

Primary Care Nursing

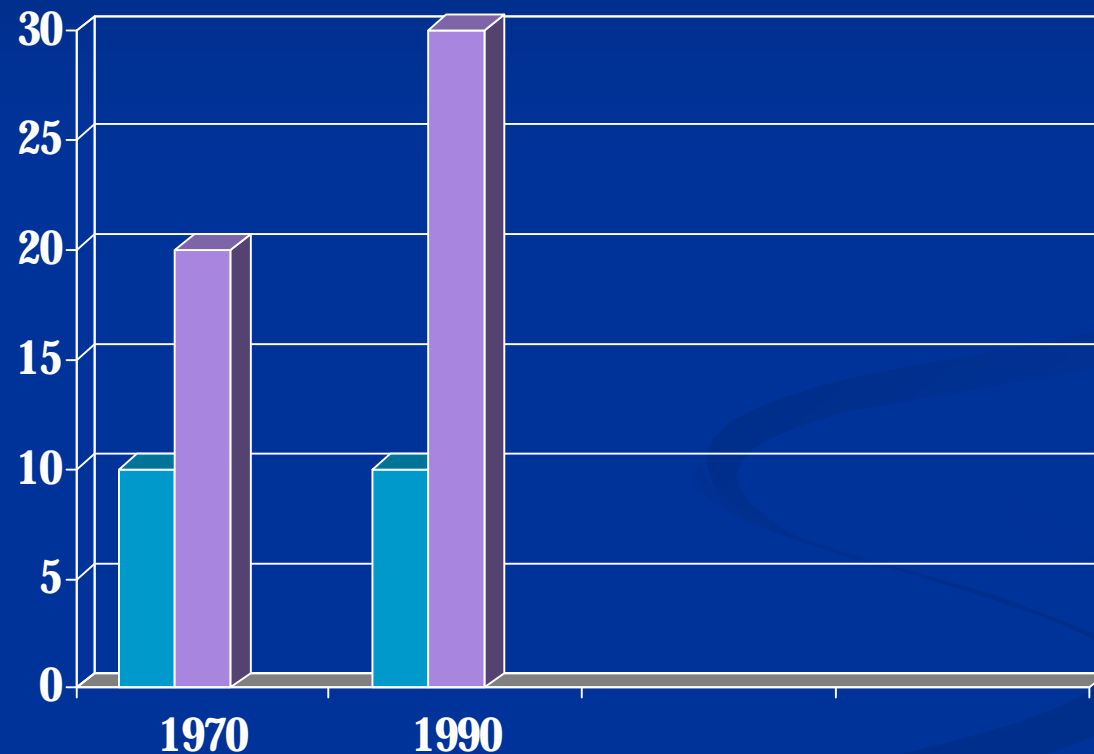
Reducing inequalities in Primary Care
provision of service

Inequalities in Health

Acheson report 1998

- n The proportion of people reporting a limiting long standing illness has risen from 15 per cent to 22 per cent since 1975.
- n The proportion reporting illness in the two weeks previous to interview nearly doubled from 9 per cent to 16 per cent.
- n There is a slight increase in the proportion of people consulting the NHS

Comparative mortality rates between social class 1 and social class 5 in UK



Inequalities in health

- n These growing differences across the social spectrum apparent for many of the major causes of death, including coronary heart disease, stroke, lung cancer and suicides among men, and respiratory disease and lung cancer among women
- n Premature mortality, that is death before age 65, is higher among people who are unskilled.
- n There are many indications of poorer health among the minority ethnic groups in England.

1990 onwards

- n Last 15 years has seen major developments in primary care nursing in the UK
- n Move from individualistic, professionally, GP led approach in Primary Care to an approach involving a team of workers with varying levels of knowledge and skills
- n Discussion of how primary care nursing has improved access to primary care

Teamworking in Primary Health Care 2000

“Professionalism has contributed a great deal to modern health care but has inhibited the ability to achieve cross boundary solutions based on team work”

Joint Report by Royal Pharmaceutical Society and
BMA

Drivers for change

- n Ageing population, complex clinical and social needs
- n Rapid developments in clinical care
- n An ageing workforce
- n Greater expectations from the public
- n The consumer culture – greater access to information and cultural changes
- n A move towards reducing inequalities in health provision and outcomes

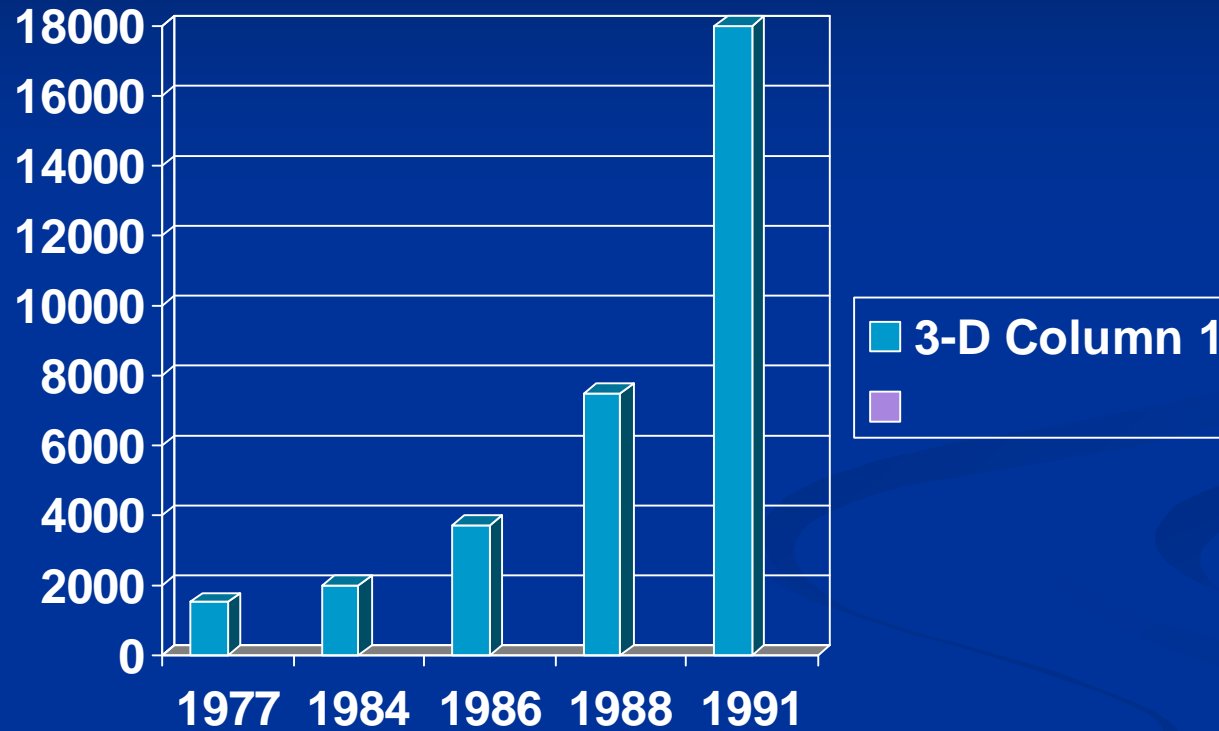
Pre 1990

- n No IT!
- n More secondary based care
- n Chronic disease monitoring rather than management
- n Little evidence based care
- n Very few National guidelines
- n No clinical governance

Heaven!?



Increase in Practice nursing



What happened in 1990

- n New GP contract
- n Incentives to provide preventative and health promotional services
- n 300% increase in practice nurses!
- n Recruitment of PNs
- n Payment for clinics
- n Unethical practice
- n Burgeoning of professional development and education for Practice nurses

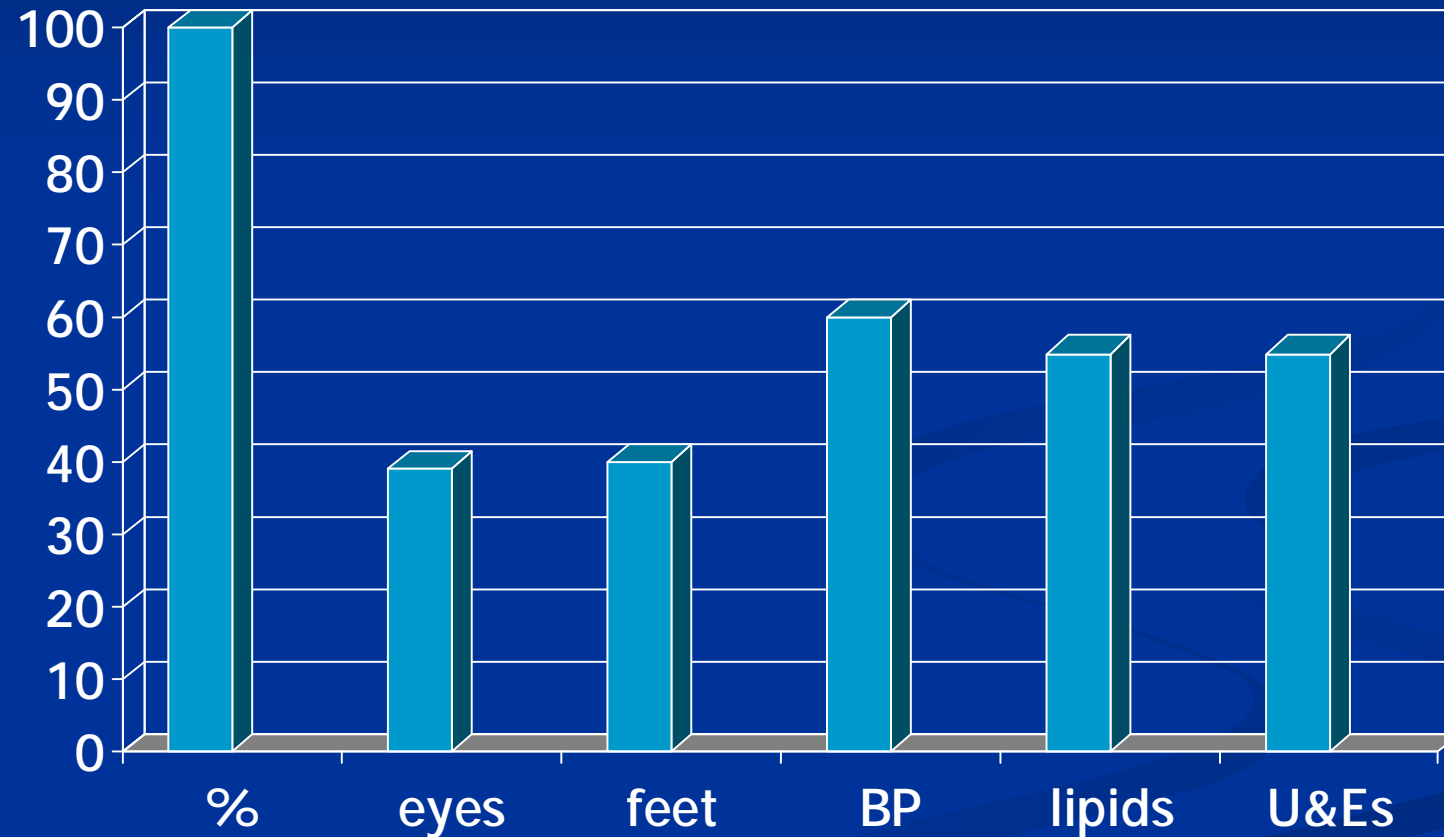
Chronic disease management in Primary Care pre 1990

- n Gps suspected asthma/COPD/diabetes
- n Referred to secondary care
- n Patients followed up bi-annually
- n Many lost to follow-up
- n Services accessed more readily by:
- n Patients who were well-educated and who understood need for monitoring
- n Patients in more affluent areas with easy access to transportation
- n No organised care in primary care
- n No efforts to engage disadvantaged groups

Practice profile

- n Inner city deprived area
- n Multi-ethnic
- n 3 Dr practice
- n 2% of population diagnosed as diabetic

Audit of diabetic patients 1991



Reasons for this

- n Practice doing quite well in areas over which they had control and which could be done quickly in the surgery in a 5-10 minute consultation
- n Other care was expected to be done at the hospital
- n Two bus rides away
- n If failed to attend x 2 removed from recall
- n Many had not been seen for 20 years

What would happen now

- n Would see PN at least twice a year and have bloods checked for fasting lipids, HbA1c. Discuss diet, exercise and lifestyle, BP check, adjust medication if necessary
- n Annual bloods for lipids, HbA1c, LFTs, TFTs, fasting glucose, FBC etc
- n Annual retinopathy screening- direct invite from central register at PCT
- n Annual podiatry review
- n Annual microalbuminuria

How has this happened?

- n Government policy
- n New knowledge
- n Advances in Evidence based practice
- n NICE
- n NSFs
- n TEAMWORKING
- n Professional development
- n Skill mix
- n Nurse Prescribing

PNs in 1990

- n Little formal education
- n Type of person attracted to practice nursing
- n Census
- n Most between ages of 40 and 49, less than 10% under 30
- n Looked at the roles and activities and developed a strategic model in order to guide future educational provision

Strategic model

A Strategic Model of the Practice Nurse Role Figure 1



Tools for
 Strategists
 Trainers/educators
 Personal development/evaluation
 Other professional groups
 Patients/CHCs etc

- Much of what we were asked to do not evidence based (urine testing)
- Frustration because data gathering exercise
- Unethical practice
- Opportunity to develop professionally
- Burgeoning of training
- Start of Improved chronic disease management for patients

- n Lots of debate about what nurses should could and shouldn't be doing
- n UKCC (now NMC) laid the responsibility for this at the feet of nurses themselves
- n A few mistakes (smears taken with tongue depressors, nurses doing fundoscopy on diabetic patients after being "shown" by the GP)
- n Mainly led to increased professionalism and nurses developing knowledge and skills, formulated groups and forums to facilitate professional development

- n Hostility from secondary care
- n Collaborative working emerged and primary care
- n Locally produced evidence based guidelines
- n It emerged that nurses were very good at following guidelines
- n Nurse-led CDM clinics proved very effective
- n Non pharmacological approaches
- n Nurses would follow protocols of medicine management closely

Secondary prevention in coronary heart disease: a randomised trial of nurse led clinics in primary care

Campbell et al. Heart 1998; 80:447-452

- n Random sample of 19 GP practices in Scotland
- n Follow-up 1 year found significant improvements in:
 - n aspirin management
 - n BP management
 - n Lipid management
 - n Physical activity
 - n Diet
- n No effect on smoking cessation
- n Most patients gained at least one effective component of secondary prevention thus future cardiovascular events and mortality could, for them be reduced by up to a third

Practice nurses and chronic disease management

- n Studies have also shown positive outcomes for nurse led:
- n Asthma care (Ram et al, 2002, Cochrane database)
- n Chronic heart failure (McMurray and Stewart 1998, Heart)
- n Hypertension (Fahey et al 2006, Cochrane database)

Organised care

- n Registers
- n Re-call systems
- n Regular contact

1990 New Contract

- n Created radical changes in the underlying philosophy of health care provision in primary care giving a new focus to health promotion and maintenance. Practices wishing to provide fuller services and to maximise their income had to employ a practice nurse
- n Primary Prevention & Oxcheck study revealed that primary prevention in Primary care was not particularly effective

I DON'T CARE WHAT IT SAYS ON THE
"CHOCOHOLICS" WEBSITE I'M NOT ABLE
TO PRESCRIBE CHOCOLATE MINI EGGS
ON THE NHS.



CDM

- n Secondary prevention and CDM more effective
- n Domain of PN
- n PNs essential – no longer a luxury

Development of Nurse Practitioner role

- n In primary care NPs grew from advancing practice nurses
- n Practice nurses taking the lead in chronic disease management
- n Patients wanting to see them about other problems
- n Need to be able to physically exam in order to progress (e.g. respiratory exam)

NP qualification

- n Barbara Stillwell developed NP certificate at RCN after training in USA
- n Worked with homeless in Birmingham
- n First course in 1990 in London
- n Satellite course in Manchester in 1993
- n Included:
 - n Consultation skills, history taking, physical examination, A&P, pharmacology

Definition of an NP RCN

- n Makes professionally autonomous decisions for which he/she is accountable
- n Receives patients with undifferentiated/undiagnosed problems
- n Screens patients for disease risk factors and early signs of disease
- n Makes differential diagnoses
- n Orders necessary investigations, provides treatment and care
- n Has the authority to admit or discharge patients from their caseload and refer patients to other health care providers as appropriate

Development of NP role

- n Acute problems
- n We needed a practice nurse!
- n Our team was developing, the receptionists doing recalls and organising clinics, the PN doing tasks such as ear syringing, phlebotomy, cervical cytology and chronic disease management
- n I was seeing some acute patients and continuing with chronic disease management
- n We were able to increase the list size

Stop Press!

- n The death of Good Nursing care
- n Nurse as wannabee Dr!
- n Dumbing down medicine!

Koperski, et al (1997) BJGP editorial

- n “Gps consistently suggest that they have more job satisfaction, offer a higher standard of care and see more patients as a result of employing a nurse practitioner”
- n Re-defining themselves in General Practice
- n Fill the care gaps e.g caring for the homeless, triage, telephone advice same day appointments , home visits

Perry et al (2005)BJN

- n Access to care improved
- n More appointments available
- n Appointments longer than previously
- n Appointments available at different times of the day
- n Access to particular GPs not always improved

Systematic reviews of Effectiveness

- n Horrocks et al (2002)
- n Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors, BMJ 2002;324:819-823
- n 11 trials, 23 observational studies
- n Main findings:
 - n No difference in health outcomes
 - n Patients more satisfied with care by a nurse practitioner
 - n Nurse practitioners had longer consultations
 - n NPs made more investigations
 - n No differences found in prescriptions, Return consultations or referrals
 - n Quality of care was in some ways better for NP consultations

Discussion points

- n Studies used many different outcome measures
- n No studies adequately powered to detect rare but serious adverse outcomes
- n Ambiguity over term “nurse practitioner”
- n Lack of good evidence about the economic impact of NPs
- n Extra length of time – may not be the case now
- n Differences in the ways GPs are educated

Substitution of doctors by nurses in primary care(Cochrane Review)

- n Reeves et al (2004)
- n 16 studies
- n No appreciable difference in:
 - n Health outcomes
 - n Process of care
 - n Resource utilisation
 - n Cost
- n Patient satisfaction higher with nurse led care
- n Greater patient compliance
- n Nurses tended to provide longer consultations
- n Gave more information
- n Recall patients more frequently
- n Impact on physician workload and direct cost of care was variable

Discussion points

- n Doctors workload may remain unchanged because nurses deployed to meet unmet need or because nurses generate demand for care
- n Longer consultation times because unable to prescribe
- n Savings in cost depend on pay differentials and may be offset by lower productivity
- n Would be interesting to repeat the studies - ? If still have longer consultation times
- n Education costs have not been included in evaluation
- n Cost savings of greater patient compliance not included

- n New Labour Government (1997)
- n Primary Care led NHS
- n Clinical Governance- framework to promote quality improvement, risk management, accountability and responsibility
- n National Service Frameworks 1998 (Setting national standards, improving quality of care and reducing health inequalities CHD, Diabetes, Mental Health, Renal, Children's,
- n NICE 1999 (established to diffuse “postcard lottery” of treatment within the NHS – appraisal of evidence based on cost-effectiveness)

Making a Difference

**(DOH 1999) Governments' strategic intentions for
Nursing, Midwifery and Health visiting**

- n Nurses mandated to:**
- n Work across organisational boundaries**
- n Help towards re-defining existing structures**
- n Support in the community for people with chronic and life-threatening illness**

Making a difference

“ the most vulnerable, those without social networks, the socially excluded, the economically disadvantaged, and some minority ethnic groups are least likely to access and use services. Nurses, midwives and health visitors must be able to adapt their practice to reach and target these groups to make services more accessible”

New Roles

- n Nurse led PMS pilot sites –mainly deprived areas
- n Nurse as independent contractor
- n Nurse as lead professional salaried by a community trust
- n Nurse as equal partner
- n Focussed on developing democratic consensus and professional responsibility
- n Needs of patient matched to skills of the practitioner
- n Thought that 50-60% of problems could be managed entirely by nursing teams
- n Expertise of GP used for more complex cases

Acceptability to patients

- n PMS nurse led pilot
- n Providing primary care services to a deprived population
- n Patients attributed high status to the nurse by emphasizing the nurse leading the practice was highly qualified
- n Others reconstructed the role and thought of the nurse as a doctor
- n Most important factor affected acceptance of the service related to the way in which the service met their needs
- n This more important than perceptions of professional identity
- n The nurse led service continued to provide the social support and continuity of care which had been provided by the previous GP

Lance's top tips

- n Be stubborn-believe in it and stand up for it
- n Listen to what people say but don't be put off
- n Remember your biggest allies are your clients-trust them
- n Develop good relationships- negotiate with the community – work across boundaries
- n Work together and remember you have to go through a “rite of passage” to be accepted
- n Be non-judgemental
- n Social and economic aspects of life are as important as health

Lance Gardner MBE

Walk-in Centres

- n First opened Jan 2000
- n Early morning to late evening
- n No appointments
- n Minor illnesses
- n Minor injuries
- n Nurse run

Headlines

n 'Walk-in centres could be a danger'
BBC

n Threat to 'immensely precious' service

n Doctors resist calls to open all hours

Evaluation of 40 WICs on behalf of DOH by Univ of Bristol. Salisbury et al 2002

- n 2556 visits in Aug 2001
- n 83% of consultations conducted by nurses
- n Average length of consultation = 14 mins
- n High proportion of young adults
- n Greater proportion of men than in GP settings
- n More like to be male , owner occupiers, educated > age 18, less likely to come from ethnic minorities
- n 4/5 local, all registered with a GP

Reasons for attendance

- n Speed of access
- n Convenience of location
- n Opening hours
- n Anonymity
- n Drop in service
- n 1/2 said they would have gone to GP if no WiC
- n 1/4 would have attended A&E
- n 1/10 would have self-managed

Impact on workload

- n Slight drop in local A&E attendance
- n In GP practices near WiC workload did not increase unlike control sites where workload rose significantly over 24 month period
- n 13% patients referred on to GP
- n 6% to A&E
- n Half re-attended GP with same problem- same as GP re-attenders

Overall evaluation

- n V. high patient satisfaction
- n Quality of care equal to GPs for the problems they saw
- n Eg viral illness, upsi, minor injuries, dressings
- n Accessible service to those who don't access other services

Cost and relative efficiency

- n Cost per consultation = £18.36
- n Cost per GP consultation = £ 15.00
- n Cost per Practice nurse consultation = £7.00
- n Increased capacity in General Practice would be less costly still.

NHS Direct

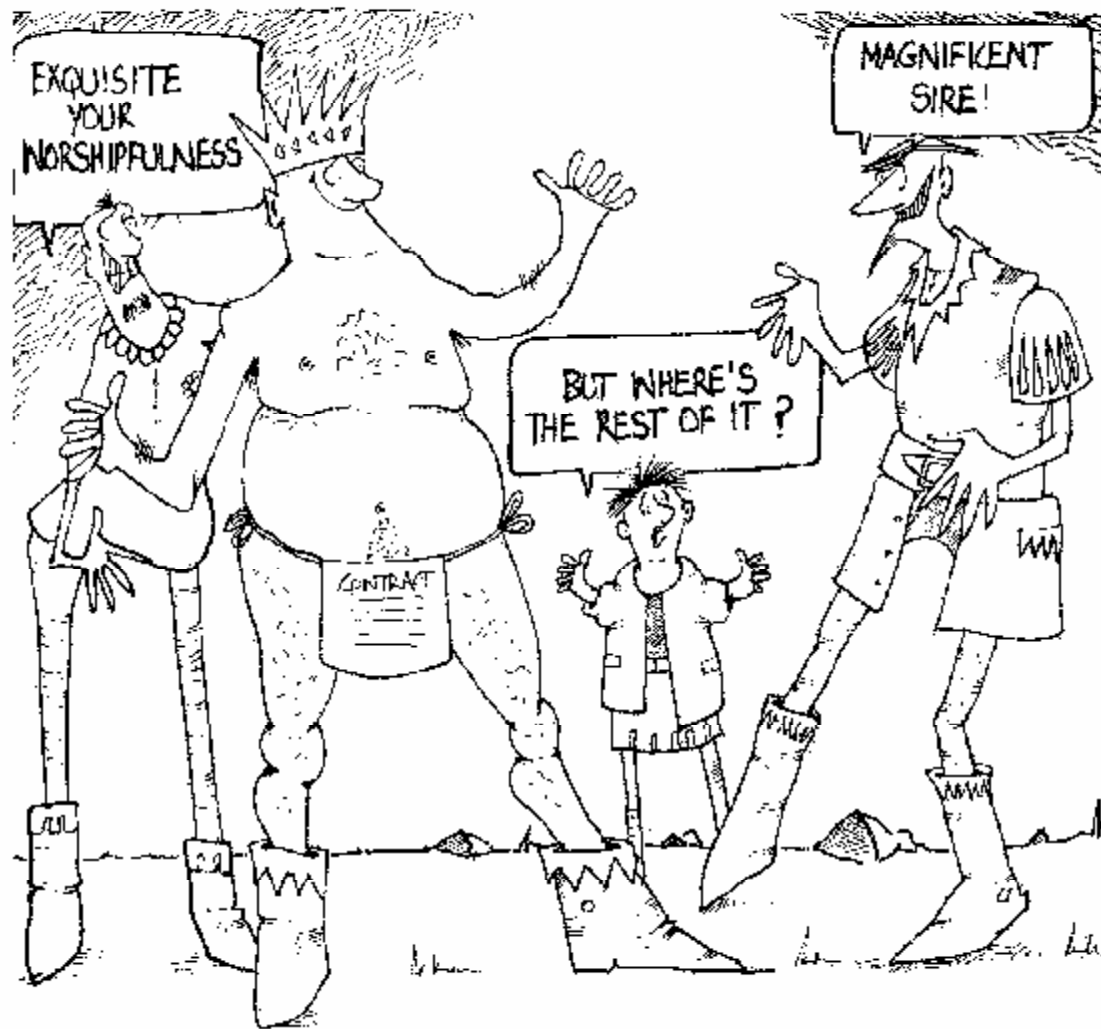
- n Nurse – led telephone advice
- n Triage
- n Computer assisted decision making

Community Matrons

- n Advanced practitioners
- n Case management
- n Patients with high intensity use of health care
- n Long term conditions
- n Prevent unnecessary hospital admissions
- n Reduce length of stay
- n Integrate elements of care
- n Help people to remain in their homes and communities

New GP contract

- n Patients registered with the practice
- n GPs able to opt out of out-of-hours care
- n Global sum of payments
- n QOF
- n Targets
- n ? Recipe book medicine



THE EMPERORS NEW CONTRACT

QOF

- n “Nurses don’t generate income.....
They generate care. For which we make no apology!”

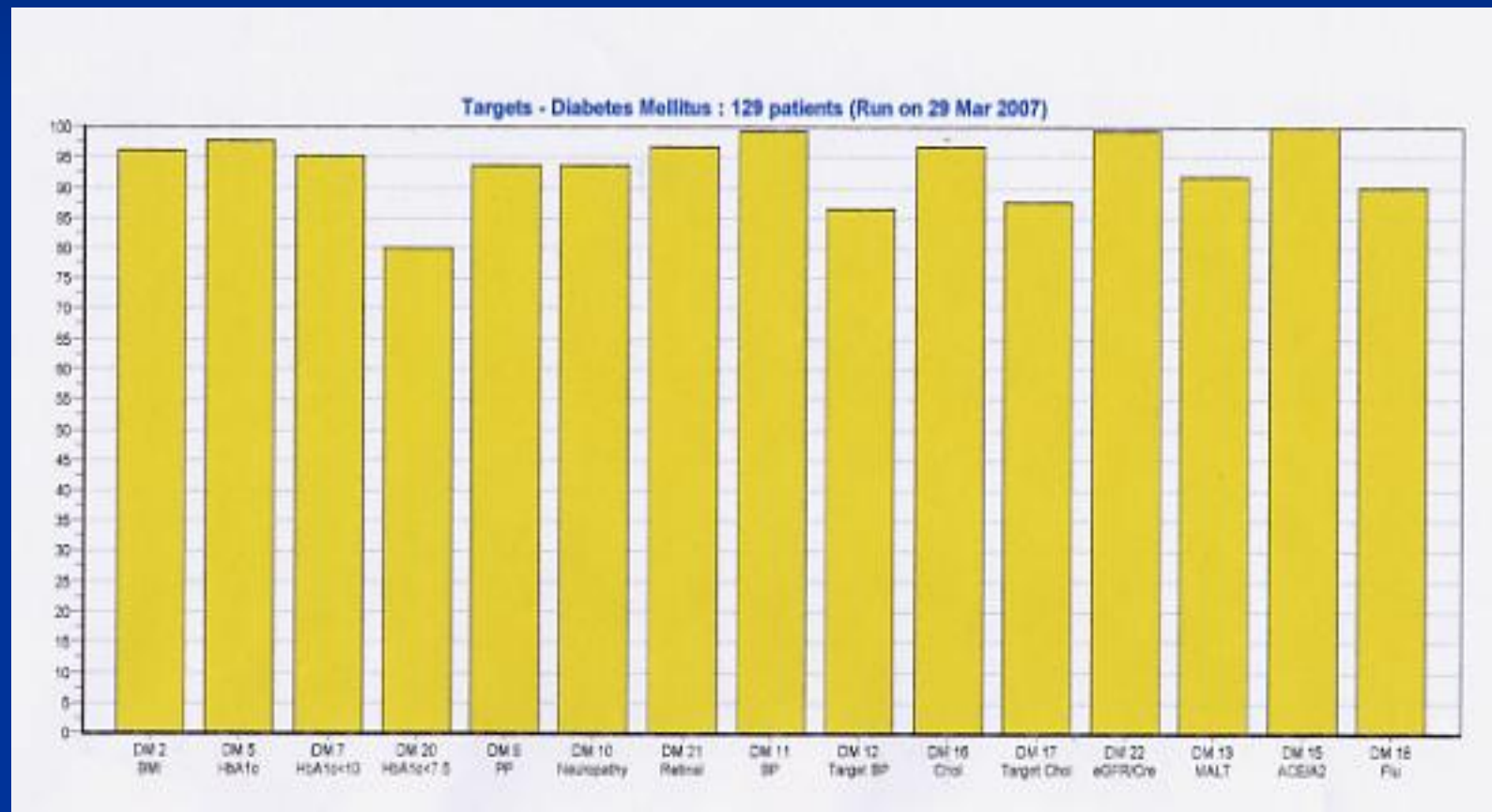
Nurse Hathaway - ER



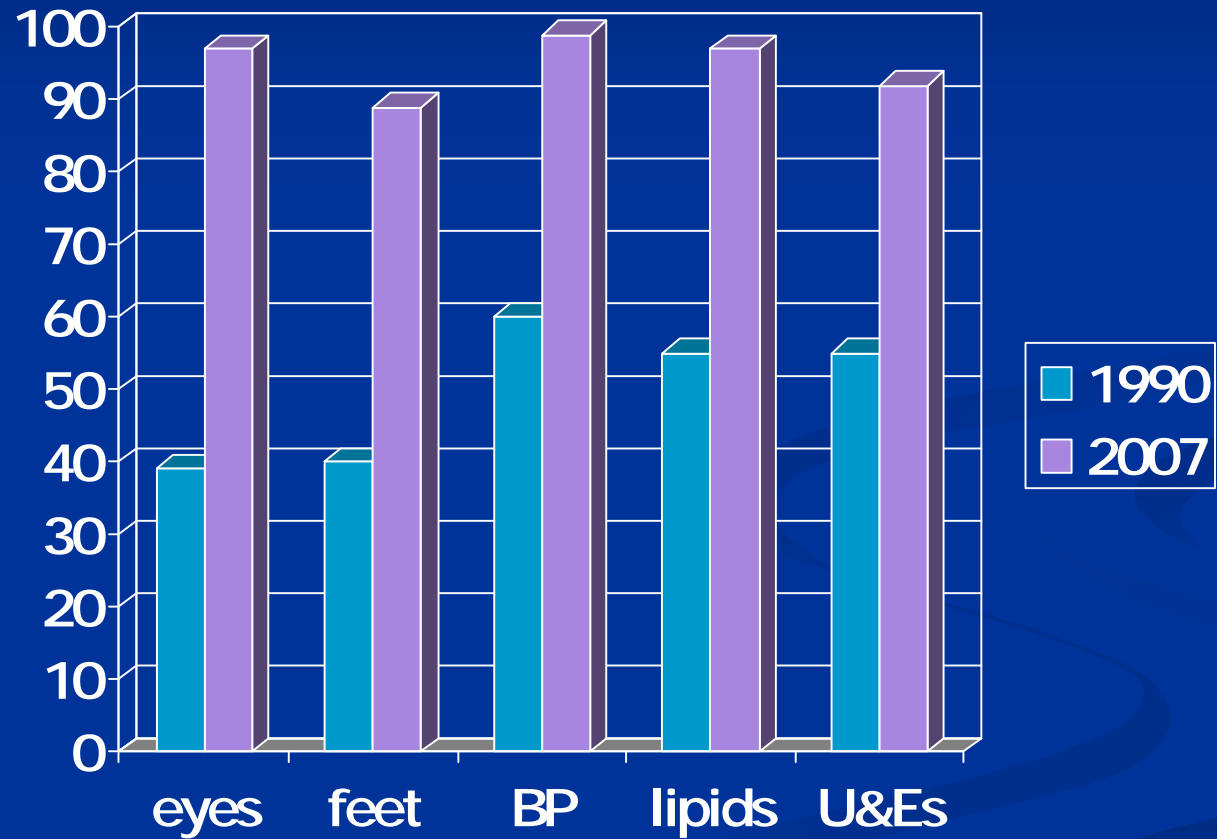
QOF

- n Focus on chronic disease management
- n Post-code lottery previously
- n Aim to provide equality of care
- n Outcomes as well as process
- n IHD, diabetes, Asthma, COPD, Mental Health ,
AF, Heart Failure

QOF 2007



1990 v 2007



Nurse Prescribing

- n Developed over past decade
- n Now 2 levels of non-medical prescribing
- n V100 – dressings, OTC products
- n V300- Independent extended prescribing –
Whole BNF available (controlled drugs for
limited indications)

Controversy

BMJ letters page (2005) 332. p 51

- n Jumped up uppity nurse!
- n Dumbing down medicine!
- n The death of Good Nursing care
- n The abolition of medicine as we know it!
- n Nurse as wannabee Dr!

NMC

Fitness to Practice

n “ to tell you the truth, its all going really well – I don’t think we’ve had any cases reported to the NMC yet”

Alison Keat NMC (March 2007)

n 2005-6

41,903 Nurse and midwifery prescribers

n 7,181 Independent/supplementary prescribers

Still the negative voices continue

**Nurses “floundering” in
new Prescribing role**

Contribution of Primary Care Nurses in Reducing Inequalities

- n Chronic Disease Management (QOF)
- n Access for previous low users of the service
- n Housebound and long-term conditions
- n Vulnerable groups – homeless, asylum seekers etc
- n Practice nurses, Nurse Practitioners, Community matrons, nurse-led services, walk-in centres,

Job Advert

n

HEALTH E1, Homeless Medical Centre

Tower Hamlets, London E1

Health E1 is an established nurse-led PCT MS practice addressing the primary, mental healthcare and substance misuse needs of homeless people in

the London Borough of Tower Hamlets.

We provide an environment which, not only gives excellent care, but also

allows for innovation in practice and a commitment to personal and professional development.

We are currently seeking to recruit:

Full-time, Lead Nurse Practitioner

Salary Scale: Band 8b - £44,984 - £56,371 p.a. inc

Leadership

- n After an extensive 3 year study of the critical variables for leadership success, the Centre for Creative Leadership recently concluded that the only statistically significant factor differentiating the very best leaders from mediocre ones is.....
- n Caring
- n Centre for Creative Leadership . April 1998

Annie and Ellie's photos

