

Guide for Commissioners

The nature of service provision within primary care has changed dramatically over the past 2–3 years. The introduction of the new *General Medical Services (GMS) contract*¹, *A Patient-led NHS*², *Our Health, Our Care, Our Say*³ and *Practice Based Commissioning* has refocused the role of general practice and the primary care trust (PCT) or primary care organisation (PCO). PCTs are facing the new challenges of a larger population size and organisational change, notably with the separation and definition of the commissioner and provider function.

The impact of such significant policy changes cannot be underestimated in defining the role of the general practice nurse (GPN). As established members of the primary health care team, GPNs are now in a clear position to support and develop services that meet the new NHS agenda. This guide provides an overview of the core responsibilities of PCT commissioners and providers so that they and practice based commissioners may consider their roles and responsibilities relating to GPNs.

Key components of the guide:

- *reviews the role of the GPN in contributing to the key functions of the PCT*
- *identifies key roles, responsibilities and skills for GPNs*
- *examines PCT responsibilities for commissioning services provided by GPNs*
- *explores the role of the PCT as the provider, in delivering services that support GPN role development*

Role of the general practice nurse in contributing to key functions of the primary care trust

Our Health, Our Care, Our Say, recognises that individuals are best placed to manage their own health needs through the promotion of self care, lifestyle changes and the development of effective strategies to manage their own health needs. Building on the long-term relationships that nurses establish with the population, the GPNs role is fundamental in providing information and support in order to enable patients to make appropriate choices for their health. Recognition of the contribution that the general practice nurse (GPN) has played in the delivery of primary care can help PCTs to develop appropriate delivery structures to meet the population need.

Service provision from GPNs

Nursing within general practice cannot, and should not, be seen in isolation from other nurses but viewed as part of the whole system of care delivery (see *Unit: Integration of general practice nurses and the community health care workforce, GPN Toolkit*). The development of key relationships with other nurses and clinicians working in primary and secondary care facilitates the delivery of patient-centred care. As a generalist, the GPN provides nursing services to a broad range of the population, often managing undifferentiated patient needs.

Key services include:

- *first-contact assessment*
- *management of long-term conditions*
- *promotion of choice and positive health.*

Delivery of these services requires skilled, knowledgeable nurses who are responsive to patients' needs and expectations. This requires a flexible approach to care that makes appropriate use of skills and recognises the importance of ensuring that the practice has enough nursing hours to provide the necessary services. The general practice setting provides an increasing range of roles for both qualified and unqualified nurses.

All roles in general practice nursing should:

- *deliver high-quality, appropriate care in a safe and effective manner*
- *listen and hear the patient's needs, and deliver care within this context*
- *provide knowledge and support for patients, encouraging them to self manage*
- *signpost and refer patients to other clinicians and services*
- *be accountable and responsible for patients' care delivery.*

Effective skill-mix, including the development and implementation of new roles, is fundamental to delivering responsive services.

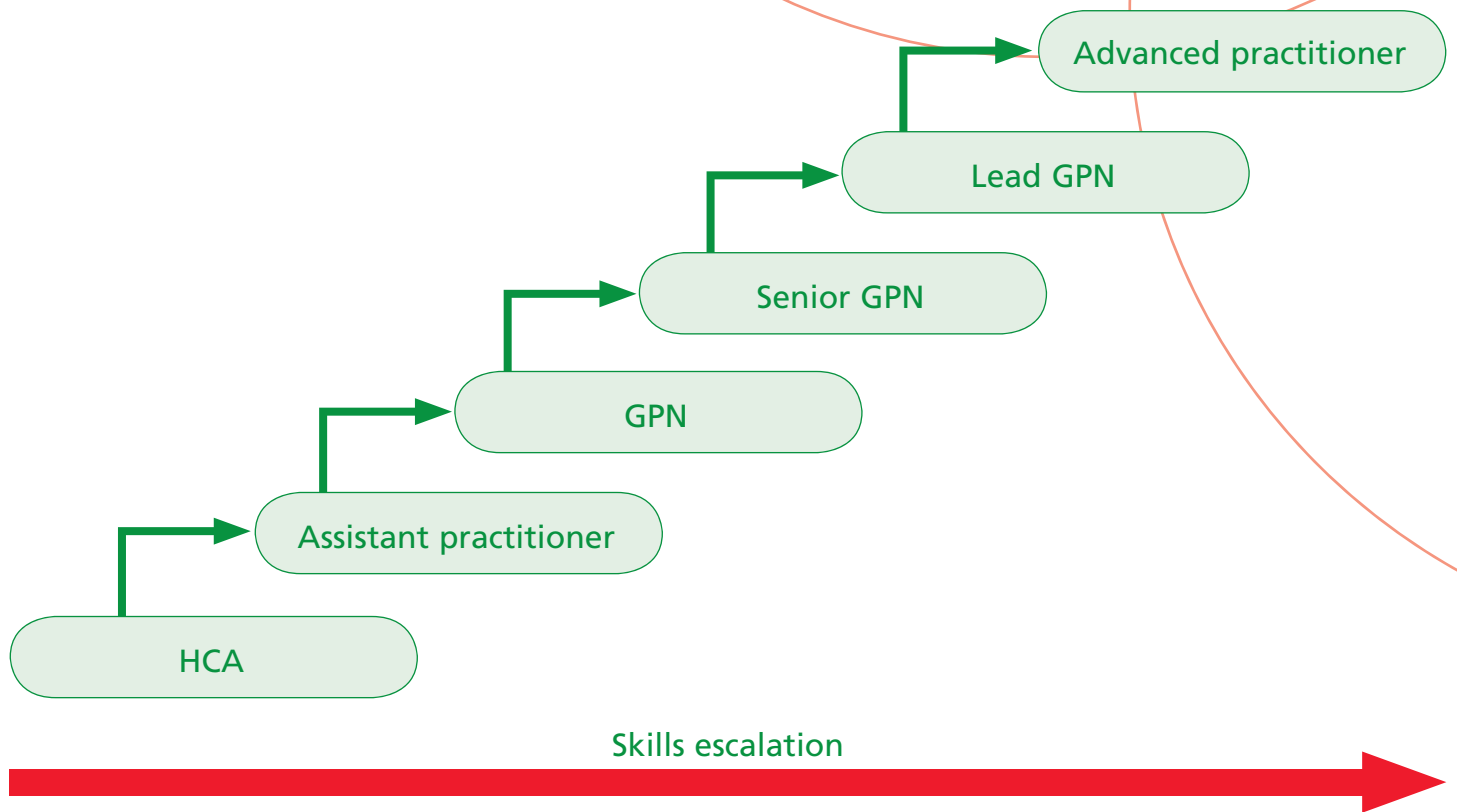
(see **HCA toolkit and Unit: Careers development of general practice nurses, GPN Toolkit**).

These new roles can be confusing for patients, particularly as there is a wide variation of titles used. However, they can be broadly categorised as:

- *HCA's*
- *assistant practitioners*
- *general practice nurses*
- *senior general practice nurses*
- *lead practice nurses*
- *advanced practitioners.*

Each of these roles should have clear functions, although the generalist nature of general practice does require some overlap, particularly at the margins of each role (see www.wipp.nhs.uk for the HCA and GPN toolkits).

The different roles that form part of the nursing team working in general practice are represented as shown in the schematic below.



Not all general practices will require a different nurse working at each level. Thorough analysis of population needs against role definitions will determine the actual skill-mix required.

Services delivered to patients

A GPN service includes:

- *services delivered to patients*
- *nursing contribution to the practice organisation.*

Patients can expect competent care delivery from nurses working within the GPN service to deliver the services listed below.

Health promotion

- Opportunistic and planned health promotion and education
- Supporting patients to self care
- Health screening
- Specialist advice (eg family planning)
- Women's health services (including cervical cytology and breast awareness)
- Men's health services
- Lifestyle advice, including smoking cessation, exercise and diet
- Vaccination and immunisation
- Travel health services

Management of long-term conditions

- Identification, diagnosis, monitoring and management of patients with long-term conditions, including diabetes, chronic obstructive pulmonary disease, cardiovascular disease, hypertension, asthma, epilepsy and chronic kidney disease
- Review of medication and adherence to treatments
- Work within practice guidelines to monitor and advise patients on long-term conditions such as thyroid disorders, rheumatoid arthritis, iron-deficiency anaemia and pernicious anaemia
- Support for patients with mental health problems
- Undertake diagnostic tests and give preventative advice for high-risk patients
- Prescribe medication after completion of a recognised extended nurse-prescribing programme

First contact

- Undertake first-contact consultations and treat or triage, as appropriate

Since the impact of increased diagnosis and effective management of long-term conditions will increase the demand for nurse consultations, the mode of care delivery will need to change. This change will include the development of closer working relationships with other organisations, for example leisure services. To support this, all nurses need to be valued for their own contribution and helped to realise their potential within a structured career pathway.

Primary care trust commissioning responsibilities for general practice nursing

The primary care trust (PCT) commissioning function involves moving from a contract focus towards one that identifies the required service provision based on the health needs of the local population. As a commissioner, the PCT needs to support the practice based commissioning cluster to commission a comprehensive and equitable range of high-quality, responsive and efficient services, within allocated resources, across all sectors including general practice.⁴ See **Identifying workload capacity in Practice Nursing tool**.

In order to commission effectively and address priorities, PCTs need to:

- *review best evidence for the model of care delivery*
- *consult with and seek the local population's views on service delivery needs*
- *identify appropriate context for care delivery, for example secondary care, primary care or general practice*
- *identify who is best placed to deliver care*
- *identify competences required to deliver care*
- *identify the number of clinicians and appropriate competences needed to deliver the service*
- *review the capacity needed for service delivery.*

See **Unit: Competences of general practice nurses, GPN Toolkit** for details of the core competences within general practice nursing.

Prior to establishing the number of general practice nurses (GPNs) with the requisite skills to deliver a service, a review of GPNs' skills and knowledge should be undertaken. For example, before commissioning the delivery of sexual health services within primary care, there is a need to understand the knowledge base of clinicians (including GPNs) to determine whether this would be sufficient to consider shifting provision from secondary care. Similarly, there is a need to review the availability of resources. This is particularly relevant for the GPN workforce as, to date, resources have not been allocated on a basis of need, and nurse development has not followed a structured approach.

The need for key GPN resources may be further compromised by the national profile of GPNs, that identifies a relatively high number of nurses nearing retirement age. The lack of a formal model for succession planning of GPNs exists predominantly as a result of the direct employment of nurses by GPs. The resulting problems may lead to difficulty in finding an appropriately skilled workforce to recruit from - and this may impact on the ability to safely commission services from general practice. See Identifying workload capacity in Practice Nursing tool. Engagement with general practices and the strategic health authority to consider the future workforce needs could help to address this situation.

Commissioning should also involve support for the development of nurses to deliver a quality service. This can include establishing a safe model of care provision, and the identification of appropriate resources to deliver the service (see *Unit: Employment of general practice nurses* and *Unit: Quality improvement and evaluating practice* of the GPN Toolkit). The number of GPNs per head of practice population is disparate and PCTs should adopt a standardised approach to defining nursing need. Identifying workload capacity in practice nursing provides a mechanism of calculating GPN hours per general practice, based on practice population and patients with long-term conditions.

See **Workload Capacity Tool** to assess whether or not there are sufficient GPN resources by facilitating a review of the GPN requirements in relation to:

- *population size*
- *number of patients in each major disease group*
- *health prevention activity*
- *number of patients requiring cervical screening, immunisations and new-patient medicals per month*
- *treatment room activity.*

This enables an analysis of the skill and grade of nurses to be provided within the general practice.

Development of appropriate service specifications

Having considered the service need, a detailed service specification is required. This should identify service outcomes, and set standards by which the service delivery will be measured. This aspect of commissioning offers a real opportunity to measure the impact of the GPN role on health care provision.

The key work areas for nursing in general practice are described below.

Long-term conditions management

In order to meet the needs of patients with long-term conditions, there is a requirement for nurses in general practice to address the needs of patients at level 1 and 2 of the long-term conditions pyramid.⁵ Patients at level 1 and 2 are predominantly mobile and therefore best suited to access nursing care through the general practice environment. This requires GPNs with appropriate skills and knowledge to encourage and support self-management, and manage the disease process as the condition changes. Service delivery must therefore be sufficiently flexible to provide easy access to the GPN. Models of care provision, that include both unscheduled and planned care will support this approach.

Increasing access

In addition to the management of long-term conditions, GPNs have the potential to support the increased access to health care provision. It is estimated that, even without additional training and development, nurses could effectively manage approximately 17% of patients' attendances to general practice.⁶ This could be increased, with advanced nurse practitioners effectively managing the majority of presenting patients in general practice.⁷⁻⁹

Health prevention/screening

The third focus of work within the general practice setting is health prevention, for example immunisation of children and adults, and cervical cytology. This has been effectively delivered in the past by general practice nurses within the general practice environment.

Defining measurable outcomes of care

GPNs and practices are individually responsible and accountable for the care provided. Care pathways may be useful in facilitating this process. These are sometimes also known as care profiles, care protocols, critical care pathways, multidisciplinary pathways of care. Key definitions of a pathway are identified as:

“An integrated care pathway determines locally agreed multidisciplinary practice, based on guidelines and evidence where available for a specific patient/client group. It forms all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement” (National Pathways Association, 1998).

A second definition helps to further explain a pathway:

“Integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem and describe the expected progress of the patient” (Campbell, et al, 1998).

They are multidisciplinary, locally agreed, evidence-based plans, describing the expected progress of a specific patient group. They form all or part of the clinical record. By facilitating the evaluation of outcome, they can be a quality improvement tool for use as part of clinical governance. See <http://www.csp.org.uk> for more information

In addition, commissioners have a responsibility for creating and monitoring standards. Although specific standards for GPN care have not been defined at a national level, these could be introduced through the *Standards for Better Health*¹⁰ domains, current best practice as outlined within national service frameworks and National Institute for Clinical Excellence (NICE) guidance to form a baseline for assessment of care.

Ongoing monitoring and evaluation

The monitoring and evaluation of service provision is a key component of commissioning. Specific mechanisms to support evaluation will already be in place, such as the *Quality and Outcomes Framework (QOF)*.¹¹ Although this framework is not GPN specific, it does enable a broad proxy measure of nursing care within general practice to be assessed. Specifically, the *QOF* identifies a number of key areas that are predominantly undertaken by nurses, for example long-term conditions management. The achievement of *QOF* can therefore, at its basic level, identify nursing input and level of service delivered. However, *QOF* does not identify the quality of the nurse–patient relationship and its impact on health. This is not an easy concept to measure. Support through reflection, clinical supervision and individual performance review also contribute to the monitoring of standards of service provision.

Clinical leadership to support commissioning

Development of and support for the GPN role is fundamental to high standards of care. While the remit of the commissioning function is clearly identified, this must receive a contribution from local clinicians with

a knowledge and understanding of general practice nursing. Clear, credible, clinical leadership from the commissioning arm of the PCT for nurses working within general practice will facilitate access to advice and support that will ultimately facilitate service provision.

GPNs are often perceived as being professionally isolated from other nurses. Although they work daily with other nurses, and generally have close working relationships with GPs, the model of employment for GPNs means that there is frequently a lack of formalised support and advice from a senior nurse. Failure to identify and implement a robust mechanism that provides nurse leadership (with clear negotiation and engagement skills) and support to GPNs has the potential to expose the PCT to clinical risk. The clinical risk will be significant given the white paper on regulation for GPNs as PCTs will have key roles in the revalidation process. Therefore, development of either a distinct role within the commissioning arm of the PCT, or contracting this work from an external organisation or the PCT provider arm, will both reduce risk and support development of future services.

The key functions of a GPN lead should focus on:

- *clinical and professional leadership*
- *service development and modernisation*
- *monitoring and evaluation of standards of care delivery*
- *identification of skills and competences required for service delivery*
- *development of specifications for training and education programmes*
- *future service needs.*

see [Tool – Job descriptions for GPN lead posts in PCTs](#)

Practice based commissioning – considering the GPN role

The ability to access information from both secondary and primary care enables the providers and the practices based consortia to shape and adapt the GPN service to identify future requirements as well as delivering current needs. The development of a service that could span practices will enable any potential risk to be shared, and supports the growth of innovative practice.

Practices and PBC clusters will need to identify the services which they wish to focus on and plan any re-design opportunities or develop new services. The context of this planning process is often misunderstood by practices and many are often relatively unaware of, or involved in, this core PCT responsibility. Learning about these processes will give practices a better understanding of the wider policy drivers, local health community priorities, and also highlight the need to tackle any particular problem areas under PBC.

Good practice examples of service re-design and development can be found at:

www.networks.nhs.uk/ideas

www.rcgp.org.uk/PDF/innov_PatientPathwayToolkit090206.pdf

Determining service provision

The decision to develop a nursing service for general practice is relatively new for many provider organisations. If this path is to be followed, the following criteria should be considered.

- ***Relationship to broad provider goals and objectives*** – *the vision statement and local delivery plan will identify the direction and priorities for care provision – development of a nursing service within general practice must demonstrate support for these priorities*

- **Nursing strategy** – this should set out the philosophy and vision for nursing within the provider organisation, identifying the role and services for nurses and the intended impact – the nursing strategy should clarify whether or not the development of a GPN service will meet the needs of the local population
- **Review of existing skills within the provider organisation nursing team** – development of a nursing service will require understanding and professional leadership for nursing in the general practice environment; a review of nurse leadership capacity and skills at the organisational level will support the decision relating to whether or not the development of a service can be successfully implemented
- **Financial consideration** – the costs of development and maintenance of a GPN service should be identified prior to any decision to develop a service
- **Support from local stakeholders** – analysis and review of local stakeholders in the development of a nursing service will identify support for the service and potential practices who may purchase this service – identifying the market for the service is important given the current competition within health care provision
- **Cost-benefit analysis of service provision** – this will allow a clear decision to be made relating to the development of a specific nursing service; a decision may be made not to provide a comprehensive GPN service.

Assessment of service provision and evaluation of new models of care can be supported through PCT information teams. This whole-system approach provides added value in the provision of PGN services, in comparison to small providers.

Delivering a GPN service

Traditionally, alternative providers have not been the main provider of GPN services. If there is agreement to develop a service, it is therefore imperative that a structured service plan is set up to identify the philosophy, structure, expectations and outcomes of the service. This will enable all commissioners of the service, including the PCT and independent GPs, to make informed (commissioning) decisions through practice based commissioning. The nature of demands from PCT commissioners and independent GPs may be different, and the model therefore needs to be sufficiently flexible to meet the needs of small organisations (individual practices) and the PCT.

Development of a clear service-delivery plan is central to marketing the service, and enabling the outcomes to be effectively measured.

What should a service delivery plan contain?

1. Philosophy of care provision
The philosophy and vision for nursing within general practice needs to be clearly articulated. This will ensure that those buying into and working within the service are aware of the underlying beliefs and values. It will establish a clear direction for nurses, other care providers and service users.
2. Outline of service to be provided
Care delivery will be enhanced by focused and explicit service provision with tangible outcomes. Although commissioners will have created a service specification, the delivery model needs to identify the model of care delivery, and the type and number of nurses required to deliver the service. The development of a GPN service will be most effective if it is an integral part of the wider nursing service, with the most appropriately qualified person undertaking the care required¹² (see **Unit: Integration of the general practice nurses in the community health care workforce, GPN Toolkit**).

Clear outcomes with realistic targets will enable measurement of GPN activity. A GPN workload tool will be invaluable to ensure that nurse resources are allocated appropriately.

See **Tool – Workload-capacity** to assess whether or not there are sufficient GPN resources by facilitating a review of the GPN requirements in relation to:

- *population size*
- *number of patients in each major disease group*
- *health prevention activity – number of patients requiring cervical screening, immunisations and new-patient medicals, per month*
- *treatment room activity.*

This enables an analysis of the skill and grade of nurses to be provided within the general practice.

3. Financial arrangements

Calculation of the complete cost of the service should incorporate:

- **staffing costs** – *these should be based on the total number and skill-mix of nurses in relation to the model of service provision and workload-capacity tool*
- **education costs** – *all nurses have learning and development needs that should be incorporated into the financial costs of the model – a model that enables the proportion of total costs to be shared across each service provided is preferable to identifying specific nurse's education needs*
- **administrative costs** – *administrative and leadership costs used within the service should be included by proportional allocation across all purchasers in a similar way to sharing the cost of learning and development.*

4. Governance

Clear lines of accountability and a robust governance structure are fundamental to service provision. The nursing service will need to be delivered within the context and structure of provider organisation policies and procedures. In addition, for those nurses employed by the provider organisation who are working within the general practice service, there is a need for clear lines of accountability through the organisation's nursing structure. This may not be directly to a senior nurse with practice nursing experience, although advice and support from such a nurse is important to both role delivery and development.

Evaluation framework

A structured evaluation of the service is essential in order to demonstrate effectiveness.

Evaluation should consider:

- *delivery of performance targets*
- *delivery of service within financial conditions set*
- *added value – this should identify and establish additional outcomes from service delivery that were not originally intended (eg improved retention rates).*

Support service to general practice – the role of the PCT provider arm

There is potential for the provider organisation to provide a service that supports all nurses working in general practice, including those employed by the independent contractor. This can enhance safety and effectiveness, and help to overcome the professional isolation that may otherwise occur for GPNs.

Most PCTs have traditionally employed a GPN within a facilitation or lead role (see

Tool – Job descriptions for GPN lead posts in PCTs). However, the implementation of separate commissioning and provider functions will necessitate a review of the function and responsibility of this role. If the GP-independent contractor is commissioned to provide a whole service, including the delivery of safe care, the provider arm of the PCT is not responsible for nurse development within general practice. However, the relatively small size of general practices would suggest that a preferable model for the development and support of GPNs is shared across organisations. This core function could be provided by one organisation.

What should be included as support for a GPN service?

- 1. Professional leadership and support**

This is needed to aid nurse development at an individual and whole-systems level. It enables all nurses working within general practice to access advice and support.
- 2. Best recruitment practice**

The adoption of a standardised recruitment process supports good employment practice. Standardised recruitment will help the recruitment panel to identify existing competences of candidates prior to commencing in post. See *Unit: Employment and professional development of general practice nurses, GPN Toolkit* for the principles of good recruiting practice in general practice.
- 3. Competence development**

The competences of GPNs must be agreed within the PCT's clinical governance framework. Implementation of standards and positive communication with all practices will help nurses to develop the requisite skills and knowledge for practice in order to deliver safe care. Adoption of core competence training programmes for all new GPNs will prevent prevailing poor custom and practice, subsequently raising standards of care delivery. See *Unit: Competences of general practice nurses, GPN Toolkit* for identification of the expectations and competences associated with the role.
- 4. Provider organisation engagement with nurses working in general practice**

GPNs must be able to engage and shape the debate around the nursing role within the provider organisation. Although there are good examples of practices supporting nurse development, there are also examples where nurses are unable to access meetings or development opportunities. Creative approaches that incorporate meetings and bulletins within web-based discussion pages can support the development of effective communication with all nurses. Flexible meeting times that are accessible to all nurses are required, although meetings should fall within the identified personal development time. The facilitation of dialogue through existing communication mechanisms, such as GPN forums, local medical committees and professional executive committee Chairs, will enable this process to become a reality.
- 5. Supporting nurses to deliver a service based on population need**

A broad spectrum of information pertinent to the development of nursing in general practice, specifically population data collated either through public health or *nGMS*¹³ contracting exists in primary care. This information has the potential to identify patient needs and influence the direction of nursing service provision by the nurse working in general practice.
- 6. Increasing capacity**

The relatively small size of the majority of general practices means that service delivery can be compromised if a GPN is unavailable. Development of a specific practice nurse support and development team can increase this capacity through the provision of a service to general practices. In addition, it can offer time to release nurses, as well as a local structure to support development, including working alongside nurses themselves. The development of a parallel nurse locum service administered within the provider organisation would support this function, without the need to develop a large team structure. See *Tool – Modified induction for locum GPNs* and *Unit: Employment and professional development of general practice nurses, GPN Toolkit*.
- 7. Development of practice**

The provider organisation could help minimise risk for practices that are looking to develop new ways of working with more nurse-led services by involving a skill-mixed team and supporting nurses to work across a number of general practices. The provider would employ the nurses, who would then be bound by provider nursing policies and procedures, so that their clinical work would be effectively controlled. These nurses would have access to provider organisation support mechanisms (used by other community nurses). This engagement would help others to facilitate best practice.

Structured career pathway

The provider organisation could be required by commissioners to support general practices to develop new roles – from health care assistant to advanced nurse practitioner level. All provider organisations may have significant knowledge relating to nurse development that can be applied to develop GPNs. The provider organisation should raise awareness of the benefits of skill-mix and disseminate examples that demonstrate the advantages of a structured career in general practice nursing. See *Unit: Careers development for general practice nurses, GPN Toolkit* and *Tool – Varying roles within general practice nursing*.

Training and development

GPNs need to be able to demonstrate the provision of safe and effective care to patients, and as such require training, development and opportunities to critically reflect upon care provision. See *Unit: Education and professional development of general practice nurses, GPN Toolkit* for details of the appropriate training and education needs for the development of nurses in general practice. Availability of clinical supervision is fundamental to enable nurses to critically explore and reflect on practice, and is an important tool in ensuring safe delivery of care. See *Tool – Clinical supervision: how and why?* in *Unit: Quality improvement and evaluating practice*.

Similarly the PCT can support practices to provide clinical placements for new practice nurses. There are a number of PCTs who have set up successful models in their area. Examples are Liverpool PCTs (Jenny Brown, Jenny.Brown@southliverpoolpct.nhs.uk) Professional Training Practices (Mike Pringle, mike.pringle@nottingham.ac.uk) and Essex (Jackie Jones, Jackie.jones@eoe.nhs.uk).

Performance management

In order to ensure safe and effective care, performance should be measured against defined standards. A provider organisation service that includes an induction programme, assessment of competence, annual appraisal and support in managing poor performance will help to establish standards, reduce potential risk and encourage practices to support staff development. Details of standardised structures can be found in the GPN Toolkit. For example, see *Tool – Sample induction programme*, *Tool – GPN competences framework*, *Tool – Documentation for appraisals – using an action plan* and *Tool – Evaluating practice*.

Financial arrangements

A structured support service provided to practices employing GPNs will need to include:

- *staffing costs* – based on the total number and skill-mix of nurses required to deliver the support service
- *administrative costs* – costs of service delivery should include the provider organisation's share of administrative and leadership costs – this should be shared proportionately in line with costs for learning and development.
- *education costs*

Evaluation framework

A structured evaluation of the service is essential to demonstrate effectiveness in delivering responsive, patient-centred care. The evaluation framework should consider:

- *delivery of service provision against service objectives*
- *delivery of service within financial conditions set*
- *added value* – this will identify and establish additional outcomes from service delivery that were not originally intended (eg retention rates of nursing staff).

Identifying workload capacity in general practice nursing

The Workload Capacity Tool has been developed by Liverpool Primary Care Trusts (PCTs) and provides a model for the calculation of practice nursing (Band 5 & 6) hours per general practice based on population size and patients with a long-term condition. It does not calculate the number of health care assistants (HCAs) and advanced practitioners per practice - the number of HCAs is calculated using a separate formula, whereas the number of advanced practitioners is considered as a substitute for a GP, and as such based on medical input required per population. The model uses a deliberate simplicity in order to enable widespread adoption.

Key assumptions

Basic practice nursing activity

- *One in four patients registered will visit the general practice for a basic practice nursing intervention once a year.*
- *Weighted, not actual, population size is used in order to consider local health needs.*
- *Basic intervention can be managed, on average, within a 15-minute appointment.*
- *A Band 5 nurse is best suited to this activity.*

Long-term conditions management

- *A total of 1.5 hours are required per disease process/patient/year - for example, a patient with two long term conditions has 3 hours allocated per year - this time can be divided as deemed appropriate (eg 6 x 15 min appointments or 3 x 30 min appointments).*
- *General practice's disease registers are accurate.*
- *A Band 6 nurse is most appropriate for this activity.*

Triage/first contact

- *This is not calculated as a discreet component but negotiated with the general practice, and is dependent on the current system in place to meet the access needs of the population.*
- *Although this may commence as telephone triage, it should develop to face-to-face contact in line with nurse's developing skills.*
- *More senior nurses at Band 6 or above are likely to be most appropriate for this activity.*

Working hours

- *Clinical sessions comprise 3 hours of patient contact.*
- *Nurses work 45 weeks per year.*
- *Whole-time equivalent (WTE) involves 10 sessions per week distributed as per model (ie 8 x clinical sessions, 1 x personal development session and 1 x practice development session).*
- *There are 51 weeks per working year (this allows for shorter weeks at Christmas and New Year).*

Calculation

Total activity

1. Basic activity

- i. Patient population x 0.25 = number of appointments per year
- ii. Appointments divided by 12 = patients per session

2. Long-term conditions

- i: Number of patients on disease register x 1.5 hour = number of nursing hours per year
- ii: Appointments divided by 2 = number of sessions

3. Triage/first contact

i: Sessions per week (telephone or face-to-face) as agreed locally

ii: Sessions per week x 51 = sessions per year

Total number of sessions per year = basic activity plus long-term conditions activity plus triage.

Nurses required

i: Sessions divided by nurse weeks per year = sessions/week

ii: Sessions per week x 51 weeks x nurse availability (assumption 2) = total nurses

Identifying Workload Capacity in Practice Nursing												
Practice Information			Nursing Hours Required Per Year			Nursing Sessions Per year	Nursing Sessions Required Per Wees			Total Nurse Sessions Required	Existing Number of Sessions	Difference
Practice Name	Practice Population	Total Long Term Conditions	Basic PN Activity	Long Term Conditions	Total		Basic PN Activity	Long Term Conditions	Total			
Practice A	10,000	1,000	625.00	1,500.00	2,125.00	708.33	4.08	9.80	13.89	19.17	10	-9.17
Practice B	3,268	631	204.25	946.50	1,150.75	383.58	1.33	6.19	7.52	10.38	12	1.62

References

- Department of Health. *Investing in General Practice: the New General Medical Services Contract*. London: Department of Health; 2003. Available at: <http://www.doh.gov.uk/gmscontract/thecontract.htm>.
- Department of Health. *Creating a Patient-led NHS: Delivering the NHS Plan*. London: Department of Health; 2005. Available at: <http://www.dh.gov.uk/assetRoot/04/10/65/07/04106507.pdf>.
- Department of Health. *Our Health, Our Care, Our Say: a New Direction for Community Services*. London: Department of Health; 2006. Available at: <http://www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf>.
- Department of Health. *PCT and SHA Functions and Roles*. London: Department of Health; 2006. Available at: <http://www.dh.gov.uk/assetRoot/04/13/47/79/04134779.pdf>.
- Department of Health. *Supporting People with Long Term Conditions: Liberating the Talents of Nurses Who Care for People with Long Term Conditions*. London: Department of Health; 2005. Available at: <http://www.dh.gov.uk/assetRoot/04/10/24/98/04102498.pdf>.
- Jenkins-Clarke S, Carr-Hill R, Dixon P. Teams and seams: skill mix in primary care. *Journal of Advanced Nursing* 1998; 28(5): 1120–1126.
- Shum C et al. Nurse management of patients with minor illness in general practice: multi-centre randomised controlled trial. *British Medical Journal* 2000; 320: 1038–1043.
- Kinnersley P et al. Randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting 'same day' consultations in primary care. *British Medical Journal* 2000; 320: 1043–1048.
- Venning P et al. Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *British Medical Journal* 2000; 320: 1048–1053.
- Department of Health. *Standards for Better Health*. London: Department of Health; 2006. Available at: <http://www.dh.gov.uk/assetRoot/04/13/29/91/04132991.pdf>.
- Department of Health. *Delivering Investment in General Practice: Implementing the New GMS Contract*. London: Department of Health; 2004. Available at: <http://www.dh.gov.uk/assetRoot/04/07/02/31/04070231.pdf>.
- Department of Health. *Liberating the Talents, Helping Primary Care Trusts and Nurses to Deliver the NHS Plan*. London: Department of Health; 2002. Available at: <http://www.dh.gov.uk/assetRoot/04/07/62/50/04076250.pdf>.
- Department of Health. *Investing in General Practice: the New General Medical Services Contract*. London: Department of Health; 2003. Available at: <http://www.doh.gov.uk/gmscontract/thecontract.htm>.

This document is intended as a guide only.

© Crown Copyright September 2006.

The text in this document may be reproduced free of charge in any format or medium providing that it is reproduced accurately and not used in a misleading context or used for commercial gain. The material must be acknowledged as Crown Copyright and the title of the document specified. Where others have been referenced on specific documents and tools, the organisation must be acknowledged in full and the title of the document specified.

All links to external websites have been provided for your information and the Working in Partnership Programme take no responsibility for any material or content accessed on any such websites