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Guest editorial

Nurses' roles in primary care: developments and future prospects

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The scope of the nurse's role in primary care has expanded considerably in the past decade and is likely to continue to do so in the medium and longer term. Many nurses' roles have shifted from predominantly delegated, task-orientated activities towards roles which include seeing patients at first point of contact, working in partnership with patients in the management of long-term conditions as well as involvement in preventative care and health promotion. Nurses working in these roles have considerable autonomy in decision making; many can now take a history, make a diagnosis and decide upon treatment options in conjunction with the patient including prescribing medication. Many services have been redesigned placing nurses at the forefront with the aim of enabling patients to have greater choice, access and equity of service. This edition of *Quality in Primary Care* has been commissioned to consider the nurse's contribution to primary care services. A number of papers are presented: some explore issues related to the advanced skills nurses require to work in new roles, such as consultation and prescribing; some address how nurses are leading on the development of new services such as case management while another contribution explores how nurses can work with other members of the primary care team to deliver different models of care.

Issues surrounding nurse prescribing are reviewed in an article by Strickland-Hodge who discusses the importance of the removal of barriers enabling 'non-medical' health professionals to prescribe. It has taken over 20 years for those with the appropriate advanced level skills and knowledge, other than doctors, to gain full prescribing rights.[1] Despite concerns that nurses may have less exposure than doctors to in-depth pharmacology during their training, Strickland-Hodge concludes that provided they practise within their level of competence, independent prescribing by nurses is vital to delivering high quality health services. However, the paper challenges the use of terms such as 'non-medical prescribing' and 'independent prescribing' suggesting they serve to maintain the historical power hierarchies between nurses and doctors. Accounts of how the medical profession dominates the healthcare agenda and how this can compromise the care nurses are able to provide, by the limits imposed on their practice, are well documented.[2] However, it is not just the medical profession itself that seeks to control and regulate nurses' roles. Nurses are also regulated by their own professional body, whom it could be argued, actively reinforce the existing hierarchies. The Nursing and Midwifery Council (NMC) has provided standards of proficiency for nurse and midwife prescribers[3] which state that nurses working in primary care can only be certified as competent to prescribe following a period of supervision and assessment carried out by a Designated Medical Practitioner (DMP) who is a general practitioner. Regulation is essential for patient safety but to be truly professional nurses need to be allowed to make judgements about their own competence and to be accountable to their patients for such decisions.

Sibbald clearly thinks nurses are more than competent to take on the challenges of new roles. Her guest editorial suggests that there is a persuasive body of evidence demonstrating nurses' technical competence and she suggests they can replace general practitioners for most routine appointments, leaving (fewer) doctors free to specialise. The public's views are important in terms of their acceptance of nurses working in new roles; and patients' expectations are partly shaped by past experience and (often outmoded) media portrayals of nurses. There is, however, growing evidence that many patients are willing to see a nurse if it means they will be seen quicker and provided they are appropriately qualified and experienced.[4,5] If general practitioners become the specialist primary care consultants of tomorrow and nurses take on most of the 'routine' primary care appointments, as suggested by Sibbald, the concept of personal continuity will inevitably extend beyond what has traditionally been viewed as general practitioner provided care.

Effective consultation skills are at the heart of providing high quality care for patients and the article by Chatwin shows how the technique of 'conversation analysis' can be used to explore nurse/patient interactions in depth. Using a worked example the paper describes how cues in the patient's description of the problem lead the nurse towards a series of questions before finally arriving at a diagnosis. The paper also explains how once the nurse picked up certain cues s/he tended to ignore other (potentially relevant) signs that the patient provided that did not 'fit' with their provisional diagnosis. Our conclusion would be that the nurse may have arrived at a diagnosis prematurely and instigated a management plan too early in the consultation, which is something we also found whilst working on developing the Consultation Assessment and Improvement Instrument for Nurses (CAIIN) study.[6] Conversation analysis could become an important tool for nurses who wish to improve their competence during a consultation.

Patients expect nurses to be technically competent but there is also evidence that they value nurses' interpersonal skills because they are perceived as having more time for them and are more empathetic.[4,7,8] A short report by Briggs *et al* discusses how patients attending a new nurse/pharmacist-led community pain clinic reported a positive impact on their pain scores, reducing the need for secondary care referral. Nurses working in extended roles in this study demonstrated an improvement in patients' pain outcomes through a combination of their technical skills (including prescribing) and interpersonal approach. By reducing the number of pain referrals to secondary care, nurse-led services also have the potential to reduce NHS costs, though this was not investigated in this study.

New posts for nurses such as 'Case Managers' have been introduced into primary care.[9] This service targets predominantly people with long-term conditions by community matrons, who case manage up to 50 patients in order to avoid unnecessary hospital admissions.[10] Using case history methodology, Elwyn *et al* explore the scope of the role and demonstrate how case management by nurses can lead to the identification of new diagnoses and the coordination of further care and services tailored to the need of the individuals. He concludes that the main benefit of this new role can be measured by patient-centred outcomes such as quality of life rather economic outputs. Leighton *et al* use a health services evaluation approach to explore the introduction of a new Community Matron Service. High levels of patient and general practitioner satisfaction with the community matron services were demonstrated. The authors were able to feedback comments to the service providers and recommend appropriate changes to the way it was delivered. These studies are beginning to demonstrate evidence about how new nurse-led community services are responding to patient needs locally, while reducing referrals to secondary care.

Offredy *et al* discuss the development of a clinical assessment service in Harrow PCT. This was stimulated by patients' preference to be seen in their own locality as well as targets to reduce referral waiting times in secondary care. The introduction of general practitioners with special interests was central to the development of the new services for cardiology and dermatology based in primary care. The paper highlights the role nurses played in assessing and triaging patients to determine their suitability for the new service.

Holt's paper describes the process through which nurses adapt their practice in response to service changes or take on new roles. The paper proposes a model of role transition which includes the search for new identity; focusing or prioritising what needs to be done; justifying the new role and the search for resources and shaping a new identity. The author discusses how knowledge of the process through which nurses develop and adapt to their new roles could help them come to terms with the process of transition and highlight to stakeholders the support nurses may require in making the change.

Funnell describes two recent initiatives, namely Local Involvement Networks (LINks) and the patient opinion website (www.patientopinion.org.uk). LINks is a network of people who want to improve care, due to be launched in spring of this year. What is exciting for nursing is that some nursing groups (specialist community public health nurses) are going to be involved in working in partnerships with patients and other groups in preventing ill health across a range of areas. The article also describes the opportunities for both patients and service providers afforded by the patient opinion website. This resource will enable health professionals from any discipline to find out what patients/public think about services in their local area(s).

Conclusion

Patients want primary care professionals to be interested and sympathetic; they want to be involved in decisions, given time and attention and advice on health promotion and self care.[11] Historical barriers such as medical dominance, unnecessary regulatory restrictions and professional uncertainty about role boundaries have previously limited nurses' contribution to primary care services. However, nurses are now being offered a range of opportunities to expand the scope of their practice in primary care and the evidence suggests they are able to meet patient-centred

priorities for care.[4,7,12] The papers presented in this edition discuss a range of issues relating to advanced nursing practice and new nursing roles. Advanced practice is now providing patients with accessible, responsive, high quality care, nurses have greater opportunities to improve their skills and advance their careers and general practitioners have more freedom to specialise in areas of interest. Case management and leading on teamwork developments is strengthening the role of some nurses by offering patients a service which is badly needed but previously did not exist. Perhaps it is time to stop arguing over traditional professional boundaries and using terms like 'nurse/doctor substitution' which serve only to define nursing in relation to doctors' work. Nurses' and doctors' roles are complementary, some tasks are distinct and others interchangeable and the boundaries of practice are continuously shifting reflecting the changing needs for health care. Nurses working in advanced roles are helping to transform services, and as such they are becoming equal players within the primary healthcare team.

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