on quality of patient care was an anxiety expressed by 67% of respondents (n=104), but particularly by general practitioners (77%). Overall concern about quality of patient care increased by 4% after the implementation of the New GP Contract, mainly reported by general practitioners and district nurses. Health visitors and practice nurses reportedly felt less worried than before about this issue.

Loss of Professional Independence

When asked if they had concerns prior to the New GP Contract about a loss of professional independence, only 39% (n=59) of all respondents reported having any concerns. As a group, district nurses expressed the greatest anxiety (63%). Overall, respondents reported that by a year later, these concerns had increased by 6 per cent. They were most marked in the case of general practitioners and health visitors, where levels of concern had risen by 27% for general practitioners and by 7% for health visitors. In contrast, practice nurses and district nurses were less worried than before.
Professional Roles and Job Definition

Health visitors and district nurses reported higher levels of concern before the implementation of the New GP Contract about how their role might be affected than did their practice nurse and general practitioner colleagues. Health visitors reported that, a year later, they were no more reassured. Levels of concern about their role changing had risen by 14 per cent. Concerns about job definition were also expressed by 71% of health visitors. General practitioners reported that, although these issues had not troubled them before the introduction of the Contract, concerns about their professional role changing increased by 44% after its implementation, and 60% of respondent general practitioners were more concerned about their job definition.

Practice nurses and district nurses reported no change in concern about their role after the introduction of the Contract, but they were more concerned about their job definition. Half of the practice nurses and 60% of their district nurse colleagues reported being more concerned about their job definition than before. Respondents were asked to outline any additional concerns that they had before or after the introduction of the New GP Contract. Ten practice nurses commented about lack of suitable education and training for practice nursing and under-use of their skills. The following summarise the comments made:

- Lack of training facilities for practice nurses.
- Nurses' skills not used to the full.

Six health visitor respondents made comments relating to their feelings prior to the implementation of the New GP Contract. They were concerned about their future employment prospects and who their employer would be. After its introduction 74% (n=25) said that they were more concerned about being under-valued.
• I'm concerned over whether GPs would eventually become responsible for the employment of us HVs.
• Worries about job prospects.
• Apparent management lack of understanding of our feelings regarding role and upgrading.
• I have been concerned about lack of working together and communicating in the primary health care team.
• Clients now offered less choice e.g. GPs want to do all immunisations and require HVs to inform clients that they may no longer attend local health Board clinics for immunisation and have to travel greater distances to GP surgery for this. Surgery clinics cannot cope with the numbers of local clinics closed. Some clients we are glad to 'catch' and immunise in any clinic

Fifty-six per cent (n=15) of district nurses said that, prior to the introduction of the New Contract they had concerns about loss of an identified role, and five were worried that other health professionals would take on some of the work categorised as being the responsibility of the district nursing service.

• The elderly visiting has always been a middle of the road decision.
• Social Work Department taking over nursing roles in some instances. This would be disastrous for the patients.
• Loss of identity. 'Blurring' of roles between DNS [District Nursing Service] and HVs.

Thirty six per cent (n=26) of general practitioners reported having other concerns prior to the implementation of the New GP Contract. Seven commented about the possible loss of income and the potential of high patient expectations

• Overwork plus cut in income.
• 'Out - of - hours' work.
• Under resourcing and possibility of retraining.
• Rising patient expectations and increasing anticipatory care.

Forty nine per cent (n=35) of doctors said they had other concerns after the introduction of the New Contract. Five found the extra administration onerous, and five felt that they were undertaking more 'mundane' tasks. Comments included:
• Undefined nature of general medical services plus a tendency for government and the profession to raise ‘standards’ without providing resources to meet extra demand.
• Mundane tasks of little clinical importance.
• Non-medical activities which do not improve patient care.

Morale

Personal Morale and the New GP Contract

Sixty nine per cent of general practitioners and 59% of health visitors reported that their morale had worsened since the implementation of the New GP Contract, but 52% of practice nurses and 60% of district nurses described it as unchanged (Table 7-4).

Table 7-4 Self-reported morale of nurses and general practitioners

<table>
<thead>
<tr>
<th>Self-reported morale</th>
<th>Better</th>
<th>Unchanged</th>
<th>Worse</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>SINCE THE NEW CONTRACT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurses</td>
<td>9.7</td>
<td>3</td>
<td>51.6</td>
<td>16</td>
</tr>
<tr>
<td>Health visitors</td>
<td>0.0</td>
<td>0</td>
<td>41.2</td>
<td>14</td>
</tr>
<tr>
<td>District nurses</td>
<td>4.0</td>
<td>1</td>
<td>60.0</td>
<td>15</td>
</tr>
<tr>
<td>General practitioners</td>
<td>4.3</td>
<td>3</td>
<td>27.1</td>
<td>19</td>
</tr>
<tr>
<td>EFFECTS OF OTHER NHS CHANGES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurses</td>
<td>0.0</td>
<td>0</td>
<td>66.7</td>
<td>20</td>
</tr>
<tr>
<td>Health visitors</td>
<td>0.0</td>
<td>0</td>
<td>17.6</td>
<td>6</td>
</tr>
<tr>
<td>District nurses</td>
<td>0.0</td>
<td>0</td>
<td>30.8</td>
<td>8</td>
</tr>
<tr>
<td>General Practitioners</td>
<td>2.9</td>
<td>2</td>
<td>28.6</td>
<td>20</td>
</tr>
</tbody>
</table>

Personal Morale and Recent NHS Changes

With the exception of the practice nurses, 67% of whom reported their morale unchanged, the other nurse respondents and the general practitioners reported that other recent changes in the NHS had also made their morale worse.
Views on the Morale of Other Members of the Primary Health Care Team

When asked their opinions about whether the morale of other members of the primary care team had been affected by the New GP Contract, 77% (n=111) of all respondents felt that the morale of general practitioners had worsened. It was also reported by respondents that the morale of health visitors (51%, n=57), practice managers (65%, n=96), and receptionists (60%, n=91) had got worse. On the other hand, the morale of practice nurses, district nurses, community nurse managers, and other health professionals was considered to be unchanged. Nevertheless, there were no reports of improved morale for any members of the primary care team.

Value and Support

Fifty five per cent of all respondents (n=85) were more concerned about being under-valued since the implementation of the New GP Contract. Half of the general practitioners were more concerned than before. Of the nurses, the health visitors, as mentioned earlier, were the group who reported feeling increasingly undervalued, whereas fewer practice and district nurses reported this as a problem.

Among the nurses, half of the practice nurses and health visitors, and three quarters of the district nurse respondents reported being more concerned about the level of support from nursing management. More than half of the general practitioners were unconcerned about this issue.
Resources and Patient Demand

Ninety two per cent of all respondents reported being more concerned about adequacy of resources as a result of the New GP Contract. Overall, 72% (n=141) of respondents expressed increasing concern about the demands and pressures from patients, 81% of general practitioners, 57% of practice nurses and 52% of district nurses. In contrast, 53% of health visitors reported being unconcerned or less concerned about demands and pressures from clients.

Training, Control and Accountability

Fifty three per cent of all respondents (n=84) reported concern about lack of training and experience in certain areas after the New Contract was introduced. The greatest concern was expressed by the practice nurse respondents, three quarters of them feeling that their training and experience was inadequate. Although to a lesser extent, this was also a concern half of the health visitors and 44% of district nurses. In contrast, over half of the general practitioners reported being unconcerned or less concerned about their own training and experience than before the introduction of the New Contract.

Three quarters of the general practitioner respondents and two thirds of the health visitors had become more concerned about the control and direction they had over their professional work, but this was reported as relatively unchanged for the practice and district nurses.

Half of all respondents (n=84) were concerned about professional accountability, but general practitioners were evenly divided in their opinion about this issue, half expressing greater concern and the other half feeling unconcerned or less
concerned. Although 59% of health visitors reported being unconcerned about accountability, half of the practice nurses and 60% of district nurses were more concerned about this issue than before the implementation of the New GP Contract.

Advantages and Disadvantages of the New GP Contract

There were a variety of answers to an open-ended question asking respondents whether they thought that some things had got better and some things had got worse as a result of the New GP Contract. Practice nurses were more positive than their district nurse colleagues about the benefits of screening, but there were comments made by practice nurses and district nurses about the financial motivation behind the aims of general practitioners to achieve targets in certain areas. Practice nurses observed:

- Screening of patients improved, but too money oriented.
- The word ‘patient’ is rarely mentioned, it is always ‘targets’.
- Practice nurses employed to run special clinics, screen new patients before doctors see them. Appears to put a monetary value on patients’ health.
- Created an awareness in patients of a healthier life style.

Health visitors were pleased to have better monitoring of target groups of the population, but were concerned about the rate of change and its effects on working relationships with other members of the primary care team. Several respondents had particular misgivings about the costs of patients having to attend doctors’ surgeries to have childhood immunisations, which were previously offered at local clinics.

- Stress on all concerned in meeting targets. Too much change at one time.
- Prior to the new developments, community staff worked with GPs as a team - there now seems a different feeling about this and not such a close relationship.
- Better: The public’s awareness of their power and rights regarding, choice of GP. Worse: Fragmentation of primary care team.
Over 75s' annual check is good. Health promotion groups are good.

We have been pressurised by GPs to ask all clients to go to CP's for immunisation, rather than their local Health Board-run clinic. We feel this is less convenient for families living in outlying areas. It is morally wrong to ask a socially deprived family with financial problems to take a six mile round trip to have their children immunised at the surgery, when there is a perfectly good clinic on their doorstep.

None of the 11 district nurses respondents who commented made any favourable remarks. They expressed concern about use of resources and the financial benefits accruing to general practitioners. These comments included the following:

- **Worse:** unnecessary screening annually of some over 75s.
- **Much time is wasted doing unnecessary screening without targeting those more needful of the resources. Workload is increased without showing any benefits.**
- **Pressure on increased appointments for screening well people means less time spent on the elderly and chronic sick.**
- **Doctors much more money oriented. Setting up clinics for financial reasons - not really to help patients.**
- **Only people to benefit are the GPs.**

General practitioners who commented considered that there was too much bureaucracy of doubtful benefit and this was an added burden on already overworked general practitioners.

- **Better:** Inclination to change plus audit; targets; formalising medical education plus visiting elderly. **Worse:** Time spent on various activities (three year checks, new patient checks constructed by someone else). Also administration. Frustration at being told what to do by people who have not done the job and are not qualified to. Lack of time for patients and for development. Unfair construction of target system and loss of faith in goodwill and desire to co-operate of the government.
- **Business-like attitude imposed - have to look at way practice is run. Changes too much too soon, most of the admin. falls to GPs.**
- **Target setting punitive to GPs. Policies may be publicly welcomed - many of doubtful scientific benefit e.g. three year checks, over 75 visiting. Legislation may have improved immunisation more effectively instead, but added burden on GPs.**
Inter-Professional Communication

Sixty three per cent (n=100) of all respondents reported no changes in concern about communication with other team members after the implementation of the New Contract. A similar percentage however, were more concerned than before about the differing expectations of other professional groups. Three quarters of all respondents were unconcerned, or less concerned, about professional isolation since the introduction of the New GP Contract, and non-work stressors were not reported to be causing increased pressure. In spite of this, 15% (n=11) of general practitioners commented on the lack of personal time available and the stress that this produced.

- Lack of time for personal relaxation.
- Lack of time to have a social life to be stressed about!
- Home life, leisure pursuits, have suffered due to less time and energy available

All respondents agreed that informal contact on a daily basis to discuss patients was a feature that was available and welcomed by doctors and nurses. Sixty three per cent (n= 59) of respondents reported that colleagues were ‘always’ happy to be contacted, and 36% (n = 33) said they were ‘usually’ happy to be contacted. Nevertheless, 78% (n=21) of district nurses reported that they had incurred 'wasted' visits to patients within the last three months because of a lack of current information from the general practitioner. Such visits could be in connection with admission to hospital of a patient that was being visited routinely, or failure to be notified about a death. Interestingly, 49% (n=35) of general practitioners made a similar complaint about lack of communication from district nurses, and 32% (n=23) reported unnecessary visits because of a lack of up-to-date information from the hospital service. As Hasler (1994) points out, good teamwork requires an awareness of colleagues' skills, roles and expectations and changes in attitude and behaviour. In the research project undertaken by Fullard et al. (1988), which was
reported in Chapter Two, this was found to be a by-product of the project. The involvement of nurse facilitators to work with, and advise practices in a preventive screening programme, also increased co-ordinated planning and co-operation within the practices.

*Practice Meetings*

There appeared to be a difference of opinion among respondents about how frequently practice meetings were held (Figure 7-4). Twenty-three per cent of respondents reported that practice meetings were held on a regular weekly basis and 46% of respondents said that this was a monthly event. When individual responses were compared by practice there was still no consensus of opinion.

*Figure 7-4 Reported frequency of practice meetings*

(Cross reference Table 1-33 in Appendix 1)

Fifty four per cent (n=38) of general practitioners reported that nursing staff were involved in arranging a suitable time for practice meetings, but 63% of the nurse respondents (n=60) reported that this was not the case. Similarly, 86% (n=62) of general practitioners reported that nursing staff were invited to practice meetings.
More than half of the nurse respondents agreed that they were always invited, although a quarter of practice nurses and a third of community nurses said they were never invited (Table 7-5).

Table 7-5 Nurses and practice meetings: Invitation and attendance

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>SOMETIMES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>PRACTICE NURSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>invited</td>
<td>65.5</td>
<td>19</td>
<td>10.3</td>
<td>5</td>
</tr>
<tr>
<td>attended</td>
<td>96.3</td>
<td>26</td>
<td>3.7</td>
<td>7</td>
</tr>
<tr>
<td>HEALTH VISITORS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>invited</td>
<td>50.0</td>
<td>17</td>
<td>11.8</td>
<td>4</td>
</tr>
<tr>
<td>attended</td>
<td>95.2</td>
<td>21</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>DISTRICT NURSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>invited</td>
<td>50.0</td>
<td>11</td>
<td>18.2</td>
<td>4</td>
</tr>
<tr>
<td>attended</td>
<td>70.0</td>
<td>19</td>
<td>0.0</td>
<td>0</td>
</tr>
</tbody>
</table>

The nurses were also asked if they attended practice meetings, and the majority of the nurse respondents reported that they did attend. It would appear from the responses that more of the nurses attended meetings than those who said that they were invited.

Content of Practice Meetings

General practitioners were asked if they invited nurses to take part in discussion of certain topics at meetings and the nurse respondents were asked whether they were, in fact, invited to do so. Eighty per cent of general practitioner respondents (n=58) reported that nurses were always invited to participate in all topic areas. The majority of the nurses (82%, n=79) agreed, and reported that they were invited to discuss patients, and innovations and improvements in the practice. Two thirds of the nurses reported that they were invited to attend meetings that
involved other professional groups, but more than half of the health visitors were not invited to meet with medical representatives.

Planning and Decision Making

Half of the practice nurse and health visitor respondents reported that they had no involvement at all in the planning and decision-making process about how work would be divided up within the practice, although two thirds of the district nurses did feel that they made a contribution to this. In respect of practice policy discussions and any decisions arising from these - of the nurse respondents, 73% of practice nurses reported that they were 'usually' or 'sometimes' involved in the discussion process, but over half (56%) were not involved in any decisions arising from these discussions. Two thirds (63%) of health visitors and district nurses reported that they were not involved in either of these processes.

Two thirds (60%) of practice nurse respondents reported involvement in discussions about practice development, but again, over half (53%) were not involved in the decision making process. Two thirds of district nurses and health visitors reported never discussing, or being involved in making decisions about, these issues. As would be expected, being self-employed and also as employers, over 90% of general practitioners reported that they were actively involved in discussions and decision making in all areas. Twelve per cent of general practitioners however, reported that they were not involved in the division of work within the practice.
**Practice and Community Nurses’ Views on an ‘Extended’ Role**

At the time the questionnaires were designed, the term ‘extended’ role was in more common usage than the more accepted ‘expanded’ role that is used at the present time. The nurses were asked whether they felt that their training and experience made them competent if asked to undertake an extended role, for example prescribing (Table 7-6). Although 97% (n=80) of all nurse respondents considered they required further training in certain areas, 78% (n=69) felt that undertaking extended roles was appropriate, and 73% (n=64) considered that such roles would not adversely affect relationships with other nursing colleagues.

**Table 7-6 Atitudes of nurses towards extended roles**

<table>
<thead>
<tr>
<th></th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>If asked to undertake an ‘extended role’ do you feel: your training/experience makes you competent to do so?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>38.7</td>
<td>61.3</td>
<td>53.1</td>
</tr>
<tr>
<td>n=</td>
<td>12</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>you require further training in certain areas?</td>
<td>97.0</td>
<td>3.0</td>
<td>97.0</td>
</tr>
<tr>
<td>n=</td>
<td>32</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>an ‘extended role’ is inappropriate?</td>
<td>12.9</td>
<td>87.1</td>
<td>28.1</td>
</tr>
<tr>
<td>n=</td>
<td>4</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>worried about professional accountability?</td>
<td>58.1</td>
<td>41.9</td>
<td>61.7</td>
</tr>
<tr>
<td>n=</td>
<td>18</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>such roles may adversely affect your relationships with other nursing colleagues?</td>
<td>32.3</td>
<td>67.7</td>
<td>37.5</td>
</tr>
<tr>
<td>n=</td>
<td>10</td>
<td>21</td>
<td>12</td>
</tr>
</tbody>
</table>

(Results expressed as percentages)

When the responses of the nurses were studied by job title it was found that a third of practice nurses reported feeling competent to undertake an extended role, but the nurses who reported that they did feel competent to do so were all practice employed. Only one practice employed nurse considered that she did not require
further training and over half of the practice nurse respondents expressed concern about their professional accountability. There was no significance however, between feelings of competence and a requirement for further training, or between competence and accountability.

Overall, 20% (n=19) of nurse respondents considered an extended role inappropriate, but there was no relationship between this and whether such a role would adversely affect relationships with other colleagues.

Health visitor respondents were fairly evenly divided about their competence to take on an extended role but, with one exception, also felt that they would require further training. Significantly more of those who thought they were already competent reported that they would require further training than those who did not consider themselves sufficiently skilled ($\chi^2=32.1$, df 4, p<0.001). There was a relationship between those who felt they were not competent to undertake an extended role and worries about accountability ($\chi^2=33.3$, df 4, p<0.001).

District nurses reported feeling more confident about their training and experience in relation to extended roles than their practice nurse and health visitor colleagues. District nurses who considered themselves competent to undertake an extended role were also less concerned about accountability ($\chi^2=5.2$, df 1, p<0.02).

**General Practitioners' Views on an Extended Role for Practice Nurses**

General practitioners were also asked about extended roles for nurses. They were specifically asked to consider these roles in respect of practice employed and
attached nurses (Table 7-7). Sixty one per cent of general practitioners felt that practice nurses were not competent to undertake an extended role at the present time and 95% felt that they would require further training to do so. General practitioners who thought that practice nurses were competent and those who thought they were not competent to undertake extended roles considered that they would require further training.

Table 7-7 Attitudes of general practitioners towards practice nurses undertaking extended roles

<table>
<thead>
<tr>
<th>If you asked a practice nurse to undertake an 'extended role' e.g. Prescribing:</th>
<th>YES</th>
<th>NO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel:</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>their training/experience makes them competent to do so?</td>
<td>39.1</td>
<td>25</td>
<td>60.9</td>
</tr>
<tr>
<td>they require further training in certain areas?</td>
<td>95.2</td>
<td>60</td>
<td>4.8</td>
</tr>
<tr>
<td>an 'extended role' is inappropriate for practice nurses?</td>
<td>15.4</td>
<td>10</td>
<td>84.6</td>
</tr>
<tr>
<td>worried about their professional accountability?</td>
<td>47.7</td>
<td>31</td>
<td>52.3</td>
</tr>
<tr>
<td>such roles may adversely affect their relationships with other nursing colleagues?</td>
<td>29.7</td>
<td>19</td>
<td>70.3</td>
</tr>
</tbody>
</table>

Only 15% (n = 10) of general practitioners felt that an extended role was inappropriate for practice nurses, and there was no relationship between the appropriateness of extended roles and accountability, training or relationships with other colleagues. Opinions were divided about accountability, 48% feeling worried about this issue and 52% having no concerns. Two thirds of general practitioners felt that relationships with other nursing colleagues would be unaffected by an extended role (Table 7-7).

**Nurse Prescribing**

The proposed nurse prescribing legislation was welcomed by all groups. Eighty two per cent of all respondents were happy that district nurses were to be included
in the Nurse Prescribing legislation and 72% were happy that health visitors were
to be included. Of the general practitioners, 75% (n=51) were happy about the
inclusion of district nurses and 64% (n=43) about health visitors (Table 7-8).

Table 7-8 Nurse prescribing legislation: Opinions of all respondents

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th></th>
<th>NO</th>
<th></th>
<th>NO OPINION</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>SHOULD BE INCLUDED:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurses</td>
<td>76.5</td>
<td>121</td>
<td>15.0</td>
<td>24</td>
<td>9.4</td>
<td>160</td>
</tr>
<tr>
<td>HAPPY THAT THEY ARE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCLUDED:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health visitors</td>
<td>71.5</td>
<td>113</td>
<td>13.3</td>
<td>21</td>
<td>15.2</td>
<td>158</td>
</tr>
<tr>
<td>District nurses</td>
<td>81.6</td>
<td>129</td>
<td>4.4</td>
<td>7</td>
<td>13.9</td>
<td>158</td>
</tr>
</tbody>
</table>

The other respondents were also asked if practice nurses should have been
incorporated in the legislation. Eighty two per cent of general practitioners
(n=56), 68% (n=23) of health visitors and 56% (n=14) of district nurses thought
that practice nurses should have been included.

Practice nurses also thought that they, as practice nurses, should have been part of
the prescribing legislation (85% n=28). There was no relationship however
between attitudes to this and their responses about competence and training
requirements. On examination of the attitudes of the combined responses from all
the nurses and general practitioners, there was no relationship between the
competence of practice nurses and whether they should be included in the
prescribing legislation, but there was a relationship between prescribing and the
requirement for further training ($x^2=90.5, df 6, p<0.001$).

As reported in Chapter Six, 60% of patients considered that practice nurses should
be able to prescribe for certain conditions, a higher level of support for nurse
prescribing than that reported for health visitors and district nurses.
'Over the Counter' Medicines

Ninety five per cent of district nurse and practice nurse respondents ‘regularly’ or ‘sometimes’ recommended products for patients to buy at the chemist. While a quarter of the health visitor respondents recommended products that patients should buy from the chemist, the majority never did (Figure 7-5).

Figure 7-5 How often do nurses recommend products to buy from the chemist?
(Cross reference Table 1-34 in Appendix 1)

![Bar chart showing recommendations for chemists](image)

General practitioners were asked whether practice nurses in their practices recommended products for patients to buy from the chemist. Ninety four per cent (n=62) of general practitioners reported that both practice employed and attached nurses did so ‘regularly’ or ‘sometimes’, only four general practitioners stating that they never did so.

Career Choice

All respondents were asked if they would recommend their chosen career as an interesting branch of the health professions. Eighty seven per cent (n=59) of general practitioners considered that they would, as did 91% (n=32) of health
visitor respondents. All the practice nurses (n=33) and district nurses who responded (n=25) said they would recommend their work as being interesting.

**Continuing Education for Nurses**

Ninety eight per cent (n=89) of nurses respondents had heard about 'PREP' (Post Registration Education and Practice Project) (UKCC 1992b; 1993) with the exception of two district nurses. All the nurses (n=91) who responded were happy to undertake continuing professional education, but 84% (n=76) felt that five days study leave every three years was inadequate. Eighty one per cent (n=73) of all nurses were willing to give up some of their free time to further their professional development and 67% (n=89) said they would be willing to pay some of the costs of continuing education themselves. Two thirds (n=17) of health visitors felt that PREP's proposals would affect them personally. Practice nurses and district nurses were more evenly divided in their opinions (Table 7-9).

Table 7-9 Continuing education for nurses: Consideration of some of PREP's proposals

<table>
<thead>
<tr>
<th></th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you happy to undertake continuing professional education?</td>
<td>100.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>n=</td>
<td>33</td>
<td>0</td>
<td>34</td>
</tr>
<tr>
<td>Do you feel that 5 days study leave every 3 years is adequate?</td>
<td>12.9</td>
<td>87.1</td>
<td>17.6</td>
</tr>
<tr>
<td>n=</td>
<td>4</td>
<td>27</td>
<td>6</td>
</tr>
<tr>
<td>Would you be willing to give up some free time to further your professional development?</td>
<td>84.8</td>
<td>15.2</td>
<td>79.4</td>
</tr>
<tr>
<td>n=</td>
<td>28</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>Would you be willing to pay some of the costs of continuing education yourself?</td>
<td>71.9</td>
<td>28.1</td>
<td>63.6</td>
</tr>
<tr>
<td>n=</td>
<td>23</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Do you feel it will affect you personally?</td>
<td>57.1</td>
<td>42.9</td>
<td>65.4</td>
</tr>
<tr>
<td>n=</td>
<td>16</td>
<td>12</td>
<td>17</td>
</tr>
</tbody>
</table>
General Practitioners' Attitudes to Continuing Professional Education for Practice-Employed Nurses

General practitioners in the 25 participating practices were also asked about continuing education for nurses, but they were asked to consider some of PREP's proposals specifically in terms of practice-employed nurses. This was in an attempt to gauge their views as employers of this particular group of nurses. Seventy two per cent of general practitioners (n=52) had not heard about PREP and, of the 28% who had, they were evenly divided about whether it would have any direct effects on them as general practitioners.

Provision of Access To In-Service Training for Nurses

The Views of Nurses

Ninety six per cent of the respondent nurses (n=92) reported having access to in-service training with the exception of two practice employed nurses. Such access consisted of attendance at conferences, professional meetings and courses.

Two thirds of the health visitors had attended between two and four events within the last year, as had nearly half of the district nurses and practice nurses. Several practice and community nurses had attended between five and ten events. (Figure 7-6). Overall, practice nurses had attended fewer events than their community nurse colleagues.
The Views of General Practitioners

General practitioners were asked if they provided in-service training for their practice employed nurses, and 88% reported that they did so. The majority (97%, n=65) of general practitioner respondents who employed a nurse felt that nurses should undertake continuing professional education and 86% (n=55) felt that five days study leave every three years was inadequate. Ninety seven per cent (n=64) of general practitioners reported that they would be willing to give their practice employed nurse time off to further their professional development and 89% (n=59) said that they would be willing to contribute to the costs of doing so.

The majority of practice nurse respondents however, reported that they had to attend any form of continuing education that they received in their own time. This was not the case for health visitors, but nearly half of the district nurses reported that they had to do so (Table 7-10).
Where payment was required for courses or conferences, five practice nurses paid themselves and eleven reported that the Health Board paid. Forty seven per cent (n=16) of practice nurses received payment from another source, such as sponsorship from a drug company. Practice employed nurses (53%, n=18) were more likely to pay for events themselves than attached nurses. Half the health visitor respondents paid themselves and half reported that the Health Board paid for them to attend. District nurses reported receiving payment from various sources. A third of district nurses said that they paid themselves, another third reported that the Health Board paid and the remaining third that they received funding from another source.

**Discussion**

This discussion includes an overview of the issues in comparison with other relevant data, particularly in relation to communication within the primary health care team.

**Response Rates**

The overall response rate to this questionnaire was 57% (168 out of 296 respondents) but, in order to preserve its anonymity, the questionnaire discussed
here was issued without reminders being sent out. The response rate was lower than the 85% response rate achieved by Atkin et al. (1993) in their survey of more than 12,000 practice nurses in England and Wales, and the 67% response rate reported by Ross and Bower (1992) in their study of practice nurses working in South West Thames Regional Health Authority.

It was similar however, to the 58% response rate reported in an earlier study by Greenfield et al. (1987) in their West Midlands questionnaire survey to practice nurses about social and occupational characteristics. A similar finding was also reported by Cockburn et al. (1988) where 52% (56 out of 108) of general practitioners consented to take part in a piece of observational research, which was designed to examine response bias in terms of attitudinal, demographic and general characteristics between participating and non-participating doctors. The authors pointed out that differences between health care professionals who consent to participate and those who do not, may distort the results of the research, particularly where response rates are low. In their conclusions the authors reported that there were in fact, no systematic differences in general characteristics or attitudes to patient care.

The 57% response rate in the present study is not so modest if one takes into account the general responses to inclusion in the workload part of the study. Twenty five out of 30 practices who declined to participate did so because they considered they would be too busy coping with the extra work involved with the introduction of the New GP Contract. Overall, two thirds of nurses responded and half of the general practitioners.
Demographic and Occupational Profile

All the practice nurse respondents were female as were the community nurses, with two exceptions, one male district nurse and one male health visitor. Only one third of general practitioners however, were reported to be female. Three quarters of the respondent nurses and general practitioners were between 30 and 49 years of age, the majority being in their early forties. The age profile of practice nurses who returned questionnaires was younger than that of the practice nurses who participated in the workload of the study. The former had an average age of forty years, but the workload participants were, on average, fifty years of age. The reason for the overall difference in age between the two groups of practice nurses was that the questionnaire included practice nurses who did not participate in the workload part of the study. A third of this particular group were in the younger age range, and had only worked as practice nurses since the year before the implementation of the New GP Contract. The age profile from the practice nurse respondents in this study is similar to that reported by Greenfield et al. (1987) and Atkin et al. (1993).

While most of the male general practitioners said that they worked full time, only a third of their female colleagues did so. In contrast to the community nurses, most of whom worked full-time, three quarters of the practice nurses reported that they worked part-time. Although practice nursing has traditionally been regarded as a part-time occupation, a proportion do work full-time and this number may be increasing. In 1987, Greenfield et al. (1987) reported that only 9% of practice nurses worked full-time, but by 1992, Atkin et al. (1993) were reporting a figure of 15 per cent, and in their survey Ross and Bower (1992) reported that 17% of practice nurses were working full-time.
Attitudes to the New GP Contract

All Respondents

All respondents had similar views on a number of issues both before and after the introduction of the New GP Contract. Prior to the implementation of the New GP Contract two thirds of respondents were unhappy about the content of the documents concerning Primary Care and the NHS, but this concern was most marked among general practitioners and health visitors. All participants particularly expressed concern about expectations of an increasing workload and quality of patient care.

A year after the implementation of the New GP Contract, while the morale of practice nurses, district nurses, community nurse managers, and other health professionals was considered to be unchanged, there were generally no reports of improved morale for any members of the primary care. Indeed, the morale of general practitioners was reported to have got worse, both self-reported and reported to have done so by nurse respondents. In addition, over 90% of all respondents reported being more concerned about adequacy of resources in the future.

Views Of Practice Nurses

The practice nurses, like the general practitioners, expressed the greatest concern about their workload increasing prior to the implementation of New GP Contract. The nurses related this concern about workload to the need to achieve certain targets that had to be met in terms of health promotion and screening procedures. Along with this were worries that their present training and experience may prove
inadequate, and almost half had increasing concerns about their accountability. Like their other nursing colleagues they had concerns about the level of support from nursing management.

Worries about an increasing workload persisted a year after the New GP Contract was introduced, and the majority of practice nurses reported that their workload had actually increased as they expected. They were increasingly involved in screening and running clinics, and reported an expansion in patient referrals generally. Over half of the practice nurses expressed concern about the demands and pressures from patients. They also noted that administration was very time-consuming.

After the introduction of the New Contract practice nurses were less concerned than some of their other nurse and doctor colleagues about loss of professional independence and changes in their role. They were also less worried than before about quality of patient care. Although their morale had not improved, half of the practice nurses reported that their morale was unchanged by the Contract, a similar view to that of the district nurses. While other respondents reported that some NHS changes had made their morale worse, two thirds of practice nurses reported that their morale had not been affected. Three nurses reported that their morale had improved - all practice employed, and four nurses reported it had got worse - all attached nurses. These seven nurses all worked in the same three practices. In general, the practice nurses were the most positive of all respondents about the changes brought about by the New GP Contract.
Views of Health Visitors

Health visitors reported that the changes taking place in the structure of the NHS left them feeling particularly vulnerable. In comparison with the general practitioners, they were concerned about their job definition, that their role would change as a result of the New GP Contract and that they would lose professional independence. These worries had reportedly increased a year later. In addition, more than all the other respondents, the health visitors reported feeling increasingly undervalued, and two thirds of them reported being more concerned than before about the support they received from nursing management. This insecurity mentioned by the health visitors is illustrated by a number of authors. Wiles and Robison (1994), Hasler (1994), Baggaley and Bryans (1995) describe the feelings expressed by health visitors that the work that they do is not valued, acknowledged or understood by others in the primary health care team.

Cubbin et al. (1990) in their overview of the implications of the New GP Contract, describe their concern about possible changes in working practices particularly in relation to target payments. Cubbin et al., Wiles and Robison, and Hasler, report the fear that some health visitors have, that practice nurses may take over their role in health promotion and home visiting. It was reported in the Health Visitors' Questionnaire that the amount of time spent on home visits was reduced, with correspondingly less time to spend with elderly patients. Cubbin et al. also describe time constraints affecting these tasks and consider this is due in part to inadequate staffing levels.

Clinics had a greater priority than before and increasingly, time was being spent on administration. Several respondents pointed out that changes in the way child immunisation was being organised meant that parents of young children who
would previously have chosen to attend a local clinic, now had to travel to a
doctor’s surgery, often at a cost they could ill afford. Cubbin et al. were concerned
that general practitioners would take over child surveillance because of the
financial incentives of immunisation programmes. This it was feared would
‘medicalise’ the service at present offered by health visitors. Health visiting
includes an overall view of a family’s health as part of child surveillance, and does
not focus only on the mechanics of the test. Similarly, Wiles and Robison (1994)
describe the conflict between health visitors and general practitioners in their
different approaches to patient care. They report that health visitors considered
that patient care was compromised as a result of too strong adherence to the
medical model of working.

Two thirds of the health visitors reported that their morale had deteriorated since
the implementation of the New GP Contract and other recent NHS changes had
taken place, and the other respondents supported this view of the health visitors’
morale. Two thirds of health visitors were concerned about the control and
direction of their professional work and half of them reported concern about lack
of training and experience in certain areas. Despite this, health visitors were less
concerned about accountability than their district nurse and practice nurse
colleagues. Baggaley and Bryans (1995) suggest that, if health visitors try to make
their skills and professional judgement visible and explicit, and demonstrate
achieved outcomes, they could convince others of their worth, and enhance
accountability.

Notwithstanding, the one positive feature of the New GP Contract commented on
by health visitor respondents in the study, was that of better monitoring of target
groups of the population. In contrast to the increasing concern of the other
respondents, the health visitors were unconcerned or less concerned about demands and pressures from clients after the new GP Contract was introduced.

**Views of District Nurses**

Prior to the introduction of the New Contract, district nurses in the study were most concerned about role overlap and their role changing, along with a loss of professional independence. They were particularly concerned that practice nurses would become involved in home visiting of elderly patients for 'over 75 check-ups'. The district nurses described this as a pointless exercise in situations where some of these elderly patients were already being visited by the district nursing service.

Following the introduction of the New GP Contract district nurses reported that their expectations of an increasing workload had fallen and that there had been no actual change overall. They were much less worried about the loss of professional independence and slightly less anxious about overlap of roles. Nevertheless, they were concerned about their role changing, and were slightly more apprehensive about the quality of patient care and adequacy of resources. Although there was a slight increase in the visiting of elderly patients, the district nurses reported that this was to undertake treatments previously done by the practice nurses, who were now doing more health screening procedures, including 'over 75' check-ups.

Unlike the general practitioners and health visitors, two thirds of district nurses described their morale as unchanged as a result of the New GP Contract, although other changes in the NHS had generally affected their morale. The NHS and Community Care Act (DoH 1990c) implemented in 1993, has resulted in a
blurring of the boundaries between ‘social’ and ‘health’ care. The consequence of this has been that district nurses have withdrawn somewhat from the social aspects of care to concentrate on the illness episodes of long term care of elderly patients (Lock, 1995).

Over half of the district nurse respondents were more concerned than before about accountability, although they were slightly less concerned about lack of training and experience in certain areas than their other nursing colleagues. While general practitioners and health visitors had become more concerned about the control and direction they had over their professional work, this was relatively unchanged for the district nurses. In their study of teamwork, Wiles and Robison (1994) report that district nurses had more control over their working situation than the practice nurses, and they felt more willing to challenge the general practitioners. In the Practice Nurse Study, unlike their health visitor colleagues, district nurses did not feel undervalued, although two thirds of them were unhappy about the level of support they received from nursing management.

District nurses did not feel that the New GP Contract had resulted in improvements in any areas. They were particularly critical of what they described as ‘unnecessary’ screening procedures, which they saw as a waste of finite resources and a means of generating extra income for general practitioners. It is interesting that informal communication between doctors and nurses is described by over 90% of all respondents as a welcome and available feature in the day-to-day running of general practice. Despite this, the district nurses reported a lack of communication between themselves and the general practitioners in relation to ‘wasted’ home visits because of a lack of current information about patients.
Views of General Practitioners

Prior to the introduction of the New GP Contract a number of general practitioners had concerns about increased patient expectations, a loss of professional independence as general practitioners and the possibility that their role may change. One year after its introduction general practitioners reported that they were working longer hours and had less time for personal relaxation. Fears about an increasing workload continued to escalate and all the respondent general practitioners reported that their workload had actually increased. This was reported to be mainly in the areas of elderly patient visiting and screening of subgroups of the practice population. In contrast, general practitioners also reported having less time to spend with patients because of an increase in administration time. A number of them commented on the amount of bureaucracy entailed. Loss of professional independence was a continuing concern, as was a worry that their role was changing. In addition, general practitioners reported increasing uneasiness about quality of patient care.

Nearly 70% of general practitioners reported that their morale had got worse since the implementation of the New GP Contract and other recent NHS changes had taken place. Three quarters of all respondents agreed with general practitioners that their morale had indeed been affected. General practitioners had also become more concerned about the control and direction they had over their professional work. In spite of that, less than half of the general practitioner respondents were concerned about their levels of training or experience, and they were equally divided in their concerns about professional accountability.

When specifically asked about potentially unnecessary home visits, almost half of the general practitioners reported having made unnecessary visits to patients
because of a lack of communication from district nursing staff, and a third of general practitioners reported a similar occurrence because of a lack of up-to-date information from the hospital service.

**The Primary Health Care Team**

*Practice Meetings*

Practice meetings were reported to take place by most respondents either weekly or monthly, although a third of district nurses reported that they never took place at all. Two thirds of nurse respondents reported that they were not involved in deciding when meetings took place and a third said that they were never invited to attend. This was particularly the experience of health visitors. This contrasted with what was reported by the general practitioners, half of them stating that nurses were involved in deciding when meetings took place, and 90% reporting that nurses were 'always' or, at least 'sometimes', invited to attend. Nurses who were invited to practice meetings said that they did attend. Most of the discussion at practice meetings was reported to be about patients or proposed innovations and improvements in the running of the practice, and nurses and doctors were all actively involved in this. Butterworth (1994) suggests that participation by nurses in case conferences could stimulate discussion about practice activity and enrich professional practice.

*Workload and Working Patterns*

As independent contractors, the general practitioners were more likely than the nurses to be involved in policy decisions concerning the practice. District nurses felt that they played an active part in planning and decision making about division of work, but this was not so for the health visitors and practice nurses. In general,
the community nurses felt more excluded from practice development and policy issues than their practice nurse colleagues, while most general practitioners reported an active involvement in all planning and decision making areas. Howkins (1995) suggests that common goals are an essential prerequisite of good meetings and that nurses need to feel more confident that they are expert in their field. There is a tendency among them to retreat from collaborative work. A successful outcome she suggests, depends on the level of mutual respect and sharing.

Perhaps the feelings of isolation from the team reported by the community nurses in this study are due in part to having a different employer, and the attitude of the general practitioners towards them because of this. Practice nurses who were employees of the general practitioners felt more secure in their relationships within the team. It would seem that general practitioners identify more strongly with the more practical role of the practice nurse and the district nurse.

Over a quarter of health visitor and practice nurse respondents, and a third of general practitioners and district nurses were ambivalent about the nursing component of health visiting. There may be a number of reasons for this difference in views. Historically, Florence Nightingale did not consider health visitors to be nurses, rather that they were family visitors who acted as health teachers and counsellors (Buttigieg 1995). Until 1962, health visitors were not required to be nurses, although the majority by that time were not only qualified nurses, but were expected to have hospital and midwifery experience (Wilkie 1984). The proactive, preventive nature of health visiting has often been misunderstood by other health professionals whose work has, until recently, been more disease oriented and of a practical, ‘hands on’ nature. As Buttigieg (1995)
suggests however, the prime function of health visiting remains that of family visiting and education, including the education of others (particularly women), and to empower families to achieve a healthy lifestyle.

The results of the questionnaires emphasise the more clinical aspect of the role of general practitioners, district nurses and practice nurses, a role which is perhaps more easily understood. Health visitors in this study did not see themselves as having a ‘hands on’ role. Over twenty years ago Gilmore et al. (1974) were reporting that difficulties in relationships, particularly between health visitors and general practitioners, were connected with the doctors’ misunderstanding about the function of the health visiting role. General practitioners responded to this by stating that the health visiting role was too general and ill-defined, whereas the work of the district nurse was clearly defined and ‘lightened the work-load of doctors considerably’ (p.85). This again raises the issue of the more clinical aspects of the district nurse and practice nurse workload. Perhaps doctors understand the work of these nurses better, because there is more delegation involved in certain aspects of the role. The work of health visitors is focused on health education, a more nebulous area and less controlled by doctors, and they also work more autonomously.

Cumberlege (DHSS 1986a) raised issues about collaboration. She cited the power and gender differences between male general practitioners and female nurses, and the conflict between professionals and health service managers. In their study Wiles and Robison (1994) report that district nurses found general practitioners unapproachable, and both district nurses and health visitors expressed concerns about general practitioner fundholding and the employment of practice nurses eroding their role. A vast literature exists on the reality or otherwise of teamwork
and writers including McClure (1984) and Bond et al. (1985) have reported low levels of collaboration and consensus about roles.

The majority of general practitioners reported that they undertook all the items of service listed in the questionnaire. To a lesser extent this was also the case for health visitors and practice nurses. Few health visitors however, reported that they immunised children. Both general practitioners and practice nurses considered it to be their responsibility to undertake child immunisation, but the majority of district nurses and health visitors did not think it should be part of their work. Indeed, half of the health visitors thought immunisation should be undertaken by the general practitioner.

While the clinical activity of the taking of cervical smears was considered by general practitioners and practice nurses to be part of their work, there was some role overlap in regard to whom should give contraceptive advice. General practitioners, practice nurses and health visitors all felt that this was part of their role. This was the case for less than half of the district nurses, who were not involved with items of service relating to pregnancy, childbirth and child immunisation.

District nurses were however, like their health visitor colleagues, engaged in screening of elderly patients because of their involvement in the home with this client group. More than half of the practice nurses too, undertook screening of the ‘over 75’ age group and thought that it should be part of the work of the practice nurse. Atkin et al. (1993) and McBeath (1994) also report similar figures in respect of screening of the elderly population by practice nurses.
Practice nurses and district nurses considered that they should be responsible for giving influenza vaccinations, a view supported by the health visitors and general practitioners. Again, access to the services of these nurses, both in the practice itself and in the home, make this a sensible and practical judgement. Health visitors however, although involved with the elderly population, did not see this as their responsibility.

It would appear that there is a degree of role overlap in service provision, but the study did not allow for exploration of the knowledge and skills used to perform the tasks described, nor did it examine outcome measures. In terms of health promotion, district nurses have a broad goal of promoting health (Hyde 1995) but they have a unique function of providing care to ill people in their own homes. Health visiting, while having its roots in public health, has the unique function of providing contact for vulnerable groups and individuals in society. Practice nurses on the other hand, unlike their community nurse colleagues, furnish direct access to the practice population on the practice premises, thus providing continuity and stability for patients who come to know them.

The nurses and general practitioners who responded to this questionnaire may not be typical in their views of workload, but they have provided data on workload within primary care at the time of the New Contract, some of which is consistent with that reported by several authors around the same period (Georgian Research Society 1991; Ross and Bower 1992; Atkin et al. 1993; Wiles and Robison 1994; Hibble 1995).
Extended Roles and Continuing Education

Respondents were asked to consider extended roles in the context of related issues, such as the requirement for further training, and on-going professional education. Respondents were given the example of prescribing as an extended role, because of the particular interest in the proposed nurse prescribing legislation at the time.

Practice nurses and district nurses reported that they were more inclined to recommend items for patients to buy from the chemist than their health visitor colleagues. At the time this questionnaire was completed practice nurses were not included in the nurse prescribing legislation, but more general practitioners thought practice nurses should be able to prescribe than those who thought health visitors and district nurses should be included. In fact, While and Rees (1993) reported from their questionnaire survey that district nurses looked forward to being included in the prescribing legislation, but health visitors were much less enthusiastic.

Community nurses were generally more confident than their practice nurse colleagues about extended roles, although all nurse respondents considered that they would require further training in certain areas. In respect of practice nurses, general practitioners also had reservations about their inability to take on extended roles, and considered further training would be necessary. They did not however, consider such roles to be inappropriate and there is evidence that general practitioners are now more accepting of the development of the role of practice nurses (The Georgian Research Society 1991; Robinson et al. 1993). The need for training expressed by practice nurses themselves is supported by the work of Ross and Bower (1992); Atkin et al. (1993); Peter (1993); Ross et al. (1994); McBeath (1994). The Cumberlege Review (DHSS 1986a) and Damant (1990) among
others, drew attention to the lack of training for practice nurses, and recent studies of practice nurse workload have also reported a need for further training for practice nurses (Hibble 1995; Jeffreys et al. 1995).

In consideration of PREP's proposals, all the nurse respondents expressed willingness to undertake continuing professional development, although they felt that the proposed study leave was inadequate. A significant number were also prepared to use their free time and to pay for the costs of furthering their professional development themselves. In spite of this, the nurses were somewhat ambivalent about whether the proposals, which were effectively designed to meet both patient and service needs, would affect them personally. Ashworth and Morrison (1994), Baggaley and Bryans (1994), Howkins (1995), and Ross and Mackenzie (1996), draw attention to the continuing debate about a lack of overall clarity about the standards. The move towards advanced and specialist nursing practice (NHSME 1995) has been described as confusing and threatening by some nurses and such changes can be seen as both an opportunity and a threat. There is no doubt however, that the requirement for nurses to maintain and update their skills is a positive feature.

Only five nurse respondents had not attended any form of in-service training events within the last year, two health visitors, two district nurses and one practice-employed nurse. Over half of all nurse respondents attended between two and four events, and a few as many as ten events. More district nurses than health visitors reported having to attend events in their own time, but for both groups payment came from different sources.
Half of the health visitors paid for events themselves, but this may be related to the relatively high number of events that they attended compared to the other nurse respondents. A third of district nurses reported receiving payment from drug companies, which may imply easier access to drug representatives within the practice because of the more clinical component of their work. Health visitors had noted earlier that they were never invited to meetings with drug representatives.

General practitioners were very positive about their employed practice nurses undertaking continuing professional education and over 90% of them said that they were prepared to contribute to the cost and give the nurses time off to attend courses or conferences. This contrasts with the reported experiences of the practice nurses themselves, the majority of whom said that they had to attend events in their own time and at their own, or a drug company's, expense. At the time that this study was undertaken, much of practice nurse education was of an informal nature and organised by the nurses themselves. Many of these events were organised for evenings after work, and may account for the level of reported attendance in their own time.

In conclusion, the modest number of respondents and the difficulty in interpreting levels of agreement and disagreement about each others roles does not detract from the issues that have been presented. There may be a blurring of boundaries between the roles of general practitioners and community and practice nurses, and these boundaries are constantly shifting as a result of economic and employment pressures. Many nurses are anxious to expand their roles with the guidance of the Scope of Professional Practice (UKCC 1992b), and many are already taking on roles previously carried out by doctors. Providing that protocols and guidelines are discussed and laid down in advance, general practitioners and nurses should feel
mutually reassured that procedures undertaken are in the best interests of the patient, in order to provide holistic care.

In the final chapter, the discussion reviews the overall content of the study, reflecting on the interrelationship between theory, research and practice in respect of practice nursing. The differences in working patterns between practice employed and attached nurses are examined in terms of traditional and more expanded roles, as are the attitudes of nurses themselves towards innovation and change and the status quo. In addition, the discussion focuses on the way forward for practice nursing and offers indications for future research in this area.
Chapter Eight

*PRACTICE NURSING: CHANGE, CHALLENGE AND OPPORTUNITY*

*Forward, forward let us range,*
*Let the great world spin for ever down the ringing grooves of change.*

'Locksley Hall'. Alfred, Lord Tennyson (1809-1892)

**Reflections on the Purpose of the Research**

At the outset I explained that the initial motivation for this piece of research was to examine the workload and working patterns of practice nurses who obtained their employment from two different sources, namely the Health Board and the general practitioner. Personal experience in practice nursing, and discussions with other practice nurses and general practitioners, led me to believe that practice nurses with different employers appeared to have different working patterns.

Within the role itself, a number of elements were of particular interest to me. Namely, traditional and more innovative ways of working, the number and nature of interruptions before and during nurse-patient consultations, and the present state and future needs of education and training. The implications for practice nursing of the introduction of the New GP Contract in 1990 (DoH 1989a) provided the stimulus to investigate these, and other issues, further.
Much has changed between 1990 and the present time. Interest in practice nursing has resulted in a proliferation of surveys since its profile was raised by the New Contract and its requirement that, among other things, priority be given to preventive health care. Nevertheless, when I first examined the literature on practice nursing prior to the introduction of the New Contract, I found that studies were mainly locally based (MacGregor et al. 1971; McIntosh and Richardson 1976; Waters et al. 1980; Greenfield et al. 1987; Fallon et al. 1988; Cater and Hawthorn 1988) or, if national, were fairly out-of-date (Reedy et al. 1976; Bowling 1981). Furthermore, many of the early studies into the work of practice nurses were undertaken by doctors, and focused on delegation of tasks.

**Understanding Practice Nursing: Some Answers and Some Questions**

The data in this study bear out some of the findings from previous studies of practice nurses, and introduce several themes that do not appear to have been previously raised in the literature on practice nursing. In this chapter I will discuss several of these issues in the context of the developing role of practice nurses. Namely, traditional and more innovative modes of practice, issues surrounding professional control, stability and change, and education and training for an expanded role in practice nursing.

**Tradition and Innovation**

It would appear that there is no single type of practice nurse, although several inter-related models of practice nursing emerged during the course of the study. Structural and organisational factors appeared to be linked to ways of working,
because attached nursing staff were generally less autonomous and more task oriented than their practice employed colleagues. The emergence of different skill mixes seemed to be more associated with managerial control over the way the nurses worked, rather than the skills and experience of individual nurses and their desire to be innovative or maintain the status quo. The attitudes however, of some practice employed nurses to part-time, irregular working patterns, resulted to some extent, in a more task-based approach to their work.

It would appear that the New GP Contract has strengthened the position of practice employed nurses whilst the future of traditional community nursing remains uncertain. In Scotland, between 1990 and 1996, according to NHSME manpower statistics, numbers of general practitioners have increased by 4%, but health visitors have decreased by 5% and district nurses by 1%. In contrast, the percentage increase of practice nurses has been greater than that of any other members of the team (39% WTE). It is unlikely however, that these levels of practice nurse recruitment will be sustained. Indeed, in many parts of the United Kingdom, general practitioners have experienced problems in practice nurse recruitment and retention (Hallows 1992), and levels are below that recommended of 0.25 WTE per 1000 patients (approximately nine hours practice nursing per 1000 patients).

The distinction between traditional and more innovative roles in practice nursing was exacerbated by the requirements of the New GP Contract. Practice nurses in the Practice Nurse Study who were general practitioner employees felt more secure in their working relationships, and it was also found that general practitioners identified more strongly with their role.
Practice employed nurses were working in an increasingly innovative way. They had longer consultations than their attached colleagues and undertook more screening, health promotion and disease management, and spent more time listening to patients and giving advice. They also managed and discharged more patients without reference to a doctor. A number of authors have challenged the view that practice nurses have autonomy in developing expanded roles (among them, Robinson 1990; The Georgian Research Society 1991), and contend that their control over independent practice is variable. It is clear from the Practice Nurse Study that practice employed nurses exercised greater clinical freedom and had less direct monitoring of their work.

In general, the attached nurses appeared to be working less to an holistic model and more towards a traditional model, undertaking more task-centred, delegated treatment room work from the general practitioner. They also had a faster style of working than their practice employed colleagues, and it is possible that nurses who have shorter consultations miss, or choose to ignore, ‘cues’ from the patient about underlying psycho-social problems or anxieties about illness.

Attached nurses are sometimes called ‘treatment room’ nurses, and for those nurses undertaking ‘core’ tasks such as venepuncture, dressings, blood pressure and ear syringing, this would seem to differentiate them from nurses whose role has developed beyond treatment room tasks alone. Division of work in this way also allows nurses to be delegated tasks that should match their training and experience. It can have the disadvantage however, that nurses may experience less control over their work and a lack of job satisfaction. The title ‘treatment room nurse’ is in itself restrictive. From a systems perspective, it conveys an expectation
of a static, closed role, rather than one of openness and interaction which is more in keeping with the flexible boundaries of a holistic approach.

Although the numbers were small, it was reported in the study that attached nurses were slightly younger on average than their practice employed colleagues. In this instance, being younger did not necessarily equate with being more innovative. There is no intention in this discourse however, to imply that attached nurses working in so-called traditional roles in general practice are any less caring than their practice employed colleagues, or that they are any less competent to take on an expanded role. It is more likely to reflect a degree of independent working not permitted to attached nurses.

The nurses who were general practitioner employees perceived that they had greater opportunities to practise more holistic care and to develop clinical practice along more innovative lines. These additional skills for example, included new registration screening, and the management of patients with diabetes, respiratory, metabolic and endocrine disease. Autonomous practice is synonymous with freedom to exercise professional judgement (Mitchinson 1996), and this was discussed earlier in Chapter Three. Autonomy in their working practice was felt by the attached nurses to be denied to them because of the strict guidelines within which they worked. This has some similarity with the findings of Bowling (1985b) and Martin (1990), who pointed out that general practitioners employed practice nurses to undertake the type of work that attached staff might be unable to perform, thus avoiding the need to negotiate with nurse management.

A major problem in terms of practice employment or Health Board attachment remains the revenue that practice employed nurses generate for the average
surgery in terms of General Medical Services payments. Kmietowicz (1996) reports that a practice nurse brings in for the average surgery an income of around £22,000 per annum. General practitioners may be reluctant to accept attached nurses who undertake task-oriented work, when practice employed nurses can use time more ‘profitably’ on items of service which attract payments. In the Practice Nurse Study, the practice employed nurses undertook more of these items of service than their attached colleagues, for example, immunisation, contraceptive advice, and screening procedures, such as taking cervical smears.

Redfern and Norman (1990) suggest that politically, task allocation is economical, measurable, and thus considered efficient. They also argue that, while cost-effectiveness is particularly important for Health Boards and Health Authorities, quantitative process measures of tasks give no indication of quality of care. Redfern and Norman propose that without this information, data on costs may be used to justify reducing the quality of care to patients. On the other hand, purchasers such as general practitioners (with the assistance of 70% reimbursement) can buy the services of nurses with a range of technical skills.

Another issue was raised by some of the attached nurses in the study, that of feelings of isolation from the practice team, particularly in relation to their contacts with doctors and reception staff. This isolation they described as resulting from not being a practice employee, and from the restrictions imposed on their activities by community nursing management. Isolation has been identified as a problem for practice employed nurses, but within a different context (Reedy et al. 1980a; Martin 1987). In this case it was described as being due to not having links with social and professional networks. In consideration of the hierarchical relationships between attached nurses and their community nurse managers, it
would appear that part of the problem lies in the changing nature of the role itself within primary care. Nurses attached to practices have traditionally been employed to undertake delegated treatment room tasks, and role confusion has been exacerbated by the demands of the New GP Contract.

Community nurse managers are usually physically removed from the nurse attachments and are unable to monitor directly, or provide supervision for, the role that attached nurses could play in the delivery of services involving an expanded role. This does not imply that attached nurses have the same clinical freedom as their practice employed colleagues. Rather, I suggest that professional control is tighter for attached nurses, and their work more circumscribed and task-oriented because community nurse managers have less opportunity to supervise or develop their activities.

Nurse managers might also have concerns that, if attached nurses expand their role, general practitioners could expect the nurses to undertake activities involving items of service payment. General practitioners would then, not only have the services of the nurses, but also receive payment for work performed by the nurses, such as cervical smears and immunisations.

It is difficult for community nurse managers to be conversant with the range of services offered by individual practices. In addition, many nurse managers do not have a background in practice nursing. In response to this difficulty however, practice nurse advisers are gradually being introduced, and there are, at present, two such posts in Scotland. These advisers are Health Board employed and provide support for practice employed and attached nurses making the transition from secondary to primary care, as well as supplying on-going support for more
established practice nurses. They also act as facilitators for courses of education and training. The advantage of having this service is that, through liaison with the nurses and general practitioners, relevant education and training packages can be developed to meet the needs of individual nurses and practices. There might be a problem however, in terms of monitoring and control of practice nurses. Health Board policy could influence the practice nurse adviser role, and this, in turn, could affect the work of practice nurses and general practitioners.

Attached nurses in the study who worked as the sole nurse in a practice were more positive about their relationships within the team. They were reportedly more involved in informal direct contact with general practitioners and other colleagues, and observed that information and knowledge were freely shared. This they considered to be of direct benefit to patient management and care.

It was a finding in the study that where general practitioner employed nurses worked for only a few hours a week organisational issues appeared to have implications for practice. These nurses, like their attached colleagues, were also identified as working in a more traditional, less innovative way. The nurses reported that they were happy to undertake task-oriented work delegated by the general practitioner, because this avoided independent decision making. The nurses identified the need to prioritise and, particularly if they had dependent children, reported that it was necessary to contain their practice within their capabilities and the demands of domestic issues.

Atkin et al. (1993) report that some nurses with family commitments and who, of necessity, work irregular hours, report a lack confidence in their knowledge base. In addition, Robinson (1992) argues that existing inequalities between men and
women in the Health Service are exacerbated by a lack of opportunity or encouragement for part-time workers with domestic responsibilities, to embark on further studies or courses.

All these circumstances may contribute to a reluctance to change and feelings of being threatened by the introduction of innovations. Unless practice nurses who work irregular hours actively seek to break down these barriers, there is a possibility that they may become stranded in repetitive working patterns. Furthermore, nurses who work short, irregular hours may experience a greater lack of status and less control over their work because of their more peripheral involvement in the day-to-day working of the practice.

It can be seen therefore, that traditional and more innovative ways of working were linked with greater or lesser degrees of autonomy. These, in turn, were linked with professional control, working relationships and a feeling of membership within the primary health care team. The four main groupings identified are summarised in the Table 8-1 below.

Table 8-1 Models of practice nursing identified in the Practice Nurse Study

<table>
<thead>
<tr>
<th>NATURE OF EMPLOYMENT</th>
<th>WORKING STYLE AND RELATIONSHIPS WITHIN THE PHCT</th>
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<tr>
<td>GROUP 1: Practice employed. Part-time, regular or irregular part-time hours.</td>
<td>Innovative style.</td>
</tr>
<tr>
<td></td>
<td>Perceived autonomy.</td>
</tr>
<tr>
<td></td>
<td>Feels secure in working relationships.</td>
</tr>
<tr>
<td>GROUP 2: Practice employed. Part-time, irregular hours.</td>
<td>Traditional style.</td>
</tr>
<tr>
<td></td>
<td>Lack of autonomy.</td>
</tr>
<tr>
<td></td>
<td>Feels less secure in working relationships.</td>
</tr>
<tr>
<td>GROUP 3: HB Attached. Full-time or regular part-time hours. Works with other practice-employed and/or attached nurses.</td>
<td>Traditional style.</td>
</tr>
<tr>
<td></td>
<td>Limited autonomy</td>
</tr>
<tr>
<td></td>
<td>Feels less secure in working relationships.</td>
</tr>
<tr>
<td>GROUP 4: HB Attached. Full-time or regular part-time hours.</td>
<td>Mix of traditional/innovative style.</td>
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<td></td>
<td>Relative autonomy within limits set by HB and GP.</td>
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<td></td>
<td>Feels secure in working relationships because sole nurse in practice.</td>
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</table>
It was considered that practice employed nurses who worked regular hours, whether full-time or part-time, were generally more secure in their working relationships with general practitioners. They were able to define their own role and parameters of practice within the limits of their education and training, and the needs of the practice population. Practice employed nurses who worked irregular part-time hours were less secure in their relationships within the primary health care team and were more likely to be working in general practice because the limited commitment provided some financial recompense and fitted in with domestic responsibilities.

Attached nurses who had less opportunity to expand their role tended to exhibit a more traditional, task oriented approach and felt less assured of their place within the team. The exception to this were attached nurses who worked as the sole practice nurse in a practice. These nurses exhibited characteristics more in line with the nurses in Group 1.

Some nurses do not want to be innovative in the way they work, and this bears some comparison with the views of Hunt (1974) and Norman (1985), described in Chapter Three. In consideration of ‘experts’ and ‘non-experts’ they emphasised the importance of skilled performance, which requires a sound knowledge base, reflection, and the ability to cope with new and different stimuli. ‘Non-experts’ on the other hand, have difficulty in coping with new problems because they find it difficult to anticipate, and tend to work backwards from the problem. These approaches have some similarity with traditional and innovative modes of nursing practice, in that some nurses will wish to attain levels of education and skill that others will not.
The present PREP (Post Registration Education and Practice) requirements for professional development, however, involve keeping up to date in order to be safe to practise. This puts the onus on nurses who work irregular hours to pursue professional development, both through regular reflection and recording of what they have learned on a day-to-day basis, and to seek out professional advice and guidance from community nurse managers, and support from general practitioner employers.

It is interesting that general practitioners do not at the present time have to undertake any portfolio learning. Continuing medical education is vocational and qualifies for a postgraduate education allowance if the particular learning programme is recognised by the SCPMDE (Scottish Council for Postgraduate Medical and Dental Education). This similarly applies in England and Wales and Northern Ireland. During 1997/98, a pilot scheme is being undertaken in England linking continuing medical education for general practitioners to personal education plans (SODoH 1997). It is proposed that this will be reviewed with particular reference to rural practice.

The essence of good teamwork is communication and mutual respect and understanding of each others roles to make the ‘team’ approach sustainable. Salisbury (1991), a general practitioner, raises this issue and criticises the restrictive nature of professionals working for different organisations, all trying to achieve good quality patient care. His views highlight the problems of different employment structures.
When teamwork has been achieved, this has usually been due to like-minded individuals working together in spite of, rather than because of, the organisational arrangements. To expect teamwork to flourish was perhaps a naive and impossible ideal, given the disparate nature of our employment, with different professionals working for different employers, and often towards different ends, with little scope for negotiation.

More recently, Hale and Hampson (1995) take a more confident stance and suggest that effective negotiation between Health Board and general practice can maximise the effectiveness of primary health care professionals at all levels. They argue that developing a positive two-way communication process is essential to improve practice.

**Summary**

It is possible that the current emphasis on primary care provision may provide an incentive to attach practice nurses to primary care. If there is less emphasis on task-oriented working patterns and an increased focus on the skills and expertise the attached nurse can bring to an expanded role, numbers of attached practice nurses may increase once more. Community Trusts (in England) and Primary Care Trusts (in Scotland) may recruit attached nurses as a possible manpower solution in areas of shortage of practice employed nurses.

Since the completion of the present study, there have been several experiments with expanded roles in practice nursing. Where before, the practice nurse herself may have lacked the power to initiate change, the New GP Contract has provided opportunities to implement work practices previously denied to her. Some recent developments include nurse telephone triage of ‘same day’ appointments (Marsh and Dawes 1995), nurse managed primary care centres (Newland and Rich

There is also increasing potential for nurse-led initiatives with contracts based on practices not just with general practitioners. One such development includes a recent proposition to run an agency of self-employed practice nurses which has been submitted as a Primary Care Act (1997) project proposal. Under the scheme, nurses would directly sell packages of care to local practices. An annual payment could provide a set number of clinical hours, sickness and maternity cover and appropriate updates to training (Nursing Standard 1997). A disadvantage of the pilot schemes would appear to be that they require approval under the name of a doctor or an NHS trust, and that nurses do not have equal status as applicants. It is not clear from the article what constitutes the ‘packages of care’ to be provided, but there is a danger that, like the attached nurses in the Practice Nurse Study, the nurses will be constrained into providing task-based services rather than those associated with the expanded role.

There was evidence from the Practice Nurse Study that traditional ways of working appeared to be linked with greater professional control, and innovative roles with more freedom to practise autonomously. The extent to which professional control determines the way practice nurses work is now examined further, as are the notions of partnership and collaboration within the primary health care team and with patients.


Issues Surrounding Professional Control and Collaboration

Practice Nurses and General Practitioners

Power remains a significant factor in blocking collaboration (Howkins 1995), because successful outcomes depend on mutual respect and sharing. The Cumberlege Review (DHSS 1986a) recommended that the future employment of practice nurses should be by the health authority, but general practitioners rejected these recommendations because, as Robinson (1990) points out, they had concerns about loss of control over practice employed staff. Moores (1992) considers that this control has had a stifling effect on autonomous practice. This was not generally the experience of the practice employed nurses in the present study. Moreover, Smith (1994) suggests that nurses enter practice nursing as general practitioner employees because they anticipate the degree of autonomy they will have, being outwith the nursing management structure. Nevertheless, although all nurses are exposed to medical control over their work, as employees of the general practitioner, practice employed nurses are particularly vulnerable.

Wiles and Robison (1994) suggest that any challenge to the ‘supremacy’ of the general practitioner within the team is most likely to come from practice nurses and nurse practitioners. While this is certainly possible, any innovative service introduced by the practice employed nurse still requires negotiation with, and the permission of, the general practitioner employer. Employee status alone is not a barrier to autonomous practice, although Mitchinson (1996), suggests that the team still often follows a primary medical care model rather than the primary health care model advocated by the World Health Organisation (1988). This further reduces the freedom of nurses to practise within a nursing framework of care.
New developments in the delivery of health services allow practice nurses to be more innovative and independent but, as has been argued, as employees of general practitioners, Health Authorities or Health Boards, they are not truly autonomous. Although, in many practices they have freedom to plan and organise their own work, they are neither financially independent, nor can they function as independent practitioners.

General practitioners are singular in that they have control over both the purchasing and the provision of services. This control is further reinforced by the recent Scottish discussion paper on primary care, ‘Primary Care: The Way Ahead’ (NHSME 1996), which stresses that it is fundamental to primary care that ‘leadership’ of the team lies with the general practitioner. The discussion paper however, also emphasises the importance of teamwork, and it is interesting that in 1986 the Cumberlege Report (DoH 1986a) recommended that:

*To establish and be recognised as a primary health care team, each general medical practice and the community nurses associated with it should come to an understanding of the team’s objectives and individuals’ roles within it.*

(p.62)

Ten years on, observations are made within ‘Primary Care: The Way Ahead’ that there are still problems of competing objectives and differing management priorities:

*The focus of members of the team (e.g. nurses who may be employees of another organisation) needs to be within the team so that there is co-ordinated clinical and managerial effort.*

(p.13.39)

In addition, the issue of ‘partnership’ is raised in the documents ‘Primary Care: The Future’ (DoH 1996a), ‘Choice and Opportunity’ (DoH 1996b), and ‘Primary Care: Delivering the Future’ (DoH 1996c), where improved partnerships between nurses and general practitioners are recommended. A salaried option for general
practitioners is also suggested, either within partnerships or within NHS trusts. This is particularly recommended in inner city areas, where services can be better tailored to the health needs of the population.

More commonly, general practitioners have formal co-operative arrangements with each other that are usually legally arranged, and the senior partner is often the doctor who has worked in the practice for the longest time. There have been instances more recently however, of nurses being taken into partnership with doctors. The present legislative framework however, precludes patients from registering with a nurse because contracts have to be made with general practitioners and not with the 'practice'. Although the present regulations covering the payment of general practitioners prevents true partnership arrangements with them, some practice nurses have already become partners in name. As these nurses make a contribution to the practice income, so they also share in the profits. From professional contact as a result of a collaborative project, I have knowledge of an example of this type of teamwork which is taking place in a practice in North Yorkshire, where the senior practice nurse and the practice manager have become business partners with the doctors.

In summary, evidence from this study strengthens the argument that practice employed nurses have greater opportunities to develop innovative roles and practice autonomously than their attached colleagues. Nevertheless, any new service envisaged by the practice employed nurse requires the approval of her general practitioner employer. Much depends on the mutual trust and respect built up between the nurse and the doctor concerned whether such innovations will proceed.
Practice Nurses and Patients

The term ‘partnership’ has already been used with reference to the relationship between nurses and other health professionals. It can also be used in connection with the relationship between nurse and patient. The Community Nursing Review team (DHSS 1986a) heard the words ‘participation’ and ‘partnership’ frequently during discussions with consumers. This was emphasised by the consumers themselves as represented by the Association of Community Health Councils in England and Wales, when they advocated that:

*It is important to generate an ethos among nurses and other professionals which would lead them to regard patients or clients, families and friends, as partners in the caring exercise. Granted that many appear to welcome dependency and traditional nursing attitudes encourage it, involvement, personal responsibility and participation would seem to be more appropriate.* (p.61)

Although partnership can equate with equality, it is difficult to apply this concept to the nurse-patient relationship, because the nurse is often in possession of professional knowledge not available to the patient. If the nurse uses that knowledge to empower the patient and give them freedom of choice however, then joint collaboration allows the patient to make informed choice about the management of their care. Cain (1995) observes that such a partnership must include a moral equality, in which the values, perceptions and judgements of clients are accorded due respect. It is interesting that the concepts so described accord with the type of holistic care provision advocated by the expanded role of the nurse.

Nurses who have worked in a practice over a period of years build up relationships with patients and their families. They often have an intimate knowledge of social and emotional problems as well as knowledge of any clinical conditions. Patients in the study valued the contribution made by the practice
nurse, particularly in relation to consultations considered too embarrassing or trivial for the general practitioner. It was found that patient education and positive practical advice allied with caring and psychological support did not always require a medical diagnosis. The nurses were easy to talk to, they listened and they were kind, caring and understanding. This finding is similar to that of Stilwell (1988b) who reported that nurses are perceived as having more time and being easier to talk to than a doctor.

Longer consultations were associated with more therapeutic listening. Practice employed nurses undertook more therapeutic listening than their attached colleagues during both recording periods, particularly in the second year. The nurses also reported that interruptions disturbed the flow of consultations, particularly when they were listening to patients’ problems, and sometimes, to such an extent that the patient was reluctant to return to discussion of the issues that had been troubling them. Listening is a form of communication, and Drury et al. (1988) reported that patients considered communication to be the most important skill in a primary health care provider.

Apart from the general practitioner, the practice nurse was the health professional patients would choose to see for a variety of disease management and health education topics. Several respondents commented on the discomfort they suffered with ‘minor’ problems, and elderly patients appeared to particularly appreciate their contacts with the practice nurse. There were several statements made by those who suffered from chronic illness that they appreciated the established relationship they had with the nurse. Their comments included the perceived benefits of the nurse listening to their problems, not making them feel hurried and the effects of ‘touch’, which had an enabling quality.
Forty-three per cent of respondents reported that they would choose to see the practice nurse instead of the doctor because she had more time to listen to them. It would appear that patients made clear distinctions about whom they chose to see, and the main benefits of choosing to attend the nurse were perceived to be ease of access, being able to attend with problems that doctors would consider unimportant, and the ability of the nurse to call on the doctor if necessary. While they particularly appreciated the service that the nurse could offer for lifestyle and non-specific worries, it would seem that listening was part of the consultation and not the focus of it.

Nurse-patient communication could be described as an open system relationship which combines the skills of listening, problem solving, advising, and the exchange of information. The nurse can assist the patient to make sense of the situation and then patients make their own choice about any action they want to take. Perhaps this makes it easier for patients to talk to nurses about issues that they consider too trivial to bother a doctor about, but are still important enough to cause anxiety and distress. An important element of the practice nurse role is to communicate information about patients and their families to the general practitioner. Sometimes patients specifically request practice nurses to act as an advocate on their behalf. On other occasions, information is conveyed to the doctor as a result of conversations that have been part of the patient-nurse consultation.

The perception of practice nurses as approachable and accessible also makes them more vulnerable to interruptions by colleagues and other health professionals. This theme is re-examined here in consideration of aspects of control and respect for the privacy of consultations by members of the primary health care team.
Interruptions

The nurses in the study who experienced interruptions reported that they were stressful and yet they made little attempt to rectify the problem until they became aware of the high levels that were taking place. The greatest proportion of the work undertaken by the nurses during both recording periods was by referral from doctors. In some cases this required an exchange of dialogue, in others the information required by the nurse to undertake the delegated task was contained in the patient case notes. In the latter circumstance, it was not necessary for the doctor to enter the nurse’s treatment room while she was consulting, particularly without knocking on the door.

It could be argued that this is another example of medical dominance, but it must be remembered that health visitor and district nursing colleagues did not always respect the privacy of practice nurse consultations either. In an effort to reduce interruptions the practice nurses negotiated with doctors other methods of passing on information about referrals, and consulted with other members of the team how best to reduce the problem. Although many of the nurses were working more autonomously in the second year, and this may have to some degree reflected a reduction in interruptions as doctor-nurse referrals lessened, the intervention also allowed them to assert their independence.

Practice nurses should endeavour to assess their working environment for possible changes that could be made to improve opportunities for sensitive consultations to take place more discreetly. As their role evolves they should be able to exercise their autonomy in appropriate situations to achieve the privacy that certain consultations require. This includes education of general practitioners and other members of the team not to interrupt nurse-patient consultations.
If practice nurses continue to expand their role and are involved in discussion of more psycho-social problems, it is important for the holistic element of the consultation that interruptions do not take place. A more expanded, autonomous role is part of the process of change from general practice to primary care. Weir (1995) suggests that empowering nurses leads to the freedom to act within the boundaries of competence and enables a degree of autonomy to exist. This will result in a service which develops and changes according to client demand. Alongside these processes of change however, practice nurses also provide continuity and stability in the general practice setting.

**Stability and Change**

This stabilising role is provided by the more permanent presence of the practice nurse on the premises, and the provision of direct access to her by the practice population for consultation, management, discharge or onward referral. General practitioners, health visitors and district nurses are more regularly off the practice premises for extended periods throughout the day.

From a time of relative post Second World War stability, the organisation of the British Health Service has seen rapid change in recent years. Over the last five years particularly, practice nursing could be described as experiencing a progression where numbers of nurses have increased faster than the education and training required to develop the role. As discussed earlier, this expansion in practice nurse employment came about primarily as the result of the New GP Contract. The requirement for general practitioners to provide services based on the health needs of the population, including health education and screening, resulted in an increase in the practice nurse workforce to provide some of these
services. Prior to this, care provision was based more on an individual-based illness model (Bryar 1994).

Starfield (1994), describes primary care as 'first contact, continuous, comprehensive, and co-ordinated care' and is the focus of over 90% of the health care in Scotland delivered to the population in a local setting (DoH 1996d). Similarly, The Damant Report (Damant 1990) refers to practice nursing as occupying a 'gatekeeping', 'sifting and sorting' role and emphasises the acceptability of the role to consumers. Apart from reception staff, practice nurses are often the first point of contact for patients and others who attend the doctor's surgery and, as such, have a central role to play in the initiation of, and continuity of, care in general practice.

Certainly, in my study the nurses were the first point of contact in half of all patient consultations in the surgery. The nurses also contributed significantly to the provision of continuity of care. As reported in Chapter Six, patients were selective in choosing when to consult the nurse or the doctor, but nearly 50% of respondents said that there were occasions when they would choose to see the nurse rather than the general practitioner. In addition, 89% of patients said that the nurse could deal with problems that did not need a doctor, and 40% said that they could get an appointment sooner to see the nurse.

It is suggested that patients should support primary care by taking responsibility for their own health, in appropriate circumstances (NAHAT 1996). Practice nurses, as 'gatekeepers' to primary care, must use any knowledge of the patient wisely, and be prepared to act as an advocate of their health and welfare, while acknowledging that patients have the right to resist the pressures of clinical
power. In consideration of the multi-dimensional approach of people, health, nursing actions and environment (Fawcett's 1989), practice nurses in the study were found to be expanding their role in a holistic manner, with a particular focus on maintaining or promoting health, and helping patients to adapt to chronic illness states. This fits well with observations made by Meleis (1991) when discussing the discipline of nursing:

*The domain of nursing deals with clients who are assumed to be in constant interaction with their environments, human beings who have unmet needs related to their health or illness status, who are not able to care for themselves or are not adapting to their environments due to interruptions or potential interruptions in health.*

(p. 112)

Practice nursing has experienced a transition in terms of role development. The transition has not always been linear however, because there have been periods of instability where practice nurses have had to adapt to internal change in relation to teamwork and working patterns, and external changes in the provision of health care. As discussed in previous chapters, practice nurses in general have received criticism (Hockey 1984; Peter 1993) for having an ill-defined role within primary care. This view was not shared by general practitioners and the nurses in the Practice Nurse Study, neither was it the response of patients. As the role evolves to include more anticipatory care, management of minor illness and chronic disease management, patients may choose to see the nurse for a variety of reasons.

Results from this study indicate that patients consulted the nurses appropriately, and that over two thirds (68%) of all patients attending the practice nurses were managed and discharged by them without a doctor being involved in the consultation. The stabilising influence and the open, friendly and understanding
style of the nurse in the general practice setting helps to promote confidence in patients (DoH 1996d). It is suggested that this allows them to make informed choices about their treatment and therefore they are more likely to comply with treatment regimes.

Facilitating change and pushing forward the boundaries of safe professional practice are essential elements of the expanded role. Empowerment and support of others are also central to clinical leadership. As the role develops, practice nurses may have to adapt the service that they offer in an attempt to meet the needs of patients, as well as that of the organisation within which they work. Practices that employ nurses to undertake an expanded role must also raise patient awareness about the services these nurses can provide.

Practice nurses have made an essential contribution to increasing the range and quality of services offered to patients (Jeffreys et al. 1995), and have helped primary care to cope with ever increasing demands and expectations. It is suggested in ‘Primary Care: The Future’ (DoH 1996a) that the role of nursing in primary care should continue to expand. In order for this to take place an education and training programme based on principles of care and clinical practice as advocated by the UKCC (1992b) is essential.

*Education, Training and the Expanded Role*

At the present time nurses are being employed in general practice in a diversity of roles and with a variety of sometimes, unusual and innovative, titles. Some are simply called ‘practice nurses’, others are known as ‘nurse practitioners’ or given the unwieldy title of ‘practice nurse (advanced practice)’. The title ‘nurse
consultant' has also been introduced within one Scottish Health Board, which has caused some unease among local general practitioners, who consider the 'consultant' title could reflect on the 'generalist' status of general practitioners.

Several practice nurses in my study described themselves as 'practice nurses' in the morning, and 'nurse practitioners' in the afternoon. This was reported to be because they were employed to work in a task-oriented way for the early part of the day - taking venepunctures and doing dressings, and in the afternoons to undertake a more independent role doing screening and clinic work.

There appears to be confusion about the titles and roles of nurses in both secondary and primary care, but it has been a particular problem in general practice nursing. The present debate about the use of the name 'nurse practitioner' appears to be on-going at the present time. The role requires clarifying for both health professionals and the public because of its unofficial status. From the patient’s perspective there is a need to be able to make an informed choice about which health care provider to consult, although the job title itself is less important.

The move towards more independent working and less direct delegation of tasks does indicate a shift towards the so-called nurse practitioner model. This model of working accords with that of earlier reports about nurse practitioners (Stilwell et al. 1987; Greenfield et al. 1987; Salisbury and Tettersell 1988). The unique nature of nursing differentiates it from an activity that can be carried out by skilled technicians, and supports the argument that it is the holistic element of the nurse practitioner role that differentiates it from that of physician’s assistant.
Several years ago, Bowling (1980) described the nurse practitioner role as ‘expanded’ and one which would require ‘an extension course’ for preparation. Salisbury and Tettersell (1988) used the term for an experienced nurse with extra training in health visiting and with a background in sick children’s nursing. Indeed, the role encompasses the work of nurses working in the primary and secondary sector, and requires clarifying for both health professionals and the public. The NHSME (1995) state:

*‘...those choosing to use the job title ‘nurse practitioner’, will wish to ascertain the nature of the role and specify what preparation is required for safe practice; this should be undertaken having regard to the UKCC standards for education and practice and to eliminating ambiguity.’* (p.6)

Bowles (1992a; 1992b; 1992c), describes herself as a nurse practitioner and defines the role as that of an autonomous provider of health care working alongside the general practitioner. Touche Ross (1994) in their evaluation of nurse practitioner pilot projects, adopted the Bliss and Cohen (1977) definition of a nurse practitioner, which described the role as requiring additional knowledge, skills and attitudes. Practice nurses who have ‘specialised’ in certain areas of care provision, such as the management of minor illness, also have the broad range of skills which go some way towards making them nurse practitioners.

The RCN believes that the role provided by the nurse practitioner should be that of a complementary source of care to that offered by medical practitioners. While acting as primary care providers in their own right, nurse practitioners work in partnership with other primary care providers, both accepting referrals from, and referring to, their colleagues when necessary. Nurses who work in this way are helping to facilitate the implementation of change within their practices. They have the positive leadership qualities of vision, reflection and the expertise to practise autonomously.
An autonomous nurse is one who practices within a self-regulating professional environment; makes decisions based on professional judgement, and has the ability to execute these in his/her own practice; and is cognizant with the bio-, psycho-, and social determining forces and has the knowledge to judge when these should be accepted or challenged.

(Wilkinson 1997, p.707)

As the scope of nursing practice widens, so do the boundaries. Nurses who wish to expand their role to that of 'nurse practitioner' require a combination of continuing academic study and increasing knowledge and skills in patient care. These are crucial to clinical practice development and the advancement of research ideas.

Results from the Practice Nurse Study showed that, following the implementation of the New GP Contract, general practitioners and the practice nurses themselves continued to express concern about the training needs of practice nurses. The need to achieve certain targets in health promotion and screening procedures had increased practice nurse workload, and the nurses were worried that their present training and experience might prove inadequate, especially if they were to extend their role. Although two thirds of all practice nurses did not feel competent to undertake an extended role, the one third who felt competent to do so with further training in certain areas, were all practice employed. Perhaps this was because practice employed nurses tended to have received more informal training and support from general practitioners than their attached colleagues.

Increasing concerns about accountability were reported by almost half of all practice nurses. While they appreciated that they were responsible for their own actions, some nurses reported that they felt vulnerable when carrying out certain medical tasks. None of the nurses worked to written protocols, although some
were found to be using ‘guidelines’ for specific procedures, and others worked to loose practice policies that were not always written down.

The nurses were critical of the lack of support for guidelines by general practitioners. Clay (1987) and Carlisle (1992) are similarly critical. Carlisle suggests that inexperience is not a defence if nurses make a mistake in performing an expanded role. Further guidelines are required if conflicts between professionals are to be restricted. Indeed, the UKCC document, The Scope of Professional Practice (1992b), emphasises professional accountability. It places judgements about the boundaries of practice in the hands of the individual practitioner, rather than placing importance in the acquisition of certificates for a string of tasks. It states:

*In order to bring into proper focus the professional responsibility and consequent accountability of individual practitioners, it is the Council’s principles for practice rather than certificates for tasks which should form the basis for adjustments to the scope of practice.*

(p.8, 14)

The UKCC also stresses the importance of knowledge, skill, responsibility and accountability as principles based on the Code of Professional Conduct (UKCC 1992a), and the nurses confirmed a need for further knowledge and skills in specific areas. This is a similar finding to the work of others (Ross and Bower 1992; Atkin et al. 1993; McBeath 1994). Ross and Bower similarly raise concerns about whether practice nurses are adequately trained for health promotion work. Although the present study did not explore this issue, Atkin et al. in their census, found that practice employed nurses did not express a need for training in health promotion work in spite of the fact that many had no formal qualifications in community nursing. It was considered that they might be under-estimating their
training needs, because they do not consider the skills required for health promotion require specialist training.

Responses from general practitioners in the Practice Nurse Study indicated that they were overwhelmingly in favour of ‘their’ practice nurses furthering their professional education and training, and the general practitioners reported that they were equally prepared to contribute to the costs. This level of support was not experienced by the nurses themselves, many of whom claimed that they had to attend events in their own time and pay for the costs themselves. Once again, this raises the problem of medical control over the nurse’s role and general practitioners’ attitudes to its expansion, a conclusion reported earlier by The Georgian Research Society (1991) in their pilot study.

McBeath (1994) also reported in another local survey of practice employed nurses in Lothian, that although all the general practitioners supported the concept of providing training opportunities for their practice nurses, only one in sixteen did so. The problem of obtaining funding for courses is not new. Ross and Bower (1992) report that this was a problem with health authorities, and Slaughter (1991) also reports the difficulty for practice employed nurses in obtaining funding. Evans (1992) suggests that practice nurses usually attend study days in their own time. In their National Census, Atkin and colleagues found that only one third of practice nurses have a specified number of study days a year and that, on average, practice nurses take six study days, paid and unpaid, a year.

There are several management and financial issues in relation to funding. The general practitioner employer may raise practical problems in relation to the nurse obtaining time away from the practice to attend courses. More than a third of
practice employed nurses work less than 20 hours a week (Hickie 1997) and almost half are acting as the sole nurse in a practice. It can be seen therefore, that there may be limited opportunity for release to undertake professional development. ‘Primary Care: Delivering the Future’ (DoH 1996c) advocates professional support and mentorship for practice nurses, with Health Boards and Health Authorities charged with identifying training needs. This will involve them in working with general practitioners to discuss how to provide cover for nurses who attend courses.

There is a particular problem in practices where a nurse is employed as the only practice nurse. In these circumstances, if the general practitioner has contributed to the costs of the nurse’s professional development, consideration must be given to the cost to the practice of being without a nurse or providing a locum in her absence. Similarly, experienced practice nurses who have become practice nurse trainers require time off to visit other practices in their role as teachers and assessors of future practice nurse trainers. Once again, the costs to the practice must be met while the nurse is absent.

The White Paper also promises that practice nurses will be able to gain access to funds held by local education consortia, so that they can attend courses which previously had to be paid for by nurses themselves, if general practitioners do not contribute. In response to the switch towards a primary care led service, the document states that formal preparation courses, possibly modular in nature, for nurses wishing to transfer from secondary to primary care should be offered, to address any shortcomings in skills required for practice nursing. Practice nursing should be formalised with dedicated, accredited courses, and experienced practice nurses should be encouraged to train in the role of practice nurse teachers.
In Scotland, until recently, training for practice nurses was organised by the National Board for Nursing, Midwifery and Health Visiting in conjunction with Institutes of Higher Education. Unfortunately, practice nurses could not have this training recorded on the UKCC register. Since 1995, there have been greater opportunities for practice nurse education with the implementation of the UKCC standards for education and practice following registration (UKCC 1994). Practice nurses will be required to complete five days of study (or the equivalent) during every three year registration period. Modular courses with academic accreditation will be provided, which include options for full-time or part-time study, or distance learning. After October 1988, preparation for specialist practice will be at degree level. Clinical supervision and teaching will also be provided by experienced, educationally prepared practice nurses who have undertaken training to be a practice nurse assessor.

The expanded role is synonymous with the provision of holistic care. Wilson-Thomas (1995) considers that it is vital that those who are involved in teaching, try to empower those who are being taught. She argues that the failure to have theories and research that are relevant to providing holistic care have perpetuated the gap that exists today between theory, research and practice. Wilson-Thomas observes that:

*Research serves as the framework through which theories are developed and practice serves as the vehicle from which theory can be generated and tested.*

(p.568)

The Damant Report considers that nursing in general practice should be defined as a practice based discipline whose theory grows from, and must be tested in, practice. Such an approach is not unique to nursing, but is, nevertheless, helpful.
Perhaps the changes in education and training that are taking place will go some way toward addressing these observations.

Education and training for an expanded role should be linked to the new discipline of Community Health Care Nursing defined by the UKCC, which includes general practice nursing (NHSME 1995). If practice employed nurses are going to have a flexible, expanding role, it is essential that their education and training reflect this. More formal training, with built-in quality standards, will increase the professional status of practice employed nurses, allow them to organise their work efficiently to meet the needs of patients, and may ultimately provide better job security.

Results from the Practice Nurse Study demonstrate that there is potential for holistic practice in an expanded role. There was no evidence however, that practice nurses were using a particular nursing model in their daily work. The implementation of the New GP Contract has made it all the more urgent to develop models of the practice nurse role, sharing aims and objectives with other community nurses and general practitioner colleagues.

Nursing and medicine should be complementary, because they both make a contribution to treatment and care, and they might be expected to share similar values about professional practice. Nursing is however, unique in its concern with the environment for the promotion of health (Meleis 1991). Over 20 years ago, Gilmore et al. (1974) described the essential characteristics of teamwork in terms of sharing a common purpose, and pooling knowledge, skills and resources. Joint education of primary care nurses and general medical practitioners continues to be encouraged (Pringle 1992; Poulton and West 1998).
Early in 1996, it was reported to Gerald Malone, the health minister at the time, on his ‘listening tour’ around the country, that co-operation between departments of post-graduate medicine and nursing could provide scope for joint learning now that nursing is university-based (Williams 1996). For this to take place however, there will need to be a commitment made to it, both financially and by allocation of time.

Service provision within general practice has expanded to the extent that the roles of doctors and other members of the team are becoming increasingly blurred. For example, as part of the team, practice nurses are in an ideal position to facilitate health education and give advice on illness and the relevant use of health services. Indeed, it has been suggested (DoH 1996d) that nurses should develop their skills for use in the areas of chronic disease management, minor illness and nurse prescribing, and during the course of the Practice Nurse Study the nurses had expanded their roles in several areas. These included chronic disease management, health promotion, stress management and counselling.

Multi-disciplinary communication in general practice should be structured to allow all members of the team to voice their concerns about how patient care is organised. Additionally, members of the primary health care team must work at improving their communication skills for the long-term benefit of patient care. In pursuit of joint learning, several facilitating approaches to team development are being introduced at the present time (Lorentzon and Hooker 1996). The authors suggest that an amalgam of personal qualities and abilities, together with a high degree of commitment, can achieve growth and innovation within the team. Exposure to joint learning schemes could provide models for replication in other
areas, and greater recognition should be given to the different models of care that can be offered by practice nurses, health visitors and district nurses.

Multidisciplinary collaboration has been encouraged for decades, but the concept of joint education schemes between departments of post-graduate medicine and nursing are still relatively new. It is also possible that the movement of nurse education into higher education could provide similar opportunities in the future. There is a climate for the promotion of a holistic approach responsive to patients’ needs that can be balanced by greater multidisciplinary collaboration and education. This, in turn, could be achieved by the practice nurse and the general practitioner having a better understanding of each other’s role and the contribution each can make to patient care.

Summary

A number of issues need to be addressed if the educational development of nurses generally is to accommodate the shift from secondary care. Practice nurses work in partnership with other health care providers and, if they are to meet the changing requirements of primary health care it is important that their professional development meets the needs of the service.

I have attempted to summarise some educational and professional development issues relevant to nursing in primary care, with particular reference to practice nursing, in Table 8-2 below.
It is proposed in the White Paper, ‘Primary care; Agenda for Action’ (p.5) that funding will be made available in 1997/98 for 10% of all practice nurses to undertake additional training leading to the specialist practitioner qualification of ‘community health care nurse (general practice)’. As discussed earlier however, unless resources are allocated to general practice to enable practice nurses to have time out of the practice to undertake education and training, general practitioner employers will be reluctant to facilitate this.
CONCLUSIONS

The contribution of theory in providing an understanding of traditional and innovative modes of practice, and in the acquisition of expert knowledge and skill, has been examined for its relevance to this study of clinical practice. Exploration of the relationship between theories, practice and research revealed that it was also possible to combine theoretical perspectives from other disciplines as well as from within nursing itself, in order to define and elucidate nursing problems. The development of the research questions were however, grounded in the practice situation.

This study of practice nurses identified that the practice nurse role is multi-faceted. As shown in the matrix 8-1, provided earlier, there also does not appear to be one ‘all encompassing’ model of practice nursing. The work of some nurses in the study was reported as being primarily task-oriented and related to the functioning of body systems, while others were more concerned with the promotion of health and the patient’s relationship with their environment. Traditional and more innovative ways of working were also linked to managerial and organisational factors and, to a certain extent, to feelings of membership within the primary health care team. Although practice nurses work within a team, there are differences in compositions of teams, and in the groups of patients that they serve, which makes it difficult to utilise one model of care.

Additionally, there were difficulties in studying change as it was taking place. The numbers of nurses recruited to the study were affected by these changes, and differences in workload and working patterns were reported by nurses with different employers. Conducting a patient satisfaction survey during a time of change, and within a limited time period, did not allow for patient adaptation to
different services provided by nurses as a result of the New GP Contract, or to changes in expectations and requirements as a result of its implementation. It would have been beneficial to conduct a patient survey at a later date to address these issues.

Further research into the development of the expanded role of practice nurses and how they are affected by changes in primary care as a whole, is also required if these areas of interest are to be developed further. Indeed, the recent Government White Paper, 'Primary Care: Delivering the Future', sets out important changes for nurses in primary care. Some concerns centre round the anxieties expressed by the medical profession about the erosion of the role of general practitioners, particularly with the introduction of the nurse practitioner role. Perhaps, as Bowling and Stilwell (1988) suggest, it is because the role of the nurse practitioner is not defined solely by the range of tasks performed, nor by skill in diagnosis and treatment.

Rather, [they suggest] the role encompasses these skills, but represents too a philosophy of autonomous nursing practice, together with accountability for that practice.

(p. 121)

Present trends indicate there is a fundamental issue associated with working in the style of the nurse practitioner, that of cost-effectiveness. Nurses in the Practice Nurse Study who had a slower consulting style were more likely to be undertaking screening procedures, listening to patients and giving advice or counselling. As suggested by Touche Ross (1994), in their study of nurse practitioners, outcome measures will need to be agreed in advance if longer consultations provided by nurses with advanced skills are to be properly evaluated. There is a danger that holistic care may be sacrificed for less skilled care at a lower cost.
In order to provide holistic care, the skills of reflection and deduction must be brought to bear. As discussed earlier, it is essential to the decision making process that the practice nurse reflects on the data that she has accumulated, so that she can make sound judgements. This type of reflection is fundamental in the performance of the ‘expert’ nurse as described by Benner (1984) and Benner et al. (1992a; 1992b). The expert has different skills and addresses a task differently from a non-expert, and these differences are both quantitative and qualitative. The expert anticipates, performs tasks with ease and makes the difficult look simple. This fits well with the role of the specialist practitioner and a more holistic type of decision making, where situations are seen as complete entities rather than as separate aspects.

There is scope for qualitative study in the area of practice nursing to look for the ‘know how’ embedded in practice, and the developing skills of practice nurses touched upon in this study could be examined in depth, including those of listening and reflection. There is a problem however, in that the qualitative nature of nurse-patient interactions makes them difficult to evaluate, and this area does not readily attract funding.

Nurses will continue to be employed in general practice in a variety of ways, some of whom will still undertake specific tasks. Others will be employed in a less prescriptive manner and be encouraged to develop their role with the support of their general practitioner employers. Practice nurses should be aware that their evolving role offers a greater degree of autonomy in their working circumstances under the conditions of the New GP Contract. This, in turn, can enable their professional development despite the constraints of professional control. Coupled with autonomy however, is accountability. When considering expansion of their
role into areas such as disease management and health promotion, practice nurses must be mindful of professional accountability for their actions. Practice nurses are effecting change within the primary care setting, but an important foundation for change to take place is stability, and this practice nurses also provide.

At the present time, we do not know whether nurses working in an expanded role will continue to be called nurse practitioners, but it is rather what the nurse brings to the role that is important, not the title itself. Empowerment is a key issue in the further development of their role. This can be accomplished with multidisciplinary collaboration between nurses and general practitioners in primary care, with mutual understanding of the part each has to play in the provision of care. In other words, if practice nurses and general practitioners are prepared to accept their differences in ideology and service delivery, a creative balance may be achieved in working together for the ultimate benefit of patient care.

Issues of medical control as exemplified by the number and nature of interruptions have had implications for the management of nurse-patient consultations. In addition, general practitioners had a controlling influence over access to continuing education and training of practice employed nurses. The practice nurses were aware that their role was changing within primary care. They were also aware that they were not yet adequately prepared educationally, or in their level of skills, to develop that role to one of ‘nurse practitioner’ equivalent.

The changes in primary and community care services have made experimentation with expanded nursing roles more urgent. Essentially, the continuing professional development of practice nursing requires an understanding of the knowledge
embedded in practice and a strong evidence base to justify accountability and the requirements for safe, autonomous practice. Practice nurses are a key resource, and education and training for the development of their role should be a priority in the new National Health Service.
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## Table 1 Employment status of participating nurses and number of hours per week worked

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<tr>
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<td>37.5</td>
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<td>20.0</td>
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<td>24.0</td>
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<tr>
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<td>20.0</td>
<td></td>
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<tr>
<td>17.5</td>
<td>23.5</td>
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</tr>
<tr>
<td>20.0</td>
<td></td>
<td></td>
<td>25.0</td>
</tr>
<tr>
<td></td>
<td>15.0</td>
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<td></td>
</tr>
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</table>

### JOINT Practice/Health Board appointments:

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</tr>
</thead>
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<td>13.0</td>
<td>13.0</td>
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<tr>
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<td>5.0</td>
<td>12.5</td>
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<tr>
<td>17.5</td>
<td>17.5</td>
<td></td>
<td>4.5</td>
</tr>
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</table>
Table 2 Nurse-patient contacts
(cross-ref for Figure 5-1, chi squares 1-3 & 1-4)

<table>
<thead>
<tr>
<th>EMPLOYED BY:</th>
<th>Practice</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>VISIT INITIATED BY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>20.3</td>
<td>866</td>
</tr>
<tr>
<td>Patient self-referral</td>
<td>26.7</td>
<td>1141</td>
</tr>
<tr>
<td>Referral from GP</td>
<td>42.0</td>
<td>1791</td>
</tr>
<tr>
<td>From receptionist</td>
<td>8.1</td>
<td>346</td>
</tr>
<tr>
<td>Other</td>
<td>3.6</td>
<td>155</td>
</tr>
</tbody>
</table>

Notes:
The percentages do not add up to 100% because in some records none of the categories were chosen, whereas in other cases more than one of the categories were ticked.

Table 3 Nurse-patient contacts - Chi squares between years 1990 & 1991
(Cross reference Table 1-2)

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice 1990 &amp; 91</th>
<th>Health Board 1990 &amp; 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISIT INITIATED BY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>92.9 df 1 p=&lt;0.001</td>
<td>6.3 df 1 p=&lt;0.01</td>
</tr>
<tr>
<td>Patient self-referral</td>
<td>*ns</td>
<td>*ns</td>
</tr>
<tr>
<td>Referral from GP</td>
<td>97.8 df 1 p=&lt;0.001</td>
<td>40.7 df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>From receptionist</td>
<td>7.4 df 1 p=&lt;0.01</td>
<td>ns</td>
</tr>
<tr>
<td>Other</td>
<td>17.3 df 1 p=&lt;0.001</td>
<td>ns</td>
</tr>
</tbody>
</table>

*Notes: ns = not significant

Table 4 Nurse-patient contacts - Chi squares between practice-employed and attached nurses
(Cross reference Table 1-2)

<table>
<thead>
<tr>
<th>VISIT INITIATED BY:</th>
<th>Practice 1990</th>
<th>Health Board 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
<td>95.2 df 1 p=&lt;0.001</td>
<td>12.9 df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Patient self-referral</td>
<td>23.9 df 2 p=&lt;0.01</td>
<td>25.9 df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Referral from GP</td>
<td>6.4 df 1 p=&lt;0.01</td>
<td>167.1 df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>From receptionist</td>
<td>100.8 df 1 p=&lt;0.001</td>
<td>141.9 df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Other</td>
<td>ns</td>
<td>45.4 df 1 p=&lt;0.001</td>
</tr>
</tbody>
</table>

Table 5 Level of general practitioner involvement in consultations
(cross reference for Figure 5-2 & chi squares Table 1-6 & 1-7)

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Joint appointment</td>
<td>6.7</td>
<td>288</td>
</tr>
<tr>
<td>Nurse requested GP help</td>
<td>8.6</td>
<td>363</td>
</tr>
<tr>
<td>GP requested nurse help</td>
<td>6.1</td>
<td>259</td>
</tr>
<tr>
<td>Advice/discussion (indirect)</td>
<td>8.3</td>
<td>355</td>
</tr>
<tr>
<td>NOT AT ALL</td>
<td>65.1</td>
<td>2780</td>
</tr>
</tbody>
</table>

Notes:
The percentages do not add up to 100% because in some records none of the categories were chosen, whereas in other cases more than one of the categories were ticked.
Table 6 Level of general practitioner involvement in consultations - Chi squares between years 1990 & 91

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice 1990 &amp; 91</th>
<th>Health Board 1990 &amp; 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP INVOLVEMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint appointment</td>
<td>14.0</td>
<td>8.3</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Nurse requested GP help</td>
<td>23.1</td>
<td>8.3</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>GP requested nurse help</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>Advice/discussion (indirect)</td>
<td>54.1</td>
<td>4.8</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.03</td>
</tr>
<tr>
<td>Not at all</td>
<td>100.4</td>
<td>170.7</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.001</td>
</tr>
</tbody>
</table>

Table 7 Level of general practitioner involvement in consultations - Chi squares between practice-employed & attached nurses

<table>
<thead>
<tr>
<th>GP INVOLVEMENT</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint appointment</td>
<td>ns</td>
<td>8.3</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.02</td>
<td>df 1 p=&lt;0.01</td>
</tr>
<tr>
<td>Nurse requested GP help</td>
<td>5.4</td>
<td>21.6</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>GP requested nurse help</td>
<td>16.4</td>
<td>3.8</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.08</td>
<td>df 1 p=&lt;0.05</td>
</tr>
<tr>
<td>Advice/discussion (indirect)</td>
<td>3.1</td>
<td>4.8</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>df 1 p=&lt;0.03</td>
</tr>
<tr>
<td>Not at all</td>
<td>55.3</td>
<td>ns</td>
</tr>
<tr>
<td>df 1</td>
<td>p=&lt;0.001</td>
<td>ns</td>
</tr>
</tbody>
</table>

Table 8 Nurse consultation by 'Nurse style' - Chi squares between years 1990 & 1991
(Cross reference Table 5-10)

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice 1990 &amp; 91</th>
<th>Health Board 1991 &amp; 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>ns</td>
<td>46.5</td>
<td>383.5</td>
</tr>
<tr>
<td>df 2</td>
<td>p=&lt;0.001</td>
<td>df 2 p=&lt;0.01</td>
</tr>
</tbody>
</table>

Table 9 Nurse consultations by 'Nurse style' - Chi squares between practice-employed and attached nurses
(Cross reference Table 5-10)

<table>
<thead>
<tr>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.6</td>
<td>798.6</td>
</tr>
<tr>
<td>df 2</td>
<td>p=&lt;0.001</td>
</tr>
</tbody>
</table>

Table 10 Disposition (Disposal)
(Cross reference Figure 5-5)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Return SOS (return if required)</td>
<td>10.3</td>
<td>408</td>
<td>9.8</td>
<td>345</td>
<td>8.9</td>
<td>167</td>
</tr>
<tr>
<td>Fixed return to nurse</td>
<td>35.1</td>
<td>1386</td>
<td>41.9</td>
<td>1474</td>
<td>38.3</td>
<td>715</td>
</tr>
<tr>
<td>Fixed return to GP</td>
<td>15.3</td>
<td>604</td>
<td>13.1</td>
<td>462</td>
<td>20.7</td>
<td>387</td>
</tr>
<tr>
<td>Return to other</td>
<td>0.2</td>
<td>8</td>
<td>0.2</td>
<td>8</td>
<td>0.3</td>
<td>5</td>
</tr>
<tr>
<td>Discharged</td>
<td>39.2</td>
<td>1546</td>
<td>35.1</td>
<td>1235</td>
<td>32.1</td>
<td>600</td>
</tr>
<tr>
<td>VALID TOTAL</td>
<td>67.8</td>
<td>3952</td>
<td>64.4</td>
<td>3695</td>
<td>32.2</td>
<td>1874</td>
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</table>

Table 11 Disposition (disposal) - Chi squares between years 1990 & 1991
(Cross reference Figure 5-5)

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice 1990 &amp; 91</th>
<th>Health Board 1990 &amp; 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return SOS</td>
<td>ns</td>
<td>7.1</td>
</tr>
<tr>
<td>Fixed return to nurse</td>
<td>35.9</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Fixed return to GP</td>
<td>7.1</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td>Return to other</td>
<td>ns</td>
<td>ns</td>
</tr>
<tr>
<td>Discharged</td>
<td>13.1</td>
<td>df 1 p=&lt;0.001</td>
</tr>
<tr>
<td></td>
<td>ns</td>
<td></td>
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Table 12 Disposition (disposal) - Chi squares between practice-employed and attached nurses
(Cross reference Figure 5-9)

<table>
<thead>
<tr>
<th>Disposition</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return SOS</td>
<td>ns</td>
<td>4.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>df 1</td>
</tr>
<tr>
<td>Fixed return to nurse</td>
<td>5.3</td>
<td>18.7</td>
</tr>
<tr>
<td></td>
<td>df 1</td>
<td>df 1</td>
</tr>
<tr>
<td>Fixed return to GP</td>
<td>26.1</td>
<td>252.7</td>
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<tr>
<td></td>
<td>df 1</td>
<td>df 1</td>
</tr>
<tr>
<td>Return to other</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Discharged</td>
<td>27.4</td>
<td>108.9</td>
</tr>
<tr>
<td></td>
<td>df 1</td>
<td>df 1</td>
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</table>

Table 13 Disposition by nurse style (all nurses)
(Cross reference Figure 5-6)

<table>
<thead>
<tr>
<th>Nurse Style</th>
<th>&lt;9 mins</th>
<th>9-11 mins</th>
<th>12+ mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged</td>
<td>38.3</td>
<td>29.1</td>
<td>34.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>39.5</td>
</tr>
<tr>
<td>Return if required</td>
<td>9.8</td>
<td>6.2</td>
<td>9.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10.6</td>
</tr>
<tr>
<td>Fixed return to nurse</td>
<td>34.3</td>
<td>39.6</td>
<td>39.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>32.7</td>
</tr>
<tr>
<td>Fixed return to GP</td>
<td>17.5</td>
<td>25.0</td>
<td>16.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17.1</td>
</tr>
<tr>
<td>Return to other</td>
<td>1.2</td>
<td>1.0</td>
<td>1.4</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>1.9</td>
</tr>
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</table>

Table 14 Interruptions as a percentage of consultations
(Cross reference Figure 5-7)

<table>
<thead>
<tr>
<th>Nurse Employed By:</th>
<th>Practice</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone - before consultation</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Phone - during consultation</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Persons - before consultation</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Persons - during consultation</td>
<td>%</td>
<td>n</td>
</tr>
</tbody>
</table>

Table 15 Interruptions as a percentage of consultations - Chi squares between years 1990 & 1991
(cross reference Figure 5.7)

<table>
<thead>
<tr>
<th>Interruptions</th>
<th>Practice 1990 &amp; 91</th>
<th>Health Board 1990 &amp; 91</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone - before consultation</td>
<td>ns</td>
<td>df 4</td>
</tr>
<tr>
<td>Phone - during consultation</td>
<td>16.6</td>
<td>df 4</td>
</tr>
<tr>
<td>Persons - before consultation</td>
<td>ns</td>
<td>df 4</td>
</tr>
<tr>
<td>Persons - during consultation</td>
<td>39.4</td>
<td>df 4</td>
</tr>
</tbody>
</table>

Table 16 Interruptions as a percentage of consultations - Chi squares between practice-employed and attached nurses
(cross reference Figure 5.7)

<table>
<thead>
<tr>
<th>Interruptions</th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone - before consultation</td>
<td>148.0</td>
<td>df 4</td>
</tr>
<tr>
<td>Phone - during consultation</td>
<td>119.0</td>
<td>df 5</td>
</tr>
<tr>
<td>Persons - before consultation</td>
<td>144.4</td>
<td>df 3</td>
</tr>
<tr>
<td>Persons - during consultation</td>
<td>206.4</td>
<td>df 4</td>
</tr>
</tbody>
</table>
### Table 17 Interruptions as a percentage of consultations by 'nurse style'
(Cross reference Figure 5-8)

<table>
<thead>
<tr>
<th></th>
<th>&lt;9 mins</th>
<th>9-11 mins</th>
<th>12+ mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone - before consultation n=</td>
<td>5.4</td>
<td>5.0</td>
<td>8.1</td>
</tr>
<tr>
<td>Phone - during consultation n=</td>
<td>8.7</td>
<td>7.9</td>
<td>16.7</td>
</tr>
<tr>
<td>Persons - before consultation n=</td>
<td>4.8</td>
<td>5.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Persons - during consultation n=</td>
<td>7.7</td>
<td>7.1</td>
<td>15.9</td>
</tr>
</tbody>
</table>

### Table 18 Interruptions as a percentage of consultations by 'nurse style' - Chi squares by 'nurse style' between practice-employed and attached nurses
(Cross reference Figure 5-8)

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone - before consultation</td>
<td>34.9</td>
<td>df 8</td>
</tr>
<tr>
<td>Phone - during consultation</td>
<td>79.8</td>
<td>df 10</td>
</tr>
<tr>
<td>Persons - before consultation</td>
<td>50.1</td>
<td>df 6</td>
</tr>
<tr>
<td>Persons - during consultation</td>
<td>116.1</td>
<td>df 10</td>
</tr>
</tbody>
</table>

### Table 19 Therapeutic listening component of nurse consultations - Chi squares between years 1990 and 1991
(cross reference Table 5-13)

<table>
<thead>
<tr>
<th>NURSE EMPLOYED BY:</th>
<th>Practice</th>
<th>Health Board</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20.9</td>
<td>6.04</td>
</tr>
</tbody>
</table>

### Table 20 Therapeutic listening component of nurse consultations - Chi squares between practice-employed and attached nurses
(cross reference Table 5-13)

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>1991</th>
</tr>
</thead>
</table>

45.2 | df 1     | p=<0.001 | 117.5    | df 1     | p=<0.001 |
### Tables for Figures in Chapter six

#### Table 21 Reported waiting times
(Cross reference Figure 6-1)

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Appointment with nurse</th>
<th>Referral from GP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>1-5</td>
<td>39.2</td>
<td>206</td>
</tr>
<tr>
<td>6-10</td>
<td>26.5</td>
<td>139</td>
</tr>
<tr>
<td>11-20</td>
<td>22.3</td>
<td>117</td>
</tr>
<tr>
<td>20+</td>
<td>12.0</td>
<td>63</td>
</tr>
<tr>
<td>Valid total</td>
<td>100.0</td>
<td>525</td>
</tr>
</tbody>
</table>

#### Table 22 Health outcome
(Cross reference Figure 6-2)

<table>
<thead>
<tr>
<th></th>
<th>Same or less</th>
<th>Much better/ Better</th>
<th>Valid total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>able to cope with life</td>
<td>40.5</td>
<td>420</td>
<td>59.5</td>
</tr>
<tr>
<td>able to understand your illness</td>
<td>45.6</td>
<td>397</td>
<td>54.4</td>
</tr>
<tr>
<td>able to cope with your illness</td>
<td>43.6</td>
<td>369</td>
<td>56.4</td>
</tr>
<tr>
<td>able to keep yourself healthy</td>
<td>51.9</td>
<td>582</td>
<td>48.1</td>
</tr>
<tr>
<td>confident about your health</td>
<td>48.8</td>
<td>607</td>
<td>51.2</td>
</tr>
<tr>
<td>able to help yourself</td>
<td>50.0</td>
<td>467</td>
<td>50.0</td>
</tr>
</tbody>
</table>

#### Table 23 Age group and sex - all respondents
(Cross reference Figure 6-3)

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>2</td>
<td>1.8</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>20-29 years</td>
<td>9</td>
<td>8.0</td>
<td>63</td>
<td>20.1</td>
</tr>
<tr>
<td>30-39 years</td>
<td>14</td>
<td>12.5</td>
<td>77</td>
<td>24.5</td>
</tr>
<tr>
<td>40-49 years</td>
<td>16</td>
<td>14.3</td>
<td>48</td>
<td>15.3</td>
</tr>
<tr>
<td>50-59 years</td>
<td>19</td>
<td>17.0</td>
<td>36</td>
<td>11.5</td>
</tr>
<tr>
<td>over 60 years</td>
<td>52</td>
<td>46.4</td>
<td>86</td>
<td>27.4</td>
</tr>
<tr>
<td>Valid total</td>
<td>112</td>
<td>46.4</td>
<td>314</td>
<td></td>
</tr>
</tbody>
</table>

#### Table 24 Knowledge of availability of nursing staff in the practice
(Cross reference Figure 6-4)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Practice nurse</td>
<td>88.7</td>
<td>418</td>
<td>0.4</td>
<td>2</td>
</tr>
<tr>
<td>Health visitor</td>
<td>66.2</td>
<td>292</td>
<td>1.6</td>
<td>7</td>
</tr>
<tr>
<td>District nurse</td>
<td>62.0</td>
<td>273</td>
<td>1.8</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 25 Age group and sex of respondents who had consulted the practice nurse within last 12 months  
(Cross reference Figure 6-5)

<table>
<thead>
<tr>
<th>Age group and sex of respondents who had consulted the practice nurse within last 12 months</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>20-29 years</td>
<td>7.7</td>
<td>5</td>
</tr>
<tr>
<td>30-39 years</td>
<td>7.7</td>
<td>5</td>
</tr>
<tr>
<td>40-49 years</td>
<td>13.8</td>
<td>9</td>
</tr>
<tr>
<td>50-59 years</td>
<td>16.9</td>
<td>11</td>
</tr>
<tr>
<td>over 60 years</td>
<td>52.3</td>
<td>34</td>
</tr>
<tr>
<td>Valid total</td>
<td></td>
<td>65</td>
</tr>
</tbody>
</table>

Table 26 Positive responses to nurse prescribing for specific conditions  
(Cross reference Figure 6-6)

<table>
<thead>
<tr>
<th>Antibiotic for urinary infection</th>
<th>Practice nurse</th>
<th>Health visitor</th>
<th>District nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>53.6</td>
<td>256</td>
<td>25.0</td>
</tr>
<tr>
<td>Inhaler for someone with asthma</td>
<td>59.8</td>
<td>283</td>
<td>33.3</td>
</tr>
<tr>
<td>Oral contraceptive pill</td>
<td>56.9</td>
<td>268</td>
<td>33.6</td>
</tr>
<tr>
<td>Ointment for a skin condition</td>
<td>70.8</td>
<td>337</td>
<td>36.5</td>
</tr>
</tbody>
</table>

Table 27 Patient choice: Practice nurse rather than doctor  
(Cross reference Figure 6-7)

<table>
<thead>
<tr>
<th>Child health &amp; development</th>
<th>Practice nurse</th>
<th>Health visitor</th>
<th>General Practitioner</th>
<th>District nurse</th>
<th>No opinion</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>&lt;20 years</td>
<td>5.3</td>
<td>24</td>
<td>34.5</td>
<td>157</td>
<td>37.8</td>
<td>172</td>
</tr>
<tr>
<td>20-29 years</td>
<td>31.4</td>
<td>43</td>
<td>6.1</td>
<td>28</td>
<td>44.1</td>
<td>201</td>
</tr>
<tr>
<td>30-39 years</td>
<td>44.1</td>
<td>28</td>
<td>44.1</td>
<td>201</td>
<td>4.8</td>
<td>22</td>
</tr>
<tr>
<td>40-49 years</td>
<td>7.2</td>
<td>34</td>
<td>6.0</td>
<td>28</td>
<td>61.9</td>
<td>291</td>
</tr>
<tr>
<td>50-59 years</td>
<td>33.8</td>
<td>154</td>
<td>1.3</td>
<td>6</td>
<td>45.5</td>
<td>207</td>
</tr>
<tr>
<td>over 60 years</td>
<td>33.8</td>
<td>154</td>
<td>1.3</td>
<td>6</td>
<td>45.5</td>
<td>207</td>
</tr>
</tbody>
</table>

### Tables for Figures in Chapter seven

#### Table 29 Responses to health professionals' questionnaire - by practice

<table>
<thead>
<tr>
<th>Practice</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>12</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>3</td>
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<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td>15</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>20</td>
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<td>0</td>
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<td>0</td>
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<td>21</td>
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<td>3</td>
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<tr>
<td>22</td>
<td>1</td>
<td>2</td>
<td>0</td>
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<td>5</td>
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<td>25</td>
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<td>0</td>
<td>0</td>
<td>1</td>
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<td>26</td>
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<td>1</td>
<td>1</td>
<td>0</td>
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<td>27</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>29</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTALS** 54 55 27 72

#### Table 30 'YES' responses to various concerns before and after the introduction of the new GP contract - percentages

(Cross reference Figure 7-1)

<table>
<thead>
<tr>
<th>Concerns re. New GP Contract</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>an increasing workload</td>
<td>67.9 81.3</td>
<td>55.9 55.3</td>
<td>56.0 52.0</td>
<td>85.5 98.6</td>
</tr>
<tr>
<td>loss of professional independence</td>
<td>25.9 17.2</td>
<td>38.2 45.5</td>
<td>62.5 29.2</td>
<td>35.3 62.4</td>
</tr>
<tr>
<td>role changing</td>
<td>43.3 41.4</td>
<td>50.0 63.6</td>
<td>60.9 60.0</td>
<td>38.2 82.6</td>
</tr>
<tr>
<td>overlap of roles</td>
<td>39.3 40.0</td>
<td>51.5 54.5</td>
<td>66.7 45.8</td>
<td>19.4 30.4</td>
</tr>
<tr>
<td>quality of patient care</td>
<td>62.1 50.0</td>
<td>61.8 60.0</td>
<td>52.2 60.9</td>
<td>76.8 82.9</td>
</tr>
<tr>
<td>other concerns</td>
<td>40.0 36.4</td>
<td>50.0 40.0</td>
<td>20.0 33.3</td>
<td>35.5 47.6</td>
</tr>
</tbody>
</table>
Table 31  Number of 'YES' responses to various concerns before and after the introduction of the New GP contract - n figures
(Cross reference Figure 7-1)

<table>
<thead>
<tr>
<th>Concerns re. New GP Contract</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>pre</td>
<td>post</td>
<td>pre</td>
<td>post</td>
</tr>
<tr>
<td>an increasing workload</td>
<td>19</td>
<td>26</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>loss of professional independence</td>
<td>7</td>
<td>5</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>role changing</td>
<td>13</td>
<td>12</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>overlap of roles</td>
<td>11</td>
<td>12</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>quality of patient care</td>
<td>18</td>
<td>15</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>other concerns</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 32  Items of service
(Cross reference Figure 7-2)

<table>
<thead>
<tr>
<th>Items of Service</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>antenatal care</td>
<td>34.4</td>
<td>11</td>
<td>72.7</td>
<td>25</td>
</tr>
<tr>
<td>postnatal care</td>
<td>33.3</td>
<td>11</td>
<td>90.9</td>
<td>31</td>
</tr>
<tr>
<td>family planning</td>
<td>39.4</td>
<td>13</td>
<td>53.1</td>
<td>18</td>
</tr>
<tr>
<td>immunisation of children</td>
<td>55.1</td>
<td>17</td>
<td>9.1</td>
<td>4</td>
</tr>
<tr>
<td>screening of elderly patients</td>
<td>56.3</td>
<td>18</td>
<td>88.2</td>
<td>31</td>
</tr>
</tbody>
</table>

Table 33  Responsibility for undertaking certain items of service: 'YES' respondents
(Cross reference Figure 7-3)

<table>
<thead>
<tr>
<th>Do you think the following items of service should be part of your work?</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>taking cervical smears</td>
<td>87.5</td>
<td>28</td>
<td>11.7</td>
<td>4</td>
</tr>
<tr>
<td>giving contraceptive advice</td>
<td>83.9</td>
<td>26</td>
<td>94.3</td>
<td>33</td>
</tr>
<tr>
<td>immunisation of children</td>
<td>71.9</td>
<td>23</td>
<td>22.9</td>
<td>8</td>
</tr>
<tr>
<td>screening of elderly patients</td>
<td>58.1</td>
<td>18</td>
<td>91.5</td>
<td>32</td>
</tr>
<tr>
<td>giving flu vaccinations</td>
<td>100.0</td>
<td>33</td>
<td>8.8</td>
<td>3</td>
</tr>
<tr>
<td>helping to compile practice annual reports</td>
<td>60.6</td>
<td>20</td>
<td>80.0</td>
<td>28</td>
</tr>
<tr>
<td>helping to design practice leaflets</td>
<td>69.7</td>
<td>23</td>
<td>94.3</td>
<td>33</td>
</tr>
</tbody>
</table>
Table 34 Reported frequency of practice meetings
(Cross reference Figure 7-4)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Practice nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
<th>General Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% n</td>
<td>% n</td>
<td>% n</td>
<td>% n n</td>
</tr>
<tr>
<td>weekly</td>
<td>29.0 9</td>
<td>40.6 13</td>
<td>33.3 8</td>
<td>10.7 9</td>
</tr>
<tr>
<td>monthly</td>
<td>48.4 15</td>
<td>43.8 14</td>
<td>33.3 8</td>
<td>48.8 41</td>
</tr>
<tr>
<td>three monthly</td>
<td>12.9 4</td>
<td>6.3 2</td>
<td>0.0 0</td>
<td>33.3 28</td>
</tr>
<tr>
<td>six monthly</td>
<td>6.5 2</td>
<td>0.0 0</td>
<td>0.0 0</td>
<td>6.0 5</td>
</tr>
<tr>
<td>not at all</td>
<td>3.2 1</td>
<td>9.4 3</td>
<td>33.3 8</td>
<td>1.2 1</td>
</tr>
<tr>
<td>Valid total</td>
<td>31 32</td>
<td>32 24</td>
<td>24 84</td>
<td></td>
</tr>
</tbody>
</table>

Table 35 How often do nurses recommend products to buy from the chemist?
(Cross reference Figure 7-5)

<table>
<thead>
<tr>
<th>Job Titles</th>
<th>REGULARLY</th>
<th>SOMEBE TIMES</th>
<th>NEVER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% n</td>
<td>% n</td>
<td>% n</td>
<td>n n</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>21.2 7</td>
<td>78.8 26</td>
<td>0.0</td>
<td>0 33</td>
</tr>
<tr>
<td>Health visitors</td>
<td>25.8 9</td>
<td>0.0 0</td>
<td>74.3 26</td>
<td>35</td>
</tr>
<tr>
<td>District nurses</td>
<td>4.0 1</td>
<td>88.0 22</td>
<td>8.0</td>
<td>3 26</td>
</tr>
</tbody>
</table>

Table 36 In-service training: Events attended in the last year
(Cross reference Figure 7-6)

<table>
<thead>
<tr>
<th>Events attended</th>
<th>P. E. nurses</th>
<th>Attached nurses</th>
<th>Health visitors</th>
<th>District nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n n</td>
<td>n n</td>
<td>n n</td>
<td>n n</td>
</tr>
<tr>
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Appendix 2

2-1 Recruitment letter to doctors with practice employed nurses, plus ‘Aims of Study’.
2-2 Recruitment letter to nurses
2-3 Recruitment letter to doctors who took part in the study of general practitioners (SHHD 1990)
2-4 Reception label (N2)
2-5 Green nurse card (Card N1)
2-6 Instruction sheet for reception staff
2-7 Guide notes for participating nurses
2-8 Card N3 (Green end-of-day card)
2-9 Guide notes for completion of end of day card
2-10 Patient satisfaction and health outcome questionnaire (peach)
2-11 Questionnaire on patients’ views of the role of community nurses (white)
2-12 Practice nurse questionnaire (green)
2-13 Health visitor questionnaire (pink)
2-14 District nurse questionnaire (yellow)
2-15 General practitioner questionnaire (blue)
2-16 Detachable front sheet of patients’ questionnaire
2-17 Personal letter to health professionals re. completion of questionnaires
Dr &DOCTOR& & Partners  
&ADD1&  
&ADD2&  
&ADD3&  

January 29, 1990

Dear Dr &NAME1&

We are writing to request your help with a research project looking at the work of practice-employed and Lothian Health Board-employed treatment room nurses, and we would be grateful if you would bring this request to the attention of your partners and nurses.

As you may know, we have recently conducted a large study of the work of 85 general practitioners in Lothian and we now wish to complement this with some information on the work of practice and treatment room nurses. The purpose of the research is to monitor the work of nurses in general practice before, and 12 months after, the implementation of the new GP Contract in April.

To this end we would like your consent to approach the nurses in your practice to ask them if they would be interested in taking part in the study. Your consent at this stage would in no way commit them to taking part until they (and you) have had an opportunity to discuss the project with us. This project has the support of Mrs Gilchrist, Director of Community Nursing Services.

The intention is to record work-flow on 15 half-day sessions over a period of six weeks. This would take place from mid-February through to the end of March 1990. We plan to repeat this exercise in February-March 1991.

In order to record 'work-flow' as accurately as possible, we would like to ask reception staff to fill in a small card recording the arrival time of all patients who have an appointment to see the nurse (Card N2 of samples attached). This card would be handed to the patient, who in turn would be asked to give it to the nurse on entry to the treatment room. Synchronised clocks will be provided for both reception and the nurse's treatment room.
We enclose a brief summary of the project, and draft samples of Cards N1, N2 (Card N2 would be printed on a self-adhesive label, not card as sample attached to draft of N1), and N3. If you would like further information please contact either myself or Mike Porter.

We realise that this is a particularly busy time for all practices, but we anticipate that the new Contract will have quite an effect on the employment and work of practice nurses and we would particularly value collecting data prior to implementation of the new Contract. As this gives us little time to carry out the study, we would be most grateful if you would let us know by Monday, 5th February whether we can approach your nursing staff. It would be very helpful if you could give us their names on the tear-off slip below.

Yours sincerely

Mrs Fiona M Paxton
Research Nurse, Principal Researcher

A M D Porter

J G R Howie

________________________

To: Mrs Fiona Paxton, Research Nurse
General Practice Research Group, University of Edinburgh,
20 West Richmond Street, Edinburgh EH8 9DX

From:

We are happy/unhappy for you to contact the practice's treatment room nurses.

Full names of treatment room nursing staff in this practice (if happy for us to contact):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

2
TREATMENT ROOM NURSE STUDY

The 'New GP Contract' (SHHD, 1989) which is to come into effect in April 1990 is likely to have a significant effect on the employment of practice employed and Health Board employed treatment room nurses, and on the type of work that these nurses do. This study is planned to complement the work that we have recently carried out on the workload and process of care of 85 Lothian general practitioners (Howie et al., 1989), and aims to provide a clearer picture of the employment and work of treatment room nurses in Lothian. In doing so, the study will illuminate some of the policy implications of the new GP contract, and provide information for the planning and development of primary care teams.

The present arrangements for providing 70% reimbursement of nursing staff employed by GPs, and of attaching Health Board employed nurses to many practices, has meant that the majority of general practitioners in Lothian (though not so many in Scotland as a whole) work side by side with nurses. There is, however, little information available on the work that treatment room nurses do, on how this work is initiated and organised, on the variation in this work between practices, or on the variation between practice employed and Health Board attached nurses. Indeed, there is no readily available information on the number of practice employed nurses in Scotland.

In some practices, patients may have direct access to the nurse by self-referral and this may be by appointment only or by simply 'turning up' and waiting to be seen. Many nurses who run appointment systems also provide for 'casuals' and emergencies to be fitted in, but this practice of slipping patients into an already busy nurse session can cause delays to other patients and frustration amongst the nurses. Although in some cases joint appointments are pre-booked with GP and nurse (for example, antenatals, medical examinations, and baby clinics), Fallon et al (1988) have reported that more than 50% of the nurse's workload appears to be delegated by doctors in the practice.

We plan to collect information on the work of practice-employed and LHB-employed treatment room nurses prior to the implementation of the New Contract, and the study will draw heavily on the research methods established in our study of the 85 Lothian GPs (Howie et al., 1989; Porter et al., 1989).

Reception Card (Card N2)
All patients attending the nurse on study days will be given a small card on arrival at reception. The receptionist will enter the day, the date, the time that the patient arrived at the reception desk, and the patient's appointment time (if relevant). The card will have a removable adhesive backing.

Nurse Card (Card N1)
Each participating treatment room and practice nurse will be supplied with pads of cards which will be pre-coded with a unique nurse number.

The nurse will stick the reception card to a nurse card and, using a clock synchronised with the clock at reception, tick the relevant information categories and record the time of the patient's departure. A nurse card will be completed for each patient seen. If the patient-nurse contact is the result of a direct referral from the general practitioner, there will be no reception card. In the space provided for the adhesive card, the nurse will be requested to enter the time that the referral was initiated. Appendix 4 illustrates how we have begun to explore the flow of patients through surgery/consulting sessions.

End of Day Card (Card N3)
The nurses will also complete a short 'end-of-day' card on which they will record, to the nearest half hour, how much time they have spent on routine treatment room sessions, specific clinics, administration, meetings etc.
Dear

I am writing to request your assistance with a research project looking at the work of treatment room nurses, both Health Board-employed and practice-employed. The purpose of the research is to monitor the work of the nurse before, and 12 months after the implementation of the new GP Contract in April.

The intention is to sample 15 half-day sessions on the basis of recording work-flow over a period of six weeks, one week of recording and one week off. This would take place from late-February through to mid-April 1990. It is proposed to repeat this exercise in February-March 1991.

You would be asked to complete a Nurse Card (Card N1) for each patient seen during the recording session and at the end of your working day a short summary of the day's activities would be completed on an 'End-of-Day' Card (Card N3). It is anticipated that completion of the 'Nurse Card' will take no more than 30 seconds and the 'End-of-Day' card about a minute.

I would very much like to meet with you to discuss our proposals, which have the support of Mrs Gilchrist, Director of Community Nursing, Lothian Health Board, and the GP in your practice has given consent to our approaching you to ask if you would agree to participate in the study.

As planning time is very short, I would be grateful if you would indicate on the attached sheet if you are willing to assist us. This would in no way commit you to the study until I have discussed all the details with you fully. It would also be helpful if you would indicate the days and times that I could contact you to arrange a meeting to expand on the proposals and discuss any problems you may envisage.

For clarification, a brief summary of the study is enclosed. If you would like further information, please do not hesitate to contact either myself or Mike Porter.

Yours sincerely

Mrs Fiona M Paxton
Research Nurse, Principal Researcher
January 18, 1990

Dear Dr,

We are writing to you because of your previous involvement with us in the GP stress/workload study, and would be grateful if you would bring the following proposal to the attention of your partners and practice nurses.

We are hoping to embark on a research project looking at the work of practice-employed and Lothian Health Board-employed treatment room nurses. The information gained would complement the study of the work of the General Practitioner in which you kindly participated. The purpose of the research is to monitor the work of nurses in general practice before, and 12 months after, the implementation of the new GP Contract in April.

To this end we would like your consent to approach the nurses in your practice to ask them if they would be interested in taking part in the study. Your consent at this stage would in no way commit them to taking part until they (and you) have had an opportunity to discuss the project with us. (We have written to Mrs Gilchrist, Director Community Nursing Services, about approaching LHB-employed treatment room nurses.)

The intention is to record work-flow on 15 half-day sessions over a period of six weeks, one week of recording and one week off, etc. This would take place from mid-February through to the end of March 1990. We plan to repeat this exercise in February-March 1991.

In order to record 'work-flow' as accurately as possible, we would like to use a system similar to that used in the 'GP stress/workload' study. The reception staff would be required to fill in a small card recording the arrival time of all patients who had an appointment to see the nurse. This card would be handed to the patient, who in turn would be asked to give it to the nurse on entry to the treatment room. As before, synchronised clocks will be provided for both reception and the nurse's treatment room.
We enclose a brief summary of the project, and draft samples of Cards N1, N2 (which would be printed on self-adhesive label, not card as sample attached to draft of N1), and N3. If you would like further information please contact either myself or Mike Porter.

We realise that this is a particularly busy time for all practices, but we anticipate that the new Contract will have quite an effect on the employment and work of practice nurses and we would particularly value collecting data prior to implementation of the new Contract. As this gives us little time to carry out the study, we would be most grateful if you would let us know by Friday, 27th January whether we can approach your nursing staff.

Yours sincerely

Mrs Fiona M Paxton  Mike Porter  John Howie
Research Nurse, Principal Researcher

PS We have sent copies of this letter to all the doctors in your practice who participated in the QQQ study.
INFORMATION FOR PATIENTS
The nurse you are seeing today is taking part in a study of the work of nurses in General Practice.
Please give this label to her on entry to the Treatment Room.

Mon □ Tue □ Wed □ Thu □ Fri □
Date: __________/________/________
Appointment Time: __________________
Arrival Time: __________________
APPENDIX 2-5

(Front of Card)

□ Mon □ Tue □ Wed □ Thu □ Fri
Date __/__/____
Time Referral Initiated ______________________

Time in ______ Nurse No.32
Waiting Time for GP ______________________
Sex: M/F D of B: __/__/____
Presenting Problems:
1 ______________________ F/R/E
2 ______________________ F/R/E

VISIT INITIATED BY?
Practice/Treatment Room Nurse □
Patient self-referral □
Referral from GP □
From Receptionist □
Other, eg HV, DN, Relative (please specify) □

GP INVOLVEMENT:
Not at all □
Joint Appointment □
GP to Nurse □
Nurse to GP □
Advice/discussion (indirect) □

INTERRUPTIONS: Before During Consultation
Phone ______________________
Persons ______________________

(Back of Card)

PLEASE TICK ALL RELEVANT BOXES

VACCINATION/IMMUNISATION
Child (0-5) □
Special group at risk □
Overseas traveller □

DIAGNOSTIC TESTS
Weight □
Recording of blood pressure □
Urine collection/testing □
Swab/specimen taking for bact. exam □
Venepuncture □
Cervical smear taking □
ECG recording □

TREATMENT
Dressing (all types) □
Therapeutic injection □
Ear syringing □
Sutures insertion/removal □
ENT/eye treatment □

OTHER ACTIVITIES
Ante-natal care □
Post-natal care □
Contraception □
Chaperoning □
Writing prescription □
Therapeutic listening □
Screening—new registration
"—child health check (0-5) □
"—elderly person □
"—other, please specify □
Health education/advice—diet
"—alcohol □
"—stress □
"—exercise □
"—smoking □
"—other, please specify □

DISPOSITION:
Discharged □
Fixed return to nurse □
Fixed return to GP □
Return to other eg HV, DN □
Return to other □

TIME PATIENT LEFT: ______________________
TREATMENT ROOM NURSE STUDY

GUIDE NOTES FOR RECEPTION STAFF

We are carrying out a study of the work of nurses in the treatment rooms of General Practice. To do this we need accurate information on the flow of patients through surgery sessions and any special clinics.

To help us gather this information we have designed a small printed self-adhesive label (Card N2) for use by reception staff.

Reception staff will be supplied with:
1) Reception Cards (N2)
2) A digital clock

RECEPTION CARD (N2)
At the start of the day please ensure that you have a supply of Reception Cards available for use.

When patients arrive at the reception desk please enter the time showing on the digital clock. Tick the day of the week in the appropriate box, and enter the date and the time of the patient's appointment to see the nurse. In the case of a joint appointment (eg husband and wife) please issue two cards with the same appointment time on each. (Only one card is needed if the patient is being accompanied by another person, eg if a mother brings a child to see the nurse and only the child has an appointment.)

If the patient does not attend, or cancels, please write 'DNA' or 'cancelled' on the card. If possible, please note the time of the appointment and the time the patient cancelled.

Please ensure that these 'DNA' or 'cancelled' cards are handed to the nurse with whom the patient had the appointment before she goes off duty.

NURSE RECORDING TIME CARD (N4)
This card will be given to reception by the nurse who is recording at any given session, and will simply state the time she starts and finishes recording that day. During these times Reception Cards need to be completed and given to patients. As nurses are being asked to record on a 'part-day' basis, these cards should clarify which part of her working day is being included in the study, particularly if she works full-time.

THANK YOU VERY MUCH FOR YOUR HELP.
TREATMENT ROOM NURSE STUDY

GUIDE NOTES FOR PARTICIPATING NURSES

RESEARCH INSTRUMENTS:
- Nurse Card (Card N1)
- Reception Card (Card N2)
- End-of-day Card (Card N3)
- Nurse recording time card (Card N4)
- Digital clock

Please ensure a green card (Card N1) is completed for every patient you see during your recording sessions.

For patients who have a return appointment, sex, DOB, and presenting problem may be completed at any time prior to seeing the patient, if case notes available.

For any patients who do not attend (DNA) or cancel an appointment, the receptionist should have completed Reception Form (N2). These cards should be given to you at the end of your recording session. Please return these cards to us along with the rest of your day's recording forms.

PLEASE RETURN DAILY IN ENVELOPE PROVIDED:
1) All Nurse Cards (N1) and attached Reception Cards (N2);
2) Any N2 Cards handed to you by reception for patients who cancelled or did not attend (DNAs);
3) Today's 'End of Day' Card (Card N3).

We realise that this study involves you in extra administration, but in order to understand the pressures and stresses of your work we need to have an impression of the factors which may have affected your day.

Overall, the more information you give us, the more sense we can make of your day, and the more we can feed back to you.

THANK YOU VERY MUCH FOR YOUR HELP.
1. At the start of every recording session please ensure you have a supply of Nurse Cards (Card N1) and digital clock. Please complete Card N4 with the times you will start and finish recording today, and give it to reception.

2. Every patient who has an appointment (arrangement), or comes VIA RECEPTION to see you, should hand you Card N2 (printed self-adhesive label) that they were given by the receptionist. Please remove the adhesive backing from the label and attach the printed label to the space assigned to it at the top (left hand corner) of Card N1.

   In the case of a joint appointment two N2 cards should have been issued to the patients by receptionist, in which case two copies of Card N1 will be required. Only one card is needed if the patient is being accompanied by another, eg if a mother brings a child and only the child has an appointment.

   If the patient/nurse contact is the result of a direct referral from the GP, or other internal source, eg HV or DN, there will be no reception card (Card N2). In the space provided for the adhesive label please enter the time that the referral was initiated and also the day and date.

3. At the top of Card N1:

   (a) Time in: please enter the time the patient entered the treatment room.

   (b) Waiting time for GP: If a patient is referred by the GP to be examined or is seen with you for a joint appointment in the Treatment Room, please record the time the GP enters the room. Also, if you ask the GP to come to see a patient for you, please record the time the GP arrives in your room.

   (c) Sex: please CIRCLE the patient's sex M/F

   (d) DOB: record the patient's date of birth (DOB)

4. PRESENTING PROBLEMS:

   The first entry should relate to the condition for which the patient has come to see you, if appropriate. The patient can be quoted: eg "sore foot", "wax in ears"? If there is chronic disease with an overlying acute condition, both diagnoses can be entered.
5. **F/R/E - Please CIRCLE**

- **F** indicates that this is the First time you have seen the patient with a new problem, or it is a new episode of an old problem.

- **R** indicates that this is a Return consultation for the present condition.

- **E** indicates that the patient is being seen as an Emergency. The condition for which they are being seen may not, in fact, turn out to be so!

6. **VISIT INITIATED BY:**

   Please tick the appropriate box or write in on line to whom 'other' refers. We are interested in who initiated the visit for this particular day, not necessarily who initiated it originally, eg the visit may have originated as a referral from the doctor and resulted in several return appointments to see the nurse, one of which is today, in which case you would tick 'Nurse'.

7. **GP INVOLVEMENT** in this consultation.

   Please tick. (More than one box may be ticked in this category.)

   **Not at all** is self-explanatory.

   - **Joint appointment** - patient has a joint appointment with GP and the nurse.

   - **GP to Nurse** - indicates that the GP has come through to the treatment room at your request, to see a patient.

   - **Nurse to GP** - indicates that you have left the treatment room to go and see the GP at the GP's request. If the GP asks to see you when you have a patient in the treatment room, this would also constitute an 'interruption' and should be ticked accordingly.

   - **Advice/discussion (indirect)** - indicates any information from any health professional pertinent to the consultation that is not made 'face-to-face', eg by telephone or message left in the case notes.

8. If you are required to visit a patient at home please use the 'time in' section to fill in the time you entered the patient's home and write 'visit' at the top of the card (no Card N2 will be required).
9. **INTERRUPTIONS**

Please put a tick in the relevant box every time you are interrupted either before you see a patient, or during the time a patient is with you. If it is possible to distinguish between telephone interruptions and people coming in or catching you between patients, it would be very helpful.

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SECOND SIDE OF CARD:

10 Please tick all relevant boxes, as more than one task may be undertaken for each patient. As the categories are fairly broad it may be necessary to write in an item that you are unsure of, or which is not adequately covered in the above list, in any free space on the card. Please do not hesitate to do this if it is taking you too long to categorise something into the other groups.

Screening: if you are undertaking a screening procedure, please also tick the relevant boxes for any activity associated with it, eg weight, BP, health education.

**Therapeutic listening and health education/advice:** These categories may be an integral part of many of your consultations. Please use them whenever necessary, even if the 'presenting problem' has not indicated that there may be a requirement for advice or a listening role.

11. **DISPOSITION**

(a) **Discharged** - by agreement with the patient he/she is not required to be seen again by you for that condition.

(b) **Return SOS** - it is not necessary to see the patient again, but if the condition does not settle he/she is invited to return for a further consultation.

(c) **Fixed Return** - the patient is given a definite appointment to return to
   (a) Nurse
   (b) GP
   (c) Other - please specify

12. **TIME PATIENT LEFT** refers to the time the patient leaves the treatment room.
TIME STARTED WORK ___________________

Please record by means of a tick (✓) what you were doing during the whole of your working day:

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<th>ROUTINE TREATMENT ROOM WORK</th>
<th>ROUTINE CLINICS</th>
<th>SPECIAL CLINICS</th>
<th>ADMINISTRATION</th>
<th>MEETINGS</th>
<th>BREAKS</th>
<th>OTHER (specify)</th>
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TIME FINISHED WORK ___________________

SIGNED ______________________________
GUIDE NOTES FOR COMPLETION OF
END OF DAY CARD (CARD N3)

PLEASE COMPLETE AT THE END OF YOUR WORKING DAY.

1. Please tick (√) the day of the week in the appropriate box and enter the date.

2. This refers to the time that you are employed to start work.

3. Please note that we are trying to get a impression of your whole working day and it may be that the time you started work does not relate precisely to the time that you start recording for the Nurse Study, eg if you work full-time, you will only be recording am or pm.

4. ACTIVITIES BOXES
Please record with a tick (√) in the grid what you were doing (to the nearest half-hour) during the whole of your working day. Entries may overlap, because it is possible, for example, to be running a routine clinic at the same time as seeing some patients for other things such as dressings. In this case 'Routine treatment room work' and 'routine clinics' may be ticked at the same times.

Routine Treatment Room Work
This category broadly covers all that you do except for the categories specified below.

Routine Clinics
This refers to Baby/Child Welfare Clinics, Ante-natal clinics, and post-natal clinics.

Special Clinics
This refers to Family Planning/ Well Woman Clinics, Hypertension Clinics, Asthma Clinics, any other special clinic that you are involved in (please specify if you have time).

Administration
This includes such items as making phone calls, writing up case notes, filling in laboratory request forms, tidying surgeries.

Meetings
This is self-explanatory.

Breaks
This covers lunch and coffee breaks, but not natural breaks that may(!!) occur between patients in the surgery.

Other
Please tick (√) the box at your discretion and specify anything that you feel is interesting or different from routine. If you feel the other categories are unsuitable for any comments you may wish to make, please feel free to use this section to expand your ideas.

THANK YOU VERY MUCH FOR YOUR HELP
(*If the patient is a child, please give her/his date of birth and sex.)

FIRST OF ALL, WOULD YOU PLEASE TELL US.......

Your Date of Birth

Are you: Male Female

PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING (√) THE APPROPRIATE BOX

1. Have you ever consulted the Practice Nurse before?
   Yes No Don't know

2. About your visit to the nurse today:
   a) Did the doctor refer you through to see the nurse?
      Yes No
   OR b) Did you make an appointment to see the nurse?
      Yes No
   OR c) Other

3. If your appointment was with the nurse, was a doctor involved in the consultation at all?
   Yes No

4. a) If the doctor referred you to the nurse today, how long did you have to wait to see her?

   OR

   b) If you had an appointment with the nurse today, how long did you have to wait to see her after your appointment was due?

5. Do you feel this was too long?
   Yes No Not relevant

6. If the doctor referred you to the nurse today, do you feel it was because the doctor was in a bit of a hurry?
   YES, very hurried
   YES, a bit hurried
   NO, not hurried
   Not relevant

7. Would you have liked more time today to talk with:
   a) the nurse?
   b) the doctor?
   YES, quite a lot more
   YES, a little more
   NO, I had enough
8. Was your consultation with the nurse today interrupted by:
   a) the telephone ringing? YES  NO  DIDN'T NOTICE
   b) someone coming into room?

9. If you were aware of an interruption, did you find it upset your consultation with the nurse at all?
   Not relevant  Not at all  A little  Quite a lot  A lot

10. Were you satisfied with your visit to the nurse today?
    Very dissatisfied  Dissatisfied  50/50  Satisfied  Very satisfied

11. Did the nurse give you the feeling she was interested in what you had to say?
    Not interested  Quite interested  Very interested

12. Given the choice, would you make an appointment to see a Practice Nurse again?
    Yes  Perhaps  No  Don't know

13. As a result of your visit to the nurse today, do you feel you are:
    able to cope with life  MUCH BETTER  BETTER  SAME OR LESS
    able to understand your illness
    able to cope with your illness
    able to keep yourself healthy
    MUCH MORE  MORE  SAME OR LESS
    confident about your health
    able to help yourself

COMMENTS:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

THANK YOU FOR HELPING US
1 Have you personally used the service of the following within the last 12 months?  

PLEASE TICK ONE BOX FOR EACH ITEM

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

a) Practice Nurse

b) District Nurse

c) Health Visitor

2 For most things, would you rather by seen by:

<table>
<thead>
<tr>
<th>MALE</th>
<th>FEMALE</th>
<th>NO PREFERENCE</th>
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</table>

3 Do you think that nurses should be able to prescribe medicines and dressings for some conditions, without having to ask a doctor?:

For example:

i) PRACTICE NURSES

a) An antibiotic to treat an infection in the urine?

b) An inhaler for someone with asthma?

c) The oral contraceptive 'pill'?

d) Ointment for a skin condition?

ii) DISTRICT NURSES

a) An antibiotic to treat an infection in the urine?

b) An inhaler for someone with asthma?

c) The oral contraceptive 'pill'?

d) Ointment for a skin condition?

iii) HEALTH VISITORS

a) An antibiotic to treat an infection in the urine?

b) An inhaler for someone with asthma?

c) The oral contraceptive 'pill'?

d) Ointment for a skin condition?

4 Are there occasions when you would choose to see the practice nurse rather than the doctor?

PLEASE TICK ONE BOX:

Yes, often

Yes, sometimes

No, not very often

Never

5 If you requested a home visit and the practice nurse came, would you mind?

PLEASE TICK ONE BOX

a) Yes, I think the doctor should always come

b) No, I think the nurse could report any problems back to the doctor

c) I think it would depend on the reason for the visit

d) I would not mind whether the doctor or the nurse came
MIGHT you choose to see the practice nurse rather than the doctor for any of the following reasons: PLEASE TICK ALL BOXES THAT APPLY

- a) you can get an appointment sooner?
- b) you don’t have to wait as long in the waiting room
  as you do to see the doctor?
- c) the nurse will give you more of her time?
- d) you don’t feel embarrassed trying to explain things to the nurse?
- e) the nurse listens to you?
- f) you can see the nurse about problems that don’t need a doctor?
- g) the nurse can call the GP through if she thinks it necessary?
- h) any other reason? (please specify) ____________________________

SOME QUESTIONS ABOUT YOUR PRACTICE AND THE SERVICES IT OFFERS

Does your practice offer the services of the following: PLEASE TICK ONE BOX FOR EACH ITEM

- a) Practice Nurse
- b) District Nurse
- c) Health Visitor

Do you know if your practice offers any of the following services:

- a) maternity care
- b) baby clinics
- c) family planning clinics
- d) cervical smear tests
- e) breast examinations
- f) well man clinics
- g) well woman clinics
- h) asthma clinics
- i) diabetic clinics
- j) any other services that you know about? ____________________________

Please specify ____________________________

KEY: (PLEASE TICK ONE BOX)

1 VERY SATISFIED
2 DISSATISFIED
3 50/50
4 SATISFIED
5 VERY DISSATISFIED

Are you satisfied with the services that your practice is able to offer you at present?

1 □ 2 □ 3 □ 4 □ 5 □

Do you think that health checks can be done by a: YES NO DON'T KNOW

- a) Practice Nurse
- b) District Nurse
- c) Health Visitor
11 Who do you feel has more time to listen to you?  

<table>
<thead>
<tr>
<th>PRACTICE NURSE</th>
<th>HEALTH VISITOR</th>
<th>PLEASE TICK ONE BOX</th>
<th>DISTRICT NURSE</th>
<th>GP</th>
<th>RECEPTION STAFF</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td>□</td>
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</tbody>
</table>

WE WOULD NOW LIKE TO ASK WHICH HEALTH PROFESSIONAL YOU WOULD CHOOSE TO DO DIFFERENT THINGS IN GENERAL PRACTICE. PLEASE TICK A BOX TO INDICATE YOUR PREFERENCE. IF YOU HAVE NO PREFERENCE AT ALL PLEASE TICK THE BOX MARKED 'NO OPINION'.

12 Who do you think is the best person to check the health and development of children under the age of five?

<table>
<thead>
<tr>
<th>HEALTH VISITOR</th>
<th>GP</th>
<th>PRACTICE NURSE</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
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</table>

13 Who do you think is the best person to give children their immunisations?

<table>
<thead>
<tr>
<th>HEALTH VISITOR</th>
<th>GP</th>
<th>PRACTICE NURSE</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
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14 Who do you think is the best person to take cervical smears?

<table>
<thead>
<tr>
<th>HEALTH VISITOR</th>
<th>GP</th>
<th>PRACTICE NURSE</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
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</table>

15 Who do you think is the best person to do 'check ups' on people over 75 years of age?

<table>
<thead>
<tr>
<th>HEALTH VISITOR</th>
<th>GP</th>
<th>PRACTICE NURSE</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
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</table>

16 Who do you think is the best person to do breast examinations?

<table>
<thead>
<tr>
<th>HEALTH VISITOR</th>
<th>GP</th>
<th>PRACTICE NURSE</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
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</table>

17 Who do you think would be the best person to talk with if you wanted information or advice about any of the following?

<table>
<thead>
<tr>
<th>PRACTICE NURSE</th>
<th>HEALTH VISITOR</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
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</table>

a) diet  
b) blood pressure  
c) heart disease  
d) alcohol control  
e) management of stress  
f) exercise  
g) giving up smoking  
h) how to cope with a sick person in your family  
i) a bereavement  
j) a problem with your marriage  
k) a child misbehaving at school  
l) someone in the family taking drugs

18 If your practice invited you to have a health check up, would you:  

<table>
<thead>
<tr>
<th>PRACTICE NURSE</th>
<th>HEALTH VISITOR</th>
<th>DISTRICT NURSE</th>
<th>NO OPINION</th>
</tr>
</thead>
<tbody>
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</table>

a) be happy to come to the surgery at an agreed appointment time?  
b) accept, if it could be done some time when you were coming to the surgery anyway?  
c) accept, if it could be done at home?  
d) only accept if you felt the health check was 'worthwhile' for you?  
e) not accept because you feel quite well?  
f) not accept because you cannot spare the time?  
g) not accept because you don't believe in health checks  
h) rather 'not know' if there was anything wrong?  
i) not come because travel to the surgery is a problem?  
j) other reason (please specify) ___________________________________________
19 APART FROM YOUR DOCTOR, which of the following would you consult for health advice?

- a) Practice Nurse
definitely  perhaps  not at all
- b) Health Visitor
- c) District Nurse
- d) Chemist
- e) Relative
- f) Friend
- g) Magazines/newspapers
- h) Television/radio
- i) Other

20 Do you know that there have been changes made during the last year in family doctor services?

YES   NO

NOW SOME QUESTIONS ABOUT YOURSELF:

What is your date of birth? __/__/____

Are you?  
- Single?
- Married, living with spouse?
- Married, but separated?
- Divorced?
- Living with partner?
- Widowed?

Do you rent your home?

Do you own your home?

Do you (or your partner) own a car?

YES   NO

Do you have any children?
IF YES, do you have any children under the age of 14 living with you at home?

- None under 14
definitely  perhaps  not at all
- One child under 14
- 1-3 children under 14
- More than 3 children under 14

Do you have to care for anyone at home who needs a lot of help because of old age, illness or disability?

IF YES, who depends on you for this care?

a) parent(s)
b) husband/wife/partner
c) child(ren)
d) Other

THANK YOU FOR YOUR HELP
# PRACTICE/ TREATMENT ROOM NURSE QUESTIONNAIRE

## ROLES, RELATIONSHIPS AND CHANGE

1. In your opinion, do you feel that the following documents have addressed the main issues concerning the NHS?  
   - a) the White Paper 'Promoting Better Health'?  
   - b) the Community Care White Paper?
   
2. In your opinion, do you feel that the following documents have addressed the main issues concerning Primary Care?  
   - a) the White Paper 'Promoting Better Health'?  
   - b) the Community Care White Paper?

3. Prior to the implementation of the New GP Contract, did you have any concerns about:  
   - a) an increasing workload?  
   - b) a decreasing workload?  
   - c) losing professional independence?  
   - d) your role as a Practice/Treatment Room Nurse?  
   - e) overlap of roles?  
   - f) quality of patient care?  
   - g) other concerns  
   please summarise briefly

4. Now that you have been working alongside the New Contract for a year, do you have any concerns about:  
   - a) an increasing workload?  
   - b) a decreasing workload?  
   - c) losing professional independence?  
   - d) your role as a Practice/Treatment Room Nurse changing?  
   - e) overlap of roles?  
   - f) quality of patient care?  
   - g) other activities  
   please specify

5. Has there been any change in your workload since the New Contract?  
   - DECREASED  
   - NO CHANGE  
   - INCREASED
6. If you have experienced any change in your workload, how has this affected your involvement with:
   a) home visits to the elderly? □ □ □
   b) home visits to mothers with young children? □ □ □
   c) screening clinics for specified sub-groups? □ □ □
   d) patient referrals in general? □ □ □
   e) other activities please specify __________________________

   DECREASED NO CHANGE INCREASED

7. If your workload has increased in any area, have you had to reduce your involvement in any other?
   YES □ NO □

   If YES, please summarise briefly __________________________

8. If you have had to reduce your involvement in any area, was this:
   BY CHOICE □ FROM NECESSITY □

9. How do you think the New Contract has affected the morale of the following?
   a) G.P.s □ □ □
   b) Practice Managers □ □ □
   c) Receptionists □ □ □
   d) Practice/Treatment Room Nurse colleagues □ □ □
   e) Community Nurse Managers □ □ □
   f) Health Visitors □ □ □
   g) District Nurses □ □ □
   h) Other Health Professionals □ □ □

   BETTER UNCHANGED WORSE

10. How has the New Contract affected your morale as a Practice/Treatment Room Nurse?
    BETTER □ UNCHANGED □ WORSE □

11. How have other recent changes in the NHS affected your morale as a Practice/Treatment Room Nurse?
    BETTER □ UNCHANGED □ WORSE □
12. Within the setting of your Primary care Team, how do you rate your working relationship with the following since the New Contract?

<table>
<thead>
<tr>
<th>Role</th>
<th>BETTER</th>
<th>UNCHANGED</th>
<th>WORSE</th>
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</thead>
<tbody>
<tr>
<td>a) G.P.s</td>
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<td>b) Practice Managers</td>
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<tr>
<td>c) Receptionists</td>
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<tr>
<td>d) Practice/Treatment Room Nurse colleagues</td>
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<td>e) Community Nurse Managers</td>
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<tr>
<td>f) Health Visitors</td>
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<tr>
<td>g) District Nurses</td>
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<tr>
<td>h) Other Health Professionals</td>
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</table>

13. Since the implementation of the New Contract, do you feel concerned about:

<table>
<thead>
<tr>
<th>Concern</th>
<th>MORE CONCERNED</th>
<th>UNCONCERNED</th>
<th>LESS CONCERNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) adequacy of resources</td>
<td></td>
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<tr>
<td>b) job definition</td>
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<tr>
<td>c) lack of training/experience in certain areas</td>
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<td>d) communication with other team members</td>
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<tr>
<td>e) the control and direction you have over your professional work</td>
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<tr>
<td>f) differing expectations of other professional groups</td>
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<tr>
<td>g) demands and pressures from patients</td>
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<tr>
<td>h) accountability</td>
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<tr>
<td>i) support from the nursing hierarchy</td>
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<tr>
<td>j) professional isolation</td>
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<tr>
<td>k) feeling under-valued</td>
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<tr>
<td>l) other, non-work stressors?</td>
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<tr>
<td>please specify</td>
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</table>

PLEASE CIRCLE THE APPROPRIATE NUMBER WHICH COMES CLOSEST TO YOUR REACTION TO THE FOLLOWING STATEMENTS:

KEY:

<table>
<thead>
<tr>
<th>Reaction</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>STRONGLY AGREE</td>
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<tr>
<td>AGREE</td>
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<tr>
<td>UNCERTAIN</td>
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<tr>
<td>DISAGREE</td>
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<tr>
<td>STRONGLY DISAGREE</td>
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14. "I had adequate opportunity prior to the New Contract to discuss how best we could work together after its implementation" with:

<table>
<thead>
<tr>
<th>Role</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>a) GPs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) Practice Managers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) Receptionists</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) Practice/TR Nurse colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) Community Nurse Managers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) Health Visitors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) District Nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h) Other Health Professionals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
15. "From a professional point of view, the work of the following has changed for the better as a result of the New Contract"

   a) GPs 1 2 3 4 5
   b) Practice Managers 1 2 3 4 5
   c) Receptionists 1 2 3 4 5
   d) Practice/TR Nurse colleagues 1 2 3 4 5
   e) Community Nurse Managers 1 2 3 4 5
   f) Health Visitors 1 2 3 4 5
   g) District Nurses 1 2 3 4 5
   h) Other Health Professionals 1 2 3 4 5

16. "Overall the public has benefited from the changes taking place as a result of the New Contract"

   1 2 3 4 5

17. If, as a result of the New Contract, you feel that some things have got better and some have got worse - would you explain in what ways?

   ____________________________________________________________

18. Do you agree that the members of your Primary Care Team listed below understand your day-to-day work as a Practice/Treatment Room Nurse?

   a) GPs 1 2 3 4 5
   b) Practice Managers 1 2 3 4 5
   c) Receptionists 1 2 3 4 5
   d) Practice/TR Nurse colleagues 1 2 3 4 5
   e) Community Nurse Managers 1 2 3 4 5
   f) Health Visitors 1 2 3 4 5
   g) District Nurses 1 2 3 4 5
   h) Other Health Professionals 1 2 3 4 5

19. Do you agree that the members of your Primary Care Team listed below value your day-to-day work as a District Nurse?

   a) GPs 1 2 3 4 5
   b) Practice Managers 1 2 3 4 5
   c) Receptionists 1 2 3 4 5
   d) Practice/TR Nurse colleagues 1 2 3 4 5
   e) Community Nurse Managers 1 2 3 4 5
   f) Health Visitors 1 2 3 4 5
   g) District Nurses 1 2 3 4 5
   h) Other Health Professionals 1 2 3 4 5
20. Do you have the same access as GPs with whom you work to:
   a) age/sex registers?
   b) the medical records?  YES  NO

21. If YES, a) Are the reception staff willing to
    take out medical records at your request?  YES  NO  SOMETIMES
   b) Are the reception staff allowed to
    take out medical records at your request?  YES  NO  SOMETIMES

22. Are the G.P.s with whom you work happy to be contacted informally on a daily
    basis to discuss patients?  ALWAYS  USUALLY

23. Have you incurred any 'wasted' visits to patients within the last three months because of a lack
    of current information from G.P.s?  YES  NO (e.g. hospital admissions/deaths)

**PRACTICE MEETINGS**

24. Approximately how often are practice meetings held?
   Weekly  YES  NO  SOMETIMES
   Monthly  YES  NO  SOMETIMES
   3 monthly  YES  NO  SOMETIMES
   6 monthly  YES  NO  SOMETIMES
   Not at all  YES  NO  SOMETIMES
   Other

25. Are you involved in deciding when practice meetings should take place?  YES  NO  SOMETIMES

26. Are you invited to attend practice meetings?  YES  NO  SOMETIMES
   If YES, are you invited to take part in the following:
      a) discussing patients?
      b) discussing innovations and improvements in the practice?
      c) meeting medical representatives?
      d) meeting other professional groups?
      e) social activities?
      f) other
         please specify ______________________

27. If you are invited to practice meetings, do you attend them?  YES  NO  SOMETIMES
28. Within the primary care team are you involved in:
   a) planning of division of work?  YES  NO  SOMETIMES
   b) decisions about division of work?  YES  NO  SOMETIMES
   c) discussions about practice policies?  YES  NO  SOMETIMES
   d) decisions about practice policies?  YES  NO  SOMETIMES
   e) discussions about practice development?  YES  NO  SOMETIMES
   f) decisions about practice development?  YES  NO  SOMETIMES

29. Do you undertake any of the following at present:
   a) immunisation of children?  YES  NO
   b) antenatal care?  YES  NO
   c) postnatal care?  YES  NO
   d) screening of the elderly?  YES  NO
   e) family planning?  YES  NO

30. Do you think the following should be part of your work as a Practice/Treatment Room Nurse?
   a) screening the elderly?  YES  NO
   b) immunising children?  YES  NO
   c) giving 'flu vaccinations?  YES  NO
   d) taking cervical smears?  YES  NO
   e) giving contraceptive advice?  YES  NO
   f) helping to compile practice annual reports?  YES  NO
   g) helping to design Practice Leaflets?  YES  NO

31. If you have answered 'No' to any of the categories in Question 30, who do you think should be responsible for:
    PRACTICE/TR NURSE  HEALTH VISITOR  GP
   a) screening the elderly?  YES  NO
   b) immunising children?  YES  NO
   c) giving 'flu vaccinations?  YES  NO
   d) taking cervical smears?  YES  NO
   e) giving contraceptive advice?  YES  NO
   f) helping to compile practice annual reports?  YES  NO
   g) helping to design Practice Leaflets?  YES  NO

32. If asked to undertake an 'extended role' (eg prescribing) do you feel:
    YES  NO
   a) your training/experience makes you competent to do so  YES  NO
   b) you require further training in certain areas?  YES  NO
   c) an 'extended role' is inappropriate for Practice/TR Nurses?  YES  NO
   d) worried about 'professional accountability'?  YES  NO
   e) such roles may adversely affect your relationships with other nursing colleagues?  YES  NO
   f) other (please specify) ____________________________________________  YES  NO
<table>
<thead>
<tr>
<th>Question</th>
<th>Regularly</th>
<th>Sometimes</th>
<th>Never</th>
<th>Yes</th>
<th>No</th>
<th>No Opinion</th>
<th>Don't Know</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Do you recommend products for patients to buy from the chemist?</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>34. Are you happy that the following are included in the new Nurse Prescribing legislation:</td>
<td>YES</td>
<td>NO</td>
<td>NO Opinion</td>
<td></td>
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<tr>
<td>a) District Nurses</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>b) Health Visitors</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>35. Do you feel that Practice/TR Nurses should be included in the new Nurse Prescribing legislation?</td>
<td>YES</td>
<td>NO</td>
<td>NO Opinion</td>
<td></td>
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<tr>
<td>36. Do you see Health Visiting as having a 'nursing' component?</td>
<td>YES</td>
<td>NO</td>
<td>DON'T KNOW</td>
<td></td>
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<tr>
<td>37. Would you recommend Practice/Treatment Room Nursing as an interesting branch of the health professions?</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td><strong>Continuing Education</strong></td>
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<td>38. Have you heard about 'PREP' (Post Registration Education and Practice) Project?</td>
<td>YES</td>
<td>NO</td>
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<td>39. In consideration of some of PREP's proposals:</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>a) Are you happy to undertake continuing professional education?</td>
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<td>b) Do you feel that 5 days study leave every 3 years is adequate?</td>
<td>0</td>
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<tr>
<td>c) Would you be willing to give up some of your free time to further your professional development?</td>
<td>0</td>
<td>0</td>
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<td>d) Would you be willing to pay some of the costs of continuing education yourself?</td>
<td>0</td>
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<td>e) Do you feel it will affect you personally? Please comment</td>
<td>YES</td>
<td>NO</td>
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<td>40. Do you have access to in-service training at present?</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>If YES,</td>
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<td>a) by conferences</td>
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<td>b) professional meetings</td>
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<td>c) courses</td>
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<td>d) other Please specify</td>
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<tr>
<td>41. If you have access to in-service training, how many events have you attended in the last year?</td>
<td>NONE</td>
<td>1</td>
<td>2-4</td>
<td>5-9</td>
<td>10+</td>
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<tr>
<td>42. If you have NOT attended any events in the last year, was this because:</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>a) work commitments prevented you from attending?</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>b) family commitments prevented you from attending?</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>c) location too far away ?</td>
<td>0</td>
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<td>d) time of day unsuitable ?</td>
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<td>e) find these events too costly ?</td>
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<tr>
<td>f) find these events 'unhelpful' ?</td>
<td>0</td>
<td>0</td>
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<td>g) other (please specify)</td>
<td>0</td>
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</tbody>
</table>
43. If you have received any form of continuing education, did you have to attend in your own time? 
   YES  NO

44. If payment was required for any of the above: 
   YES  NO
   a) Did you have to pay for it yourself?  
   b) Did your Health Board pay? 
   c) Payment from another source, eg drug company? 
   If YES, please specify __________________________

PERSONAL/ PROFESSIONAL DETAILS

45. Date of Birth: __________________________

46. Sex
   MALE  FEMALE
   □  □

47. Do you work:
   FULL TIME  PART TIME
   □  □

48. What qualifications do you have? 
   a) RGN/ SRN  
   b) RMN  
   c) RSCN  
   d) SEN/EN  
   e) CMB( Part 1)  
   f) SCM/ RM  
   g) NDN Certificate  
   h) HV Certificate  
   i) Family Planning Certificate  
   j) Practice Nurse Certificate  
   k) BA/ B.Sc. in Nursing  
   l) Post-graduate degree  
   m) Other degree (please specify) ________________  

49. Why did you choose to work as a Practice/TR Nurse? 
   YES  NO
   a) an interesting job  
   b) hours compatible with family commitments  
   c) location  
   d) salary  
   e) other reasons (please specify) ____________________  

50. How much experience do you have as a Practice/TR Nurse? 
   Less than 1 year  
   More than 1 year  □  ____ Yrs
ROLES, RELATIONSHIPS AND CHANGE

1. In your opinion, do you feel that the following documents have addressed the main issues concerning the NHS?  
   a) the White Paper 'Promoting Better Health'?  
   b) the Community Care White Paper?  

   YES  NO  NO OPINION

2. In your opinion, do you feel that the following documents have addressed the main issues concerning Primary Care?  
   a) the White Paper 'Promoting Better Health'?  
   b) the Community Care White Paper?  

   YES  NO  NO OPINION

3. Prior to the implementation of the New GP Contract, did you have any concerns about:  
   a) an increasing workload?  
   b) a decreasing workload?  
   c) losing professional independence?  
   d) your role as a Health Visitor?  
   e) overlap of roles?  
   f) quality of patient care?  
   g) other concerns?  
   please summarise briefly ____________________________

4. Now that you have been working alongside the New Contract for a year, do you have any concerns about:  
   a) an increasing workload?  
   b) a decreasing workload?  
   c) losing professional independence?  
   d) your role as a Health Visitor changing?  
   e) overlap of roles?  
   f) quality of patient care?  
   g) other activities?  
   please specify ____________________________

5. Has there been any change in your workload since the New Contract?  

   DECREASED  NO CHANGE  INCREASED

1
6. If you have experienced any change in your workload, how has this affected your involvement with:
   a) home visits to the elderly? □ □ □
   b) home visits to mothers with young children? □ □ □
   c) screening clinics for specified sub-groups? □ □ □
   d) client referrals in general? □ □ □
   e) other activities
   please specify ______________________

   DECREASED  NO CHANGE  INCREASED

7. If your workload has increased in any area, have you had to reduce your involvement in any other?
   YES □ □ NO □ □
   If YES, please summarise briefly ______________________

8. If you have had to reduce your involvement in any area, was this:
   BY CHOICE FROM NECESSITY □ □

9. How do you think the New Contract has affected the morale of the following?
   BETTER UNCHANGED WORSE
   a) G.P.s □ □ □
   b) Practice Managers □ □ □
   c) Receptionists □ □ □
   d) Practice/Treatment Room Nurses □ □ □
   e) Community Nurse Managers □ □ □
   f) Health Visitor colleagues □ □ □
   g) District Nurses □ □ □
   h) Other Health Professionals □ □ □

10. How has the New Contract affected your morale as a Health Visitor?
    BETTER  UNCHANGED  WORSE
    □ □ □

11. How have other recent changes in the NHS affected your morale as a Health Visitor?
    BETTER  UNCHANGED  WORSE
    □ □ □
12. Within the setting of your Primary care Team, how do you rate your working relationship with the following since the New Contract?

<table>
<thead>
<tr>
<th></th>
<th>BETTER</th>
<th>UNCHANGED</th>
<th>WORSE</th>
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<tbody>
<tr>
<td>a) G.P.s</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>b) Practice Managers</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>c) Receptionists</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>d) Practice/TR Nurses</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>e) Community Nurse Managers</td>
<td>□</td>
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<tr>
<td>f) Health Visitor colleagues</td>
<td>□</td>
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<td></td>
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<tr>
<td>g) District Nurses</td>
<td>□</td>
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<td>□</td>
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<tr>
<td>h) Other Health Professionals</td>
<td>□</td>
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</table>

13. Since the implementation of the New Contract, do you feel concerned about:

<table>
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<tr>
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<th>MORE CONCERNED</th>
<th>UN-CONCERNED</th>
<th>LESS CONCERNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) adequacy of resources</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>b) job definition</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) lack of training/experience in certain areas</td>
<td>□</td>
<td>□</td>
<td></td>
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<tr>
<td>d) communication with other team members</td>
<td>□</td>
<td>□</td>
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<tr>
<td>e) the control and direction you have over your professional work</td>
<td>□</td>
<td>□</td>
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<tr>
<td>f) differing expectations of other professional groups</td>
<td>□</td>
<td>□</td>
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<tr>
<td>g) demands and pressures from clients</td>
<td>□</td>
<td>□</td>
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<tr>
<td>h) accountability</td>
<td>□</td>
<td>□</td>
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<tr>
<td>i) support from the nursing hierarchy</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>j) professional isolation</td>
<td>□</td>
<td>□</td>
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<tr>
<td>k) feeling under-valued</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>l) other, non-work stressors?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>please specify_____________________</td>
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PLEASE CIRCLE THE APPROPRIATE NUMBER WHICH COMES CLOSEST TO YOUR REACTION TO THE FOLLOWING STATEMENTS:

KEY:

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<tbody>
<tr>
<td>STRONGLY AGREE</td>
<td>AGREE</td>
<td>UNCERTAIN</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
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</table>

14. "I had adequate opportunity prior to the New Contract to discuss how best we could work together after its implementation" with:

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<tr>
<td>a) GPs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>b) Practice Managers</td>
<td>1</td>
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<tr>
<td>c) Receptionists</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>d) Practice/TR Nurses</td>
<td>1</td>
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<tr>
<td>e) Community Nurse Managers</td>
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<tr>
<td>f) Health Visitor colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) District Nurses</td>
<td>1</td>
<td>2</td>
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<td>5</td>
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<tr>
<td>h) Other Health Professionals</td>
<td>1</td>
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15. "From a professional point of view, the work of the following has changed for the better as a result of the New Contract"

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<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
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<tr>
<td>a) GPs</td>
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<tr>
<td>b) Practice Managers</td>
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<tr>
<td>c) Receptionists</td>
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<tr>
<td>d) Practice/TR Nurses</td>
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<tr>
<td>e) Community Nurse Managers</td>
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<tr>
<td>f) Health Visitor colleagues</td>
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<tr>
<td>g) District Nurses</td>
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<tr>
<td>h) Other Health Professionals</td>
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16. "Overall the public has benefited from the changes taking place as a result of the New Contract"

1 | 2 | 3 | 4 | 5

17. If, as a result of the New Contract, you feel that some things have got better and some have got worse - would you explain in what ways?

---

18. Do you agree that the members of your Primary Care Team listed below understand your day-to-day work as a Health Visitor?

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<td>AGREE</td>
<td>UNCERTAIN</td>
<td>DISAGREE</td>
<td>STRONGLY DISAGREE</td>
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<tr>
<td>a) GPs</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) Practice Managers</td>
<td>1</td>
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<tr>
<td>c) Receptionists</td>
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<td>d) Practice/TR Nurses</td>
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<tr>
<td>f) Health Visitor colleagues</td>
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<tr>
<td>g) District Nurses</td>
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<tr>
<td>h) Other Health Professionals</td>
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</table>

19. Do you agree that the members of your Primary Care Team listed below value your day-to-day work as a Health Visitor?

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<td>STRONGLY DISAGREE</td>
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</tbody>
</table>
20. Do you have the same access as GPs with whom you work to:
   a) age/sex registers?
   b) the medical records?

21. If YES, a) Are the reception staff willing to take out medical records at your request? b) are the reception staff allowed to take out medical records at your request?

22. Are the G.P.s with whom you work happy to be contacted informally on a daily basis to discuss clients?

23. Have you incurred any 'wasted' visits to clients within the last three months because of a lack of current information from G.P.s? (e.g. hospital admissions/deaths)

24. Approximately how often are practice meetings held?
   - Weekly
   - Monthly
   - 3 monthly
   - 6 monthly
   - Not at all
   - Other

25. Are you involved in deciding when practice meetings should take place?

26. Are you invited to attend practice meetings?
   If YES, are you invited to take part in the following:
   a) discussing clients?
   b) discussing innovations and improvements in the practice?
   c) meeting medical representatives?
   d) meeting other professional groups?
   e) social activities?
   f) other
   please specify __________________________

27. If you are invited to practice meetings, do you attend them?
28. Within the primary care team are you involved in:  
   a) planning of division of work?  
   b) decisions about division of work?  
   c) discussions about practice policies?  
   d) decisions about practice policies?  
   e) discussions about practice development?  
   f) decisions about practice development?  

29. Do you undertake any of the following at present:  
   a) immunisation of children?  
   b) antenatal care?  
   c) postnatal care?  
   d) screening of the elderly?  
   e) family planning?  

30. Do you think the following should be part of your work as a Health Visitor?:  
   a) screening the elderly?  
   b) immunising children?  
   c) giving 'flu vaccinations?  
   d) taking cervical smears?  
   e) giving contraceptive advice?  
   f) helping to compile practice annual reports?  
   g) helping to design Practice Leaflets?  

31. If you have answered 'No' to any of the categories in Question 30, who do you think should be responsible for:  
   a) screening the elderly?  
   b) immunising children?  
   c) giving 'flu vaccinations?  
   d) taking cervical smears?  
   e) giving contraceptive advice?  
   f) helping to compile practice annual reports?  
   g) helping to design Practice Leaflets?  

32. If asked to undertake an 'extended role' (eg prescribing) do you feel:  
   a) your training/experience makes you competent to do so  
   b) you require further training in certain areas?  
   c) an 'extended role' is inappropriate for Health Visitors?  
   d) worried about 'professional accountability'?  
   e) such roles may adversely affect your relationships with other nursing colleagues?  
   f) other (please specify)  

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**Table:**

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<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>SOMETIMES</th>
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<td>28. b) decisions about division of work?</td>
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<td>32. f) other (please specify)</td>
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</table>
33. Do you recommend products for patients to buy from the chemist?  
   REGULARLY  SOMETIMES  NEVER  
   □  □  □  □

34. Are you happy that the following are included in the new Nurse Prescribing legislation:  
   a) District Nurses  
   □ □ □  □
   b) Health Visitors  
   □ □ □  □

35. Do you feel that Practice/TR Nurses should be included in the new Nurse Prescribing legislation?  
   YES  NO  NO OPINION  
   □ □ □  □

36. Do you see Health Visiting as having a 'nursing' component?  
   YES  NO  DON'T KNOW  
   □ □ □  □

37. Would you recommend Health Visiting as an interesting branch of the health professions?  
   YES  NO  
   □ □

CONTINUING EDUCATION

38. Have you heard about 'PREP' (Post Registration Education and Practice) Project?  
   YES  NO  
   □ □

39. In consideration of some of PREP's proposals:  
   a) Are you happy to undertake continuing professional education?  
      □ □ □  □
   b) Do you feel that 5 days study leave every 3 years is adequate?  
      □ □ □  □
   c) Would you be willing to give up some of your free time to further your professional development?  
      □ □ □  □
   d) Would you be willing to pay some of the costs of continuing education yourself?  
      □ □ □  □
   e) Do you feel it will affect you personally?  
      Please comment ________________  
      YES  NO  
      □ □

40. Do you have access to in-service training at present?  
   If YES,  
   a) by conferences  
      □ □ □  □
   b) professional meetings  
      □ □ □  □
   c) courses  
      □ □ □  □
   d) other Please specify ____________________  
      YES  NO  
      □ □

41. If you have access to in-service training, how many events have you attended in the last year?  
   NONE  1  2-4  5-9  10+  
   □ □ □ □ □

42. If you have NOT attended any events in the last year, was this because:  
   YES  NO  
   □ □
   a) work commitments prevented you from attending?  
      □ □ □  □
   b) family commitments prevented you from attending?  
      □ □ □  □
   c) location too far away?  
      □ □ □  □
   d) time of day unsuitable?  
      □ □ □  □
   e) find these events too costly?  
      □ □ □  □
   f) find these events 'unhelpful'?  
      □ □ □  □
   g) other Please specify ____________________  
      □ □
43. If you have received any form of continuing education, did you have to attend in your own time? YES NO

44. If payment was required for any of the above: YES NO
   a) Did you have to pay for it yourself? □ □
   b) Did your Health Board pay? □ □
   c) Payment from another source, eg drug company? □ □

If YES, please specify_____________________

PERSONAL/ PROFESSIONAL DETAILS

45. Date of Birth: ____________________________

46. Sex MALE FEMALE
   □ □

47. Do you work: FULL TIME PART TIME
   □ □

48. What qualifications do you have?
   a) RGN/SRN □
   b) RMN □
   c) RSCN □
   d) SEN/EN □
   e) CMB(Part 1) □
   f) SCM/RM □
   g) NDN Certificate □
   h) HV Certificate □
   i) Family Planning Certificate □
   j) Practice Nurse Certificate □
   k) BA/B.Sc. in Nursing □
   l) Post-graduate degree □
   m) Other degree (please specify) □

49. Why did you choose to work as a Health Visitor? YES NO
   a) an interesting job □ □
   b) hours compatible with family commitments □ □
   c) location □ □
   d) salary □ □
   e) other reasons (please specify)______________________ □ □

50. How much experience do you have as a Health Visitor? □ □
   Less than 1 year □
   More than 1 year □ ___ Yrs
DISTRICT NURSE QUESTIONNAIRE

ROLES, RELATIONSHIPS AND CHANGE

1. In your opinion, do you feel that the following documents have addressed the main issues concerning the NHS?  
   a) the White Paper 'Promoting Better Health'?  
   b) the Community Care White Paper?  
   □ YES  □ NO  □ NO OPINION

2. In your opinion, do you feel that the following documents have addressed the main issues concerning Primary Care?  
   a) the White Paper 'Promoting Better Health'?  
   b) the Community Care White Paper?  
   □ YES  □ NO  □ NO OPINION

3. Prior to the implementation of the New GP Contract, did you have any concerns about:  
   a) an increasing workload?  
   b) a decreasing workload?  
   c) losing professional independence?  
   d) your role as a District Nurse?  
   e) overlap of roles?  
   f) quality of patient care?  
   g) other concerns  
   please summarise briefly __________________________________________

4. Now that you have been working alongside the New Contract for a year, do you have any concerns about:  
   a) an increasing workload?  
   b) a decreasing workload?  
   c) losing professional independence?  
   d) your role as a District Nurse changing?  
   e) overlap of roles?  
   f) quality of patient care?  
   g) other activities  
   please specify __________________________________________

5. Has there been any change in your workload since the New Contract?  
   □ DECREASED  □ NO CHANGE  □ INCREASED
6. If you have experienced any change in your workload, how has this affected your involvement with:

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<tr>
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<th>NO CHANGE</th>
<th>INCREASED</th>
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<tbody>
<tr>
<td>a) home visits to the elderly?</td>
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<tr>
<td>b) home visits to mothers with young children?</td>
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<td>c) screening clinics for specified sub-groups?</td>
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<tr>
<td>d) patient referrals in general?</td>
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<td>e) other activities</td>
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please specify ____________________________

7. If your workload has increased in any area, have you had to reduce your involvement in any other?  

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If YES, please summarise briefly ____________________________

8. If you have had to reduce your involvement in any area, was this:

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<th>BY CHOICE</th>
<th>FROM NECESSITY</th>
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9. How do you think the New Contract has affected the morale of the following?

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<th></th>
<th>BETTER</th>
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<tr>
<td>a) G.P.s</td>
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<td>h) Other Health Professionals</td>
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10. How has the New Contract affected your morale as a District Nurse?

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11. How have other recent changes in the NHS affected your morale as a District Nurse?

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12. Within the setting of your Primary care Team, how do you rate your working relationship with the following since the New Contract?

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<td>District Nurse colleagues</td>
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<td>Other Health Professionals</td>
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13. Since the implementation of the New Contract, do you feel concerned about:

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<th>LESS CONCERNED</th>
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<td>adequacy of resources</td>
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<td>job definition</td>
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<td>lack of training/experience in certain areas</td>
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<td>communication with other team members</td>
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<td>the control and direction you have over your professional work</td>
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<td>differing expectations of other professional groups</td>
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<td>demands and pressures from patients</td>
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<td>accountability</td>
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<td>support from the nursing hierarchy</td>
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<td>professional isolation</td>
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<td>feeling under-valued</td>
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<td>other, non-work stressors?</td>
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PLEASE CIRCLE THE APPROPRIATE NUMBER WHICH COMES CLOSEST TO YOUR REACTION TO THE FOLLOWING STATEMENTS:

KEY: 1 2 3 4 5

14. "I had adequate opportunity prior to the New Contract to discuss how best we could work together after its implementation" with:

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15. "From a professional point of view, the work of the following has changed for the better as a result of the New Contract"

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16. "Overall the public has benefited from the changes taking place as a result of the New Contract"

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17. If, as a result of the New Contract, you feel that some things have got better and some have got worse - would you explain in what ways?

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18. Do you agree that the members of your Primary Care Team listed below understand your day-to-day work as a District Nurse?

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19. Do you agree that the members of your Primary Care Team listed below value your day-to-day work as a District Nurse?

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20. Do you have the same access as GPs with whom you work to:
   a) age/sex registers?
   b) the medical records?
   YES   NO

21. If YES, a) Are the reception staff \textit{willing} to take out medical records at your request? YES   NO   SOMETIMES
   b) Are the reception staff \textit{allowed} to take out medical records at your request? YES   NO   SOMETIMES

22. Are the G.P.s with whom you work happy to be contacted informally on a daily basis to discuss patients?
   ALWAYS   USUALLY

23. Have you incurred any 'wasted' visits to patients within the last three months because of a lack of current information from G.P.s?
   YES   NO
   (e.g. hospital admissions/deaths)

PRACTICE MEETINGS

24. Approximately how often are practice meetings held?
   Weekly
   Monthly
   3 monthly
   6 monthly
   Not at all
   Other

25. Are you involved in deciding when practice meetings should take place?
   YES   NO   SOMETIMES

26. Are you invited to attend practice meetings? YES   NO   SOMETIMES

   If YES, are you invited to take part in the following:
   a) discussing patients?
   b) discussing innovations and improvements in the practice?
   c) meeting medical representatives?
   d) meeting other professional groups?
   e) social activities?
   f) other
   please specify ____________________

27. If you are invited to practice meetings, do you attend them? YES   NO   SOMETIMES
28. Within the primary care team are you involved in:
   a) planning of division of work? □ □ □
   b) decisions about division of work? □ □ □
   c) discussions about practice policies? □ □ □
   d) decisions about practice policies? □ □ □
   e) discussions about practice development? □ □ □
   f) decisions about practice development? □ □ □

29. Do you undertake any of the following at present:
   a) immunisation of children? □ □ □
   b) antenatal care? □ □ □
   c) postnatal care? □ □ □
   d) screening of the elderly? □ □ □
   e) family planning? □ □ □

30. Do you think the following should be part of your work as a District Nurse?
   a) screening the elderly? □ □ □
   b) immunising children? □ □ □
   c) giving 'flu vaccinations? □ □ □
   d) taking cervical smears? □ □ □
   e) giving contraceptive advice? □ □ □
   f) helping to compile practice annual reports? □ □ □
   g) helping to design Practice Leaflets? □ □ □

31. If you have answered 'No' to any of the categories in Question 30, who do you think should be responsible for:
   a) screening the elderly? □ □ □
   b) immunising children? □ □ □
   c) giving 'flu vaccinations? □ □ □
   d) taking cervical smears? □ □ □
   e) giving contraceptive advice? □ □ □
   f) helping to compile practice annual reports? □ □ □
   g) helping to design Practice Leaflets? □ □ □

32. If asked to undertake an 'extended role' (eg prescribing) do you feel:
   a) your training/experience makes you competent to do so □ □ □
   b) you require further training in certain areas? □ □ □
   c) an 'extended role' is inappropriate for District Nurses? □ □ □
   d) worried about 'professional accountability'? □ □ □
   e) such roles may adversely affect your relationships with other nursing colleagues? □ □ □
   f) other (please specify) ____________________________ □ □
33. Do you recommend products for patients to buy from the chemist?  
   | REGULARLY | SOMETIMES | NEVER |
   | □ | □ | □ |

34. Are you happy that the following are included in the new Nurse Prescribing legislation:  
   a) District Nurses  
   b) Health Visitors  
   | YES | NO | NO OPINION |

35. Do you feel that Practice/TR Nurses should be included in the new Nurse Prescribing legislation?  
   | YES | NO | NO OPINION |

36. Do you see Health Visiting as having a 'nursing' component?  
   | YES | NO | DON'T KNOW |

37. Would you recommend District Nursing as an interesting branch of the health professions?  
   | YES | NO |

CONTINUING EDUCATION  
38. Have you heard about 'PREP' (Post Registration Education and Practice) Project?  
   | YES | NO |

39. In consideration of some of PREP's proposals:  
   a) Are you happy to undertake continuing professional education?  
   b) Do you feel that 5 days study leave every 3 years is adequate?  
   c) Would you be willing to give up some of your free time to further your professional development?  
   d) Would you be willing to pay some of the costs of continuing education yourself?  
   e) Do you feel it will affect you personally?  
      Please comment ________________________  
   | YES | NO |

40. Do you have access to in-service training at present?  
   If YES,  
   a) by conferences  
   b) professional meetings  
   c) courses  
   d) other Please specify ________________________  
   | YES | NO |

41. If you have access to in-service training, how many events have you attended in the last year?  
   | NONE | 1 | 2-4 | 5-9 | 10+ |

42. If you have NOT attended any events in the last year, was this because:  
   a) work commitments prevented you from attending?  
   b) family commitments prevented you from attending?  
   c) location too far away?  
   d) time of day unsuitable?  
   e) find these events too costly?  
   f) find these events 'unhelpful'?  
   g) other (please specify) ________________________  
   | YES | NO |
43. If you have received any form of continuing education, did you have to attend in your own time?
   YES □ NO □

44. If payment was required for any of the above: YES □ NO □
   a) Did you have to pay for it yourself?
      □ □
   b) Did your Health Board pay?
      □ □
   c) Payment from another source, eg drug company?
      □ □
      If YES, please specify ________________________

PERSONAL/PROFESSIONAL DETAILS

45. Date of Birth:

46. Sex
   MALE □ FEMALE □

47. Do you work:
   FULL TIME □ PART TIME □

48. What qualifications do you have?
   a) RGN/SRN □
   b) RMN □
   c) RSCN □
   d) SEN/EN □
   e) CMB(Part 1) □
   f) SCM/RM □
   g) NDN Certificate □
   h) HV Certificate □
   i) Family Planning Certificate □
   j) Practice Nurse Certificate □
   k) BA/B.Sc. in Nursing □
   l) Post-graduate degree □
   m) Other degree (please specify): □

49. Why did you choose to work as a District Nurse?
   YES □ NO □
   a) an interesting job
      □ □
   b) hours compatible with family commitments
      □ □
   c) location
      □ □
   d) salary
      □ □
   e) other reasons (please specify): ________________________

50. How much experience do you have as a District Nurse?
   □
   Less than 1 year
   □
   More than 1 year
   □ □ Yrs
QUESTIONNAIRE FOR GENERAL PRACTITIONERS

ROLES, RELATIONSHIPS AND CHANGE

1. In your opinion, do you feel that the following documents have addressed the main issues concerning the NHS? YES NO NO OPINION
   a) the White Paper 'Promoting Better Health'? □ □ □
   b) the Community Care White Paper? □ □ □

2. In your opinion, do you feel that the following documents have addressed the main issues concerning Primary Care? YES NO NO OPINION
   a) the White Paper 'Promoting Better Health'? □ □ □
   b) the Community Care White Paper? □ □ □

3. Prior to the implementation of the New GP Contract, did you have any concerns about: YES NO
   a) an increasing workload? □ □ □
   b) a decreasing workload? □ □ □
   c) losing professional independence? □ □ □
   d) your role as a General Practitioner? □ □ □
   e) overlap of roles? □ □ □
   f) quality of patient care? □ □ □
   g) other concerns □ □ □
   please summarise briefly ________________________________

4. Now that you have been working alongside the New Contract for a year, do you have any concerns about: YES NO
   a) an increasing workload? □ □ □
   b) a decreasing workload? □ □ □
   c) losing professional independence? □ □ □
   d) your role as a General Practitioner changing? □ □ □
   e) overlap of roles? □ □ □
   f) quality of patient care? □ □ □
   g) other activities □ □ □
   please specify ________________________________

5. Has there been any change in your workload since the New Contract? DECREASED NO CHANGE INCREASED
   □ □ □
6. If you have experienced any change in your workload, how has this affected your involvement with:
   a) home visits to the elderly? □ □ □
   b) home visits to mothers with young children? □ □ □
   c) screening clinics for specified sub-groups? □ □ □
   d) patient referrals in general? □ □ □
   e) other activities
   please specify ________________________________

   DECREASED NO CHANGE INCREASED

7. If your workload has increased in any area, have you had to reduce your involvement in any other?
   YES NO
   □ □ □
   If YES, please summarise briefly ________________________________

8. If you have had to reduce your involvement in any area, was this:
   BY CHOICE FROM NECESSITY
   □ □ □

9. How do you think the New Contract has affected the morale of the following?
   BETTER UNCHANGED WORSE
   a) G.P. colleagues □ □ □
   b) Practice Managers □ □ □
   c) Receptionists □ □ □
   d) Practice/Treatment Room Nurses □ □ □
   e) Community Nurse Managers □ □ □
   f) Health Visitors □ □ □
   g) District Nurses □ □ □
   h) Other Health Professionals □ □ □

10. How has the New Contract affected your morale as a General Practitioner?
    BETTER UNCHANGED WORSE
    □ □ □

11. How have other recent changes in the NHS affected your morale as a General Practitioner?
    BETTER UNCHANGED WORSE
    □ □ □
12. Within the setting of your Primary Care Team, how do you rate your working relationship with the following since the New Contract?

<table>
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13. Since the implementation of the New Contract, do you feel concerned about:

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<td>a) adequacy of resources</td>
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<td>i) support from the nursing hierarchy</td>
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<td>j) professional isolation</td>
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<td>k) feeling under-valued</td>
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<td>l) other, non-work stressors?</td>
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Please specify __________________________

PLEASE CIRCLE THE APPROPRIATE NUMBER WHICH COMES CLOSEST TO YOUR REACTION TO THE FOLLOWING STATEMENTS:

KEY: 1 STRONGLY AGREE  2 AGREE  3 UNCERTAIN  4 DISAGREE  5 STRONGLY DISAGREE

14. "I had adequate opportunity prior to the New Contract to discuss how best we could work together after its implementation" with:

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<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

17. If, as a result of the New Contract, you feel that some things have got better and some have got worse - would you explain in what ways?

---

18. Do you agree that the members of your Primary Care Team listed below understand your day-to-day work as a District Nurse?

<table>
<thead>
<tr>
<th>Role</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) GP colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>b) Practice Managers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>c) Receptionists</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>d) Practice/TR Nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>e) Community Nurse Managers</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>f) Health Visitors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>g) District Nurses</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>h) Other Health Professionals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

19. Do you agree that the members of your Primary Care Team listed below value your day-to-day work as a District Nurse?

<table>
<thead>
<tr>
<th>Role</th>
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<th>2</th>
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<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>a) GP colleagues</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
20. Do the nursing staff in the Practice have the same access as GPs to:
   a) age/sex registers?
   b) the medical records?

21. If YES,
   a) Are the reception staff willing to
      take out medical records at their request?
   b) Are the reception staff allowed to
      take out medical records at their request?

22. Are the following with whom you work happy to be contacted informally on a daily basis to discuss patients?
   a) Practice/Treatment Room Nurse(s)
   b) District Nurse(s)
   c) Health Visitor(s)

23. Have you incurred any 'wasted' visits to patients within the last three months because of a lack of current information from?
   a) Hospital
   b) District Nurse(s)
   c) Health Visitor(s)

PRACTICE MEETINGS

24. Approximately how often are practice meetings held?
   Weekly
   Monthly
   3 monthly
   6 monthly
   Not at all
   Other

25. Are the nursing staff in the Practice involved in deciding when practice meetings should take place?

26. Are the nursing staff in the Practice invited to attend practice meetings?

   If YES, are they invited to participate in the following:
   a) discussing patients?
   b) discussing innovations and improvements in the practice?
   c) meeting medical representatives?
   d) meeting other professional groups?
   e) social activities?
   f) other
   please specify

   □ □ □ □ □ □
27. If practice meetings are arranged, do you participate in them?  □  □  □

28. Within the primary care team are you involved in:
   a) planning of division of work? □  □  □
   b) decisions about division of work? □  □  □
   c) discussions about practice policies? □  □  □
   d) decisions about practice policies? □  □  □
   e) discussions about practice development? □  □  □
   f) decisions about practice development? □  □  □

29. Do you undertake any of the following at present:
   a) immunisation of children? □  □  □
   b) antenatal care? □  □  □
   c) postnatal care? □  □  □
   d) screening of the elderly? □  □  □
   e) family planning? □  □  □

30. Do you think the following should be part of your work?
   a) screening the elderly? □  □  □
   b) immunising children? □  □  □
   c) giving 'flu vaccinations? □  □  □
   d) taking cervical smears? □  □  □
   e) giving contraceptive advice? □  □  □
   f) helping to compile practice annual reports? □  □  □
   g) helping to design Practice Leaflets? □  □  □

31. If you have answered 'No' to any of the categories in Question 30, who do you think should be responsible for:
   a) screening the elderly? □  □  □
   b) immunising children? □  □  □
   c) giving 'flu vaccinations? □  □  □
   d) taking cervical smears? □  □  □
   e) giving contraceptive advice? □  □  □
   f) helping to compile practice annual reports? □  □  □
   g) helping to design Practice Leaflets? □  □  □

32. If you ask a Practice/TR Nurse to undertake an 'extended role' (eg prescribing) do you feel:
   a) their training/experience makes you competent to do so □  □  □
   b) they require further training in certain areas? □  □  □
   c) an 'extended role' is inappropriate for District Nurses? □  □  □
   d) worried about 'professional accountability'? □  □  □
   e) such roles may adversely affect their relationships with other nursing colleagues? □  □  □
   f) other (please specify) ________________________________ □  □  □
33. Do your Practice/TR Nurses recommend products for patients to buy from the chemist?  

<table>
<thead>
<tr>
<th>REGULARLY</th>
<th>SOMETIMES</th>
<th>NEVER</th>
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<tbody>
<tr>
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</table>

34. Are you happy that the following are included in the new Nurse Prescribing legislation:  

- District Nurses  
- Health Visitors  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>NO OPINION</th>
</tr>
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<tbody>
<tr>
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</table>

35. Do you feel that Practice/TR Nurses should be included in the new Nurse Prescribing legislation?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>NO OPINION</th>
</tr>
</thead>
<tbody>
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</table>

36. Do you see Health Visiting as having a 'nursing' component?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
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37. Would you recommend General Practice as an interesting branch of the health professions?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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CONTINUING EDUCATION

38. Do you employ a Practice Nurse?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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39. Do you have the services of a Health Board employed Treatment Room Nurse?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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40. Have you heard about ‘PREP’ (Post Registration Education for Practice) Project for nurses?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

41. In consideration of some of PREP’s proposals as applied to practice-employed nurses:  

- a) Do you think they should undertake continuing professional education?  
- b) Do you feel that 5 days study leave every 3 years is adequate?  
- c) Would you be willing to give them time off to further their professional development?  
- d) Would you be willing to pay some of the costs of continuing education yourself?  
- e) Do you feel it will affect you personally?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

Please comment _________________________

e) Do you feel it will affect you personally?  

42. If you employ a Practice/TR Nurse, do you provide access to in-service training at present?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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If YES,  

- a) by conferences  
- b) professional meetings  
- c) courses  
- d) other (please specify) _________________________

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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7
43. Date of Birth: ________________________________

44. Sex

<table>
<thead>
<tr>
<th></th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
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<tbody>
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45. Do you work:

<table>
<thead>
<tr>
<th></th>
<th>FULL TIME</th>
<th>PART TIME</th>
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</table>

46. Why did you choose to work as a General Practitioner?

- a) an interesting job
- b) hours compatible with family commitments
- c) location
- d) salary
- e) other reasons (please specify) ______________________

   YES NO

   □ □

47. How much experience do you have as a General Practitioner?

- Less than 1 year □
- More than 1 year □ ___ Yrs
TREATMENT ROOM NURSE STUDY

PATIENT QUESTIONNAIRE

The nurse that you saw today is taking part in a study of nurses' work, and we hope the results of the study will help us all to provide a better service for patients.

This questionnaire is about your visit here today, and will only take a short time to fill in.

Will you please answer ALL the questions, put the questionnaire in the attached envelope and place it in the box provided at Reception.

None of your answers and comments will be seen by any of the doctors, nurses or practice staff and we do not need to know your name.

If you do not wish to take part, please put the unanswered questionnaire in the box anyway.

THANK YOU FOR HELPING US
November, 1991

Dear

TREATMENT ROOM NURSE STUDY

I have been given your name as being a member of the primary care team at the above address. I hope that I also have your job title correct.

Since early last year I have been undertaking a research project into the work of Treatment Room nurses, both Health Board-employed and practice-employed. The study has involved collecting workload/workflow information from these nurses prior to the introduction of the New Contract last year, and a repeat of the exercise this year. We anticipated that the new GP Contract was likely to result in some significant shifts in the work of nurses in primary care, and this study has been an attempt to look at these changes.

I am contacting you at this time because our funding body (SHHD) asked us:
'To identify community nurses' and general practitioners' perceptions of future developments in primary care nursing so as to identify areas of common interest and potential disagreement'.

Would you be willing to complete the enclosed questionnaire covering these issues? The questionnaire has the support of Miss E Alexander, Director of Nursing Services (Primary Care), Edinburgh and Midlothian, and Mrs M Wright, Assistant Director of Nursing Services, (Community), West Lothian. I am sending similar to questionnaires to all GPs, Community Nurses and Practice/Treatment Room Nurses in participating Practices.

I would be very grateful if you would return the completed questionnaire, as soon as possible, in the enclosed envelope via the Lothian Health Board van service. Your reply will be anonymous, and the only coding on the form is a number we have allocated to your Practice.

Your answers will be put together with those of other health professionals and we hope the results will help us to provide a better service for patients. In due course we will send you a summary of the replies we receive.

Yours sincerely,

Fiona M Paxton
Research Associate, Principal Researcher