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# RCN Policy Unit

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**Policy Briefing 09/2006**

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## **Nursing Models in Patient-led Primary Care Service**

### **ABSTRACT**

This briefing on Nursing Models in Patient-led Primary Care Service has been compiled by the RCN Policy Unit. We are aware that policy impacts upon practice in a number of ways, not always for the better. In the RCN Policy Unit we depend heavily upon RCN member feedback and contribution to our policy development work. We have included sources of further reading and links through to other parts of the RCN website within the briefing and we look forward to hearing your views via the policy discussion zone or the [policycontacts@rcn.org.uk](mailto:policycontacts@rcn.org.uk) e-mail address

May 2006

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# Introduction

As part of the RCN Policy Unit's work on new models of service provision, this paper is intended to stimulate discussion about the respective value of a range of nurse-led models of provision in primary care services. It is intended that this paper will assist the RCN to determine which of models best fit with the principles and aspirations of our members. Our work on new models continues and this paper should therefore be considered as a "work in progress". It is intended to act as the basis for consideration, debate and reflection. For further information and to pass on comments, please contact Colin Beacock in the RCN Policy Unit at colin.beacock@rcn.org.uk .

## A Primary Care-Led NHS; the Recent Policy Background

In 2000, the government set out a ten year plan for the reform of the NHS in England.<sup>1</sup> In June 2004, a year before a forthcoming General Election, the Department of Health gave added impetus to the reform programme with the publication of further guidance on the implementation of those reforms in *The NHS Improvement Plan; Putting People at the Heart of Public Services*.<sup>2</sup> In that document, the Department of Health not only emphasised the place of users at the heart of public services, they also described how, in primary care services:<sup>3</sup>

... the NHS will be developing new ways of meeting patients' needs closer to home and work. New flexibilities will enable PCTs to commission care from a wider range of providers, including independent sector organisations, to enhance the range and quality of service available to patients.

*The NHS Improvement Plan* went on to applaud the initiative and professional efforts of NHS staff and cited developments in nursing specialities and increasing flexibilities in nursing practice as being central to the reform agenda and the future provision of primary care services. Furthermore, the report went on to consider the nature of integrated services and referenced newly established systems of GP contracts as an opportunity to create more patient-led services and new forms of provision which, it said:<sup>4</sup>

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<sup>1</sup> Department of Health, *NHS Plan*, (DH, 2002)

<sup>2</sup> Department of Health, *The NHS Improvement Plan; Putting People at the Heart of Public Services* (DH London, 2004)

<sup>3</sup> Dept. of Health, *The NHS Improvement Plan; Putting People at the Heart of Public Services- Executive Summary*, (DH, London 2004) p.3

<sup>4</sup> Dept of Health, *The NHS Improvement Plan; Putting People at the Heart of Public Services*, (DH, London 2004) p.53

... will include PCTs directly providing care, and contracting with the independent sector where this is the best option.

*Creating a Patient-led NHS; Delivering the NHS Improvement Plan*<sup>5</sup>, in March 2005, again held great potential for nurse-led services in primary care. It recognises key factors upon which nursing practice can build:

- establishing alternative models of service to match developing patient choice,
- innovation in establishing new models of practice, e.g. community matrons,
- developing new types of provider organisations,
- radically different types of provision, e.g. walk-in centres and NHS Direct,
- freeing up entrepreneurial approaches within primary care practitioners,
- collaborative working between primary and secondary care organisations, as well as integration of health and social care provision and commissioning
- emphasis upon early intervention and disease prevention,
- and, recognition that existing systems of primary care provision in the NHS has many strengths.

## Developing Nursing to Transform Primary Care

It was against this policy background that Nicola Walsh produced a paper<sup>6</sup> for the Department of Health Strategy Unit and Nursing Directorate in April 2005. Walsh's paper sought to address what she identified as key characteristics of wider government policy. These being<sup>7</sup>;

- improving patient access and choice;
- building capacity by organisations and professionals working together to the benefit of their community;

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<sup>5</sup> Department of Health, *Creating a Patient-led NHS; Delivering the NHS Improvement Plan*, (DH, March 2005)

<sup>6</sup> Walsh N., *Developing Nursing to Transform Primary Care*, (DH internal report) May 2005

<sup>7</sup> *ibid*, p.2

- promoting a greater focus on health and well-being;
- increasing clinical engagement in the commissioning of healthcare services; and
- Improving health outcomes.

Walsh goes on to reference research findings which confirm the positive impacts of doctor-nurse substitution in terms of:

- improved patient outcomes
- greater cost benefit
- more even distribution of workload and roles, and
- Enhanced patient experience.

Walsh then builds upon these positive indicators when she illustrates 10 potential nursing models for the future development of services in primary care. These are:

- nurse-run practice
- nurse-led primary care services
- multi-disciplinary professional partnerships
- limited companies
- multi-speciality teams
- co-located nursing services
- primary care nursing teams
- limited liability partnerships
- nursing co-operativity partnerships

# Evaluation of models

A preliminary evaluation of each of Walshs models has been undertaken using the RCN principles<sup>8</sup> and four additional factors which are referenced by Walsh as crucial. These are evidence base, applicability, format and

Partner practice base and four which have a more community wide application.

These models were;

## GP/ Partner Practice-based services

i) Nurse Run Practices, by Walsh's definition, this model is orientated towards nurses managing and organising GP-led practices.

- Their function appears to be focussed upon a small team of nurses, or an individual fulfilling that role.
- The business and organisational format is geared towards private and individual enterprise and there is scope for the use of PMS and APMS contracts for these services.
- In terms of RCN priorities, this model does not guarantee opportunity for patient and public involvement, nor staff side representation in the governance of the service, neither does it necessarily promote public ownership.
- Because the model is based upon nurses running and managing GP practices, there is limited scope for cost efficiency savings other than in the practice itself, nor is there the guarantee of efficiencies and surplus being further invested in NHS primary care services.

ii) Multi Disciplinary Professional Partnership, like the previous example, this model focuses upon managing and organising services at practice level with the same issues and concerns in terms of the framework factors but, additionally;

- The model allows greater flexibility in developing nursing and AHP roles within the management team but not in clinical practice, other than by transfer or roles and responsibilities at Partner level.
- The business is owned on a "partnership" or shared basis with partners choosing from a range of systems of reward.

iii) Nursing Chambers is a format which is entirely geared to private, rather than public ownership and does not, therefore, evaluate as having a high potential given the criteria used. This model of service provision may, however, be of benefit to nurses who wish to pursue a form of business which offers them flexibility of employment.

## Community-based services

### iv) Nursing Co-operatives

- This model offers opportunity for establishing a mutual form of organisation based upon a social enterprise approach
- There is no immediate example of models of this kind operating in the UK
- The model has the benefit of enabling continuing membership of the NHS family for RCN members
- Although there is no immediate models of nursing co-operatives in the UK, GPs have successfully operated this system in the provision of out-of-hours services
- Through a Co-operative approach this model also offers high levels of user engagement in governance and reinvestment of surplus and efficiency savings in future NHS primary care services

### v) Primary Care Nursing Teams

This model has many of the features of the previous approach but also has;

- Models presently operating in New Zealand, albeit on a small scale
- The option of utilising the LLP basis for business organisation, which can be interpreted as offering greater incentives for nurses to innovate and adapt to patient needs
- Opportunities for integrated services and establishing partnership agreements (e.g. s31) for provision of services to identified client groups
- This model holds the potential for use of 4 types of contracting mechanism, including the PCTMS with retention of full NHS rights for our members

limited company and mutual systems and PCT provision

- The model has high potential to establish systems of reinvestment in services and public ownership
- Highly applicable in services for people with long-term conditions

vii) Nurse-led primary care services

Although this model does carry the threat of being seen as parochial it has the potential to achieve all of the characteristics of the previous 3 models and achieve all of the RCN's priorities.

- Nursing control over referral and discharge enables easy transition between secondary and primary care services
- Promotes integrated working in primary care
- Offers a range of format options including employment by PCT and the use of PMS, APMS and PCTMS contracting systems, ensuring membership of the NHS family for our members.

## Comment

The criteria being used for this evaluation prioritise collective, rather than individualised models of provision and service organisation. Whilst the 3 models which focus upon GP/Partner practices do not evaluate highly in these circumstances, they may well be of interest to individuals and small cohorts of nurses (and AHPs) who wish to establish more innovative approaches to service development at practice level. As Walsh identifies in the "barriers" section of her summaries, it has long been the case, however, that GPs have dominated this area of primary care services and cultural and attitudinal change at commissioner and provider level will be as essential as structural reconfiguration in achieving changes of this nature.

Nonetheless, there are other models of GP/Partner practice-based services which can be supported by the RCN and which would be relevant to the future provision of primary care services. Based upon the Social Enterprise approach and using the mutual model format for the business organisation of its services, East London Integrated Care promotes multi-professional and multi-agency provision of primary care services. Furthermore, this model has the added guarantees of reinvestment of surplus in future services and continuing membership of the NHS family for nurses and other NHS staff. Further consideration is given to this model of provision in appendix 3 of this report, as part of the analysis of the Social Enterprise approach to service development.

Of the 4 community-based models of service provision described by



Walsh, Nurse-Led Primary Care Services and Primary care Nursing Teams scored highest in the framework of analysis, followed closely by Nursing Co-operatives. In the case of these models, as well as offering the potential use of mutual forms of business arrangements with consequent benefits in terms of public engagement and community enterprise, they each have the added value of being suitable for the use of SPMS and, in the case of Nurse-Led Primary Care Services and Primary Care Nursing Teams, the use of PCTMS contracts, whereby PCTs can continue in the provision of primary care services. Meanwhile, although based upon a smaller scale of service, Nurse Run Practice may be a model of primary care GP services which enable nurses to give leadership and management to local services without automatically scoring high on other service features, chiefly in respect of governance arrangements.

Colin Beacock  
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May 2006

# Appendix 1

## Indicators

Each of the models described by Nicola Walsh<sup>9</sup> can be evaluated against the following criteria which the RCN consider essential in determining their support for the reconfiguration of primary care services. The model offers opportunity for;

### 1) Nursing

- Nurse Executive/ Partner input at Board level
- Continuity of professional development for nurses
- Development of nursing practice and role in primary care

### 2) Value for money

- Achieving of cost benefits through developing nursing roles and practice
- Guaranteed reinvestment of surplus into primary care services

### 3) Public/patient involvement

- Community partnerships and public ownership through governance arrangements
- Staff constituency or representation in governance arrangements

### 4) Human resource management

- Partnership working and staff side representation
- Applying the principles of Improving Working Lives
- Maintains NHS pension and national pay for nurses and healthcare workers

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<sup>9</sup> Walsh N., *Developing Nursing to Transform Primary Care*, (DH, Internal paper, London, May 2005)

Furthermore, the models

# Appendix 2

	Nurse Run Practice	Multi-disc Partnership	Nursing Chambers	Nur <input type="text"/>
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