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A primary health care team's views of the nurse practitioner role in primary care

Janet Marsden and **Clare Street** Department of Health Care Studies, Manchester Metropolitan University, M13 0JA, UK

The study reported here is one part of a wider study, evaluating the role of the nurse practitioner (NP) in primary care This part of the study focussed on the views of the primary health care team (PHCT) regarding their experience of working with two NPs. A project to place Master's prepared nurse practitioners (NP) in general practitioner practices was undertaken with the intention of more fully meeting the needs of practice populations in a deprived inner city area. The roles were supported and funded by the health authority and the placements were intended to be time limited with placement and funding to be reviewed. The project incorporated a planned evaluation of the role and this included a study of consultation patterns, caseload and this particular element, a study of PHCT members' attitudes to and experiences of the role. A purposive sample of 27 staff were interviewed using a partially structured interview format. Each interview lasted around 30 minutes with two researchers undertaking both collection and analysis of the interview data. Subsequently, an additional six staff were also interviewed in an opportunistic manner, at their request. The findings identified two main foci of the NP; as an 'extra pair of hands' and as a colleague undertaking a different, valuable and complementary service to existing staff. The pivotal role of the receptionist in the integration of the new role in to the practice and the acceptance of it by patients was clear. General practitioners (GPs) exhibited paradoxical views, particularly with respect to problems of throughput; the NP having longer appointments and therefore usually undertaking fewer consultations than GPs in any session, leading to perceptions of an expensive and perhaps less effective service in terms of its effect on the workload. Within the same interview however, GPs discarded throughput as an effective measure of patient care and highlighted the many benefits of NP consultation. This tension between cost and effectiveness would benefit from more effective analysis and evaluation. The members of the PHCT express many different views, often related to their professional priorities, but all appear to support the NP role enthusiastically, considering it a positive step which benefits the team, patient care and choice.

Key words: general practice; nurse practitioner; Primary Health Care Team

Introduction

This paper focuses on a project undertaken in an inner city area, with high levels of socio-economic deprivation, located in the north west of England. The former health authority responsible for primary health care services was concerned that these services were increasingly failing to meet the needs of its local populations. This was felt to be partly due to difficulties in recruiting general practitioners (GPs), and in response to these difficulties, a nurse practitioner (NP) role was conceived as one which might add to the range of services and, thus, choice available for patients. Four GP practices were selected after a bidding process to pilot the development of this role. The pilot project was supported and funded by the health authority for a

Address for correspondence: Janet Marsden, Senior Lecturer, Department of Health Care Studies, Manchester Metropolitan University, Hathersage Road, M13 0JA, UK. Email: j.marsden@mmu.ac.uk

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fixed period of time. Evaluation was built into the project and it was intended that the scheme would be reviewed following the results of evaluation. This paper reports the outcomes of that part of the evaluation which considered the PHCT's views of the NP role.

Background

Two Master's prepared NPs worked part-time, each in two different practices (a total of four practices). One practice was single handed and the others included a number of partners. The roles differed slightly across practices but all included the treatment of minor illness through booked and open access clinics. The NPs also took the lead in medication review and in screening patients for depression.

The context of NP practice

Early examples of the emergence of NP roles in primary care can be traced back to the USA during the 1960s. Often, these early examples were a response to concerns about the lack of medical care in rural and inner city populations or the consequence of adapting to changing health trends, the rising cost of health care provision and a move to a model of primary health care concerned with health as well as illness (O'Hara Devereaux, 1991). These tentative beginnings have been widely evaluated with generally positive outcomes being noted. For example, Spitzer *et al.* (1974) noted that NPs could provide first contact primary clinical care as safely and effectively and with as much satisfaction to patients as a family physician. The United States Office of Technology Assessment (1986) showed high levels of patient acceptability, compliance and positive health outcomes and felt that in areas of communication and preventative care, NPs were 'more adept than physicians'. NPs were reported to have a positive influence on patient related outcomes such as health knowledge, compliance, health maintenance and return for follow up (Crosby *et al.,* 1987). They improved accessibility to health care and lowered hospitalisation rates. The NP's practice was usually equal and occasionally superior to other practitioners and their interpersonal skills were perceived to be better than physicians'. Brown and Grimes (1993) suggested that NPs provide more health promotion than physicians and a higher quality of care.

The NP role in primary care in the UK has largely evolved in an *ad hoc* manner, partly as the role of Practice Nurses was extended (Jones *et al.*, 1997). As in the USA, this was often driven by professional concerns about staff shortages and inequalities in access to health care provision (Burke-Masters, 1986; Stilwell, 1981); and patient concerns (Cartwright, 1989).

This *ad hoc* development has led to confusion over role definition, although it can be argued that there are four universal models of NP practice; the doctor substitute (common in acute settings), the doctor assistant (clinical nurse specialist/physician's assistant), the complementary partner in health promotion (practice nurse roles) and the complementary partner in the treatment of minor illness (NP in primary care) (Chambers, 1991). There are a number of definitions of the NP in primary care which share similar key features. Stilwell (1985) notes that the NP role involves autonomous decision making and an undifferentiated caseload who consult the NP with undiagnosed problems – a role encompassing diagnosis, prescription, care and referral. The International Council of Nurses (ICN) role definition of a nurse practitioner reflects this early definition, suggesting a high level of professional autonomy and independent practice, along with a personal case load and a role as the first point of contact for clients (ICN, 2002). The lack of role standardisation reflects the practice of NPs in response to local population needs (Bagnall and Gardner, 1997; Hirst *et al.*, 1995), and the different practice contexts, although certain aspects of practice such as research, examination and diagnosis are common (Hicks and Hennessy, 1999).

As in the USA, there have been a number of evaluations of the NP role in UK primary care services and the outcomes of the UK studies are congruent with the USA evaluations. NPs have been found to be effective in dealing with 'minor illness' (Marsh and Dawes, 1995); patients with a wide range of conditions; and substituting for GPs in the surgery (University of Newcastle, 1998). A high level of consultation performance was identified by Bond *et al.* (1999). NP consultations

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were very highly rated and identified as safe (Kinnersley *et al*., 2000; Marsh and Dawes, 1995; Shum *et al*., 2000; Touche Ross for NHSE South Thames, 1995; University of Newcastle, 1998). Both Shum *et al*. (2000) and Kinnersley *et al*. (2000), have also noted that generally, patients consulting NPs were considerably more satisfied with their care and received significantly more information about their illness than those consulting doctors. Patient satisfaction is a constant theme in evaluations of the role and satisfaction with NP practice is consistently high, both when considered alone and, perhaps more significantly considering the generally positive nature of patient satisfaction studies, when compared with medical practice (Chapple *et al*., 2000; Reveley, 1998; Touche Ross for NHSE South Thames, 1995; University of Newcastle, 1998). In terms of clinical cost effectiveness, Venning *et al*. (2000) state that the clinical care and health service costs of the NPs and GPs in their multicentre randomized controlled trial were similar. They felt that NPs could be more cost effective than GPs if they could reduce their consultation time and return rates while maintaining the perceived benefits of an NP led service. Cost effectiveness was also highlighted in a Coopers and Lybrand for NHSE evaluation (1996) which concluded that NP projects were cheaper and better than conventionally delivered services. They cautioned, however, that some identified advantages of NP services, such as a more holistic approach to care, are not easily measured and quantified.

NP roles appear to offer some major benefits for patients; and therefore for primary care as a whole (Bond *et al*., 1999). However, a key issue which will influence the future development of the NP role in primary care is the acceptability of the role to the PHCT. Unless the role is supported by the PHCT, it is unlikely to fulfil its potential in primary care. The effects of the role on the PHCT and on the practice are likely to shape the attitudes of the team to the role and to the nurses undertaking it. No study was identified from within primary care relating to PHCT members' views of the NP role.[1] However, one study, Dolan *et al*. (1997) found general acceptability among staff, mainly in Accident and Emergency departments. It is this under explored aspect of the NP role in primary care which is the focus for this study.

The study

Method

The aim of the study was to obtain the views of members of the PHCT about the new role of the NP and generally to explore further how this was perceived to impact on them, the practice and patient care. In order to achieve this it was decided to employ partially structured interviews. This method of data collection allows the interviewees 'room' to express their own views freely through open ended questions and general prompting, while ensuring that certain questions were covered at some point in the interview. Key questions included; the effect of the role on the practice, on staff (their own staff group and others) and the perceived effect on patients. Questions on the viability and long term impact of the role were included in those interviews with health care professionals. The interviews were carried out by two interviewers over a total of four practices, with two practices covered by each interviewer, allowing practice staff to become familiar with a single researcher.

The population included all primary care personnel within the four practices, a total of 44 staff. Community nurses and peripatetic staff were extra to this total as they do not form a core part of the PHCT but were enabled to contribute to the work at their request and because it was felt that their input would add to the richness and completeness of the data. A total of 27 members of the PHCT were interviewed initially. The aim was to include a sample, representative of each group within the setting and this was achieved by purposive sampling. The personnel interviewed included the three practice managers, four practice nurses from the three practices where these posts existed, nine GPs and 11 reception staff. Two health visitors and two district nurses, the data manager from one of the practices and a peripatetic community practitioner were included later at their request.

Individual and group interviews were used, in a pragmatic strategy to include as many of the PHCT as possible and make best use of time within these busy settings The interviews were tape recorded

[1] See study by Long *et al.* in this issue.

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with the permission of the interviewees and transcribed.

Data analysis were undertaken using methods adapted from Huberman and Miles (1994) for generating meaning, including noting patterns and themes, looking for concepts that describe related statements, comparing and contrasting categories and exploring the relationships between statements. Inter-rater reliability was established by each of the researchers analysing each interview and comparing and contrasting findings. Data was analysed according to professional role.

No local research ethics committee approval[2] was required for the study by the health authority and participants were assured of anonymity of the data which was transcribed without identification except by group. Tapes and transcripts were kept separately and only the researchers had access to the raw data. The eventual report to the health authority ensured anonymity for the participants.

Results

The results are presented in sections relating to professional groups and short, illustrative quotes are provided to give some flavour to the summaries of the themes provided.

Receptionist and practice management staff

Consistently, the receptionist and practice management staff applauded the role of the NP. In particular, the contribution of the NP to the practices related to the management of patient numbers and meeting the needs of patients.

Patient management '. . . not as much aggro'

A day-to-day concern for these 'front line' staff is to manage throughput and prevent 'log jams' of patients building up in the reception area. Extended waiting times increase patient frustration – all of which has to be dealt with by the staff behind the reception desks. They have little control over the speed at which patients are seen, so having another member of staff to whom they could refer patients can ease the pressure:

> 'Workload in reception area being managed better because of option to refer to NP'. At one practice, it was felt that practice expansion would not have been possible in the absence of a NP.

More efficient throughput of patients has had a benefit not only for patients but also reception staff because:

> 'receptionists are not getting as much aggro and verbal abuse as before.'

This enhancement of the everyday work experience of key staff was noted at all the practices.

Meeting needs, enhancing quality and choice '. . .how we managed without her I don't know'

Receptionist and practice management staff pointed to many features of the NP role that they considered enhanced the quality of care that could be offered by the practice. Their comments related to generic aspects of the role such as the fact that the NP had more time available and also to particular skills demonstrated by the NPs including health education and the focus on enabling self care and coping skills.

The nature of the patient group registered with the practices did vary but in areas of high socio-economic deprivation and transient populations many problems experienced by those registered with the GPs were 'social . . . rather than medical . . . requiring education . . . rather than treatment'. Patients often needed general advice and to have questions answered; the reception staff, in particular, relied on the expertise of the NP, especially when the doctors were absent. The choice afforded to the patients given the presence of the NP was also seen as a bonus and the nature of the appointment system meant that the NP had more time to spend with the patient.

Comments made by the receptionists clearly point to the pivotal role they, in particular, have in promoting the integration of a new role into the everyday services offered to patients. All staff agreed the NP role provided patients with more opportunities but these would not be manifest without some tactical manoeuvring on the part of the reception staff. Critically, patients tended to '. . . want to see a doctor . . .' although once they did consult the NP, the receptionist staff at all of the

[2] Were this study to be commenced now, new arrangements for research governance in the UK NHS would require approval by a local research ethics committee (Ed.).

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practices noted that they would ask to see her again and this reinforced the receptionists general appreciation of the role.

The general practitioners

The general tenor of comments regarding the role of the NP was positive, although more ambiguous, either relating to the concept of the NP, or to the perceived competence of the person in post and the role that person played.

Role ambiguity '. . . similar to nurse triage. . .?'

Some of the ambiguity stemmed from the fact that the role of the NP was perceived as being new. It was certainly unfamiliar and several GPs reported that they had been uncertain about the role and were not sure what to expect. In a number of cases, the role seemed to be 'different to what I thought [it was going to be]' and there was a perception by a small minority of the GPs that the role was very similar to that of the practice nurse.

GPs seemed to feel that the role was in its infancy and they needed to get used to it before they could make any firm judgement about what the NP had to offer compared with a GP and how far the role might develop. Some felt that it was a significant development for nurses that not all would be able to fulfil and several felt unable to judge the value of the role per se. Their judgements were made on their impressions of the capabilities of the *person* in post.

Regarding the role confusion, some did acknowledge that it was, 'Probably me who's unclear about the role', and they were readily able to reassess initial caution based on their experience of working with the NP. Doctors who had been involved with the project from an early stage were aware of the role. Those peripheral to the project or new to the practice did not appear to have a comprehensive understanding of the role.

Precious time '. . . helps us keep our sanity'

Despite lack of clarity regarding the role by some GPs, benefits were perceived by all. Perhaps as a reflection of peculiarities of the role of a GP, one of the most commonly noted effects of the NP was a release of consultation time. GPs had noticed a drop in workload and welcomed the '. . . extra pair of hands'.

It was acknowledged that the NP fulfilled a specific function because of the ability to treat minor ailments:

> '. . . take some workload off me . . . UTIs, chest infections . . . self limiting and straightforward . . .'
> '. . . free us to deal with more complex cases'
> '. . . Has taken some stress off appointment times, can do a little bit better with what you've got . . .'

Unfortunately, these benefits were being diluted, apparently for two reasons. Firstly, a general increase in workload had meant demands on GP consultation time were rising anyway. This was particularly apparent for the single handed GP who stated that the NP role is . . . '. . . no solution to my increasing workload'. The demand was seen as insatiable, partly because of the nature of the practice population. Secondly, as the NP post had become established other functions were delegated to her or had naturally developed as relationships with patients were cultivated.

> '. . . booked up . . . not seeing as many acute people . . . gets filled up with reviews . . . depression project.'
> '. . . depression clinic . . . its been useful for her and for the practice . . . giving people more time to go into problems.'

The NP role

Education was one of the key functions identified by GPs as being undertaken by the NP. It was recognized that the NPs main role was in treating minor illnesses and in doing so, the NP was described as follows:

> [she] '. . . deal with problems very well . . . excellently . . . very thorough'
> [she is] '. . . better . . . [at]. prescribing than doctors and gives more appropriate prescriptions'
> [she] '. . . probably prescribes slightly better for chronic conditions than doctors'
> [she is] 'very effective in chronic disease . . . takes time – and goes through management'
> [she is] '. . . better at sticking to protocols than GPs.'

The NP was felt to be able to offer specific and very effective education regarding chronic diseases and minor illness and this was clearly seen as a function of the time available during consultations:

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> '. . . we (as a practice) are providing people with more information about their conditions
> '. . . not medicalising too many things . . . giving them more control'
> '. . . Skills, opportunity, time and remit . . . can fulfil that niche . . . health education linked to illness . . . concrete thing that applies to you . . . NP is dealing with ill people, so different focus [to] practice nurse.'

Other more general benefits to the role were also noted. The presence of a NP was seen to offer more choice and continuity of care to patients for 'female' problems, the role was felt to enhance the quality of service available to patients and in this case, the availability of longer consultations was perceived to be a positive benefit to the practice and to patients. The advantage of a NP over a locum or trainee was the continuity of patient care provided by them. One doctor in particular valued the opportunity to discuss patient needs with a colleague, particularly the social and psychological aspects of management. Several of the GPs saw the role as a way forward and proposed expansions of the role such as home visits.

Limitations of the role

Some GPs appeared to have a particular view of work of primary health care based largely on *their* workload demands and the frustrations and stresses these create. A tendency emerged, therefore, to judge the benefits and disadvantages of the work of the NP from this perspective only. Some GPs expressed concerns that indicated a tension between the *quantity* and *quality* of consultations, for example:

> '. . . 15 minute appointment impracticable'
> '. . . 20 minute appointments, some patients don't need that much . . .'
> '. . . couldn't have NP for open access surgery . . . wouldn't get through numbers'
> '. . . length of time it takes . . . 4–5 patients, whereas we will see 9–12 . . .'
> '. . . What [she] . . . sees in 20 minutes . . . I see in 5 minutes'

These comments do not take into account quality as a measure of effectiveness nor consider the actual content of the NP consultation, merely wishing to enhance throughput.

This tension regarding length of consultation prompted some to muse over the cost effectiveness of the role, judged, almost exclusively, on the basis of 'through put' and related to the salary of an NP compared with that of a GP:

> '. . . how many patients seen . . . what is the cost. . .'
> '. . . problem of cost effectiveness . . .'
> 'depends on level of pay . . . throughput etc.'
> '. . . how do you evaluate new service?'
> '. . . although if . . . trying to work out purely on cost effectiveness basis, I don't know whether salary she would get compared with a doctor would equate at the end of the day'.
> 'might as well pay a Locum GP to do this'.

It must be stressed that these were minority views and those GPs who expressed them tended to move away from throughput as a measure of effectiveness when issues of illness management, health promotion and patient education were addressed as a function of the NP role. The appropriateness of substituting a GP locum for the NP was in fact, directly challenged by the GPs themselves, particularly in relation to what the NP offered.

> '. . . Locum . . . good clinically, and are paid to do the clinical work . . . not part of job to educate'.

GP trainees were also felt to be an inadequate substitute for the NP:

> 'GP trainee is learning on the job; they are under close supervision . . . they have a different focus . . . less on educating patients'.

Another issue worth noting is that some GPs felt that full advantage of the NP role could not be developed as it was initially a temporary post and the practice was not able to rely on the role's continuance. The part-time nature of the post was also seen as a barrier to complete integration into the work of the practice.

What gets in the way

Certain elements such as the time limitations on the role, were seen as interfering with the ideal functioning of the role. The key issue for the GPs though was the inability of the NP to sign prescriptions. This was felt to cause problems mainly

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because it wasted time but also because the autonomy and, therefore, perhaps the credibility of the NP in the eyes of the patient was compromised. One doctor commented:

> '. . . in other countries you can get these things over the counter', and felt that NPs '. . . should have a list that she can sign for . . .'

A number of the GPs felt that the role of the NP would always have limitations because the ultimate responsibility for patient care still lies with the GP:

> '. . . the buck stops with the GP . . . he can't pass on to anything'
> '. . .comes to me or another GP with a problem . . . this is not budgeted into GP time . . . not a problem for me . . . but could be problematic with a more stressed GP'.

The GPs noted, however, that they also consulted with colleagues and perhaps therefore, this was not a new or limiting issue.

Despite noted limitations the GPs were positive about the NP and saw a future for the role.

Primary health care nurses

The main group of PHC nurses interviewed were the practice nurses given that, being practice based, their work role might have the strongest links with that of the NP. District Nursing and Health Visiting staff were also involved at their request.

Overall impressions – 'Almost like having a perfect doctor'

The primary health care nursing staff were able to discern many benefits stemming from the role of NP. One commented that it was 'almost like having a perfect doctor' in that the NP had developed skills of diagnosis, decision making and prescribing that were medical in nature on top of a background of expert nursing practice and skills and, therefore, embodied the best of both professions, able to consider patients' needs from both a medical and nursing perspective. The prime benefit perceived by the primary health care nurses stemmed from what the NP was able to offer the patients; longer, more detailed consultations were available with better patient support and a different approach which could better 'unravel' complex patient problems:

> 'I have a feeling that patients get more things out of her . . . different approach'
> '. . . She has time to investigate'
> '[she] can re-educate them. . .'

Patients benefited from shorter waiting times

> 'Minor ailments . . . hopefully more time for doctor to see other things . . .'
> 'Shares female GP's workload'

The PHC nurses felt that the NP was able to give more information, and a more holistic and empathetic response to patients' concerns, considering that some patients do not want to 'waste the doctor's time' and will tell the nurse things that they do not want the doctor to know as they feel that they might be 'told off'. Patients:

> '. . . can sometimes talk more easily to a nurse, also helps that she's a woman . . .'
> '. . . we do have patients who can't cope well . . . can ask for advice, open up to her more . . .'.

This, in part at least, was thought to stem from the skills brought to the role from a nursing background:

> 'Her insight, from a nursing perspective. Some patients 'want to see a nurse' because '. . . patients seem to feel that you [as a nurse] will do your best for them'.

It was felt that the NP practiced 'more of a social model of health . . .' than a doctor and was more understanding of the daily living experiences of patients. It was felt important that the patient knows that the NP is 'not going to judge them'.

Other benefits were clearly related to how they saw the different nursing roles fitting together and complementing each other.

Documentation was felt to be very helpful:

> '. . .[she] enters things on computer really well so can see exactly what she has done. . .'
> '[her] notes are wonderful, can follow exactly what she's done . . . easier for me to follow on . . .'

Practice nurses in particular felt that they gained support in their role from the NP with referrals to and from the NP occurring appropriately.

Importantly, none of the other PHCT nurses felt that the NP role affected them in any negative way.

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It was acknowledged that initial concerns had existed, primarily focused on role boundaries and lack of understanding of the NP role. All conceded that these feelings of threat were unfounded as the role of the NP complements their roles so that now they expressed views such as:

> 'I wasn't quite sure . . . [now] not quite sure what we would do without her.'

The importance of communication in reducing any possible tension during the introduction of such a role was stressed, and the necessity to have a good relationship between the nurses. It was felt that overlap between the roles was inevitable but there was plenty of work for everyone.

The inability of the NP to prescribe was raised as the only major constraint, again because of wasted time for the NP, the patient and the GP. The nurses felt, without exception that this was the way forward in the primary care setting.

Other staff 'she does her consultations absolutely perfectly'

Only two other primary health care staff were interviewed. One specifically requested the opportunity to comment on the NP role because they felt that the work (which related to them) was of such a high standard:

> 'Always gives a full picture of what has happened to the patients . . . phenomenal help to me . . . anyone who sees the patient next knows exactly what to do.'

The other was a peripatetic professional with a specific primary health care focus who observed that:

> '. . . [the] practice will benefit from another pair of hands . . . a qualified person to take work . . . a valued member of the team.'

Discussion

Interviews with staff in the PHCT who were affected by the NP role have identified a number of benefits of the role to both the patients and the team: the role offers patient choice and a different model of care, which is perceived to be more holistic and with a focus on information strategies and disease management. The NP is valued as a professional colleague, working with rather than for the doctor (see also Bowling and Stilwell, 1988) who has different knowledge and a different perspective; a complementary partner (as found by Chambers, 1991) which is important to the other professionals within the team.

In particular, the opportunity the NP has for educating patients and providing information is recognized as important. Patients registered at some of the practices are young, experience many stressful situations and are judged to lack some of the skills that enable basic self help and competency. The opportunity afforded by the presence of the NP to spend time educating patients regarding self help and minor ailments is seen as highly beneficial not only to the patients themselves but also to the doctors.

The presence of another professional in the practice (the 'extra pair of hands') helps manage the workload, echoing Dolan *et al's*. (1997) findings of reduction in waiting times and less aggression and dissatisfaction in the waiting areas as a positive benefit of the NP role. Although the addition of a clinician – whether an NP or not – would be likely to give this effect, it is clear that it is the different role of the NP that is important in both this and the Dolan *et al*. (1997) study.

The quality of patient care is perceived to have been enhanced in these practices, partly due to the enhanced availability of appointments, but also because of the extra time that the NP is able to give to her patients and her ability to combine nursing and medical skills. The PHCT's perceptions are congruent with the findings of the Horrocks *et al*. (2002) systematic review in which NPs were found to give a higher quality of care in some areas with more advice and information, more compete records and better communication than their medical colleagues. NP's prescribing was identified by the GPs in this study as being superior to some medical colleagues and this finding does not appear to have been previously noted in the literature in this context.

Confusion or lack of knowledge about the role of the NP created tensions both in terms of the appropriateness of referral of patients to the NP but more importantly perhaps, in terms of the fact that a number of the GPs identified that they were unclear of the function of the NP in practice. This may be due to the nature of the scheme as a pilot but it is clear that for these roles to be effective, all clinicians must understand what they entail so

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that there can be realistic expectations of the likely effects of the role on the practice and on individual professionals. This lack of clarity about the role did not hinder support of it due to its perceived effects on the practice, the workload and on patient care. The pivotal role of the receptionist in introducing the NP role and service to patients does not appear elsewhere in the literature.

There was no role conflict reported, although this had been anticipated, particularly by practice nurses. This finding supports Reveley's (2001) conclusions and contrasts with earlier literature which suggests inevitable conflict after the introduction of NP roles (Kaufman, 1996).

The paradox displayed between GPs' concern for cost effectiveness based solely on throughput on the one hand, balanced against their perception and acceptance of the benefits of longer consultation times and the added value in terms of education and management on the other is interesting and shows perhaps some of the tensions inherent in the role of the GP in primary care. Some of the GPs' perceptions of primary health care workload appear to be based only on the demands and frustrations of their role. A tendency emerges, therefore, to judge NP work from this perspective only and these opposing views did not appear to be recognized or reconciled by all of the GPs. This tension between cost and effectiveness as perceived by GPs, does not appear previously in literature considering this role. Venning *et al.* (2000) however, suggested that NPs could be more cost effective than GPs if they could reduce consultation time while maintaining the benefits of the NP led service. This highlights the problem of a perceived benefit of longer consultation but a consequent higher cost. It could be argued that the benefits of the NP service are inherently linked to their ability to spend more time with patients and that if consultation time reduces, these benefits are likely to reduce also. Perhaps it must be recognized that high quality care is likely to be expensive and, as Cooper and Lybrand (1996) highlighted, many of the benefits of NP consultation are not measurable or quantifiable. Issues highlighted here demonstrate the necessity and urgency of developing more effective ways of analysing the (cost) effectiveness of new clinical roles. It is very difficult to measure cost benefit in terms of a new found ability to self care or cope and reduced attendance at surgery because of this. Attribution is always problematic and perhaps comparison of services pre and post NP employment is an area which should be considered for future research. As practice expansion was facilitated by the NP role in this study, perhaps a more complex analysis of cost effectiveness is required taking this and similar factors into account.

Conclusion

While it is clear that all these differing views of the NP role represent the differing priorities of the groups involved and, although some tensions exist within the NP role in the practices which participated in this study, the role's acceptability is overwhelmingly demonstrated. The halo effect when evaluating a new role, however, including the recognition that new roles tend to attract the most enthusiastic and able people may well have enhanced the positive findings from this evaluation. On the other hand, the perceived 'temporary' nature of the post (in the pilot study) led to a perception that the role has not yet been developed to its full potential and the part-time nature of the post has perhaps hindered integration into the practice. The pivotal role of the receptionist in facilitating integration of the role is an interesting and novel finding. Autonomous prescribing for nurses is the major issue identified here which hinders the role's development, although this is likely to have been dealt with, at least in part, by the recent availability of extended prescribing for nurses. Evaluation of nurse prescribing should allow wider comparisons of prescribing within the PHCT.

This study considered one health authority's introduction of service change in response to user need. The conclusions must, therefore, be seen in this light, with the applicability to other settings of the findings regarding the acceptability of the role and other issues noted here being considered carefully. The findings serve to illustrate some areas within service development and workforce planning which may need to be considered by PCTs in order to effect role and service delivery change envisioned in '*Making a Difference*' (Department of Health, 1999) and thus move towards the fulfilment of the government's aims for delivery of the NHS plan (Department of Health, 2001) in primary care through its vision for primary care services (Department of Health, 2001) and the

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development of the recent priorities and planning framework (Department of Health, 2002).

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