

elsewhere,^{14,15} show that health needs assessment is both possible and effective. In this regard, it is perhaps noteworthy that of the five practices that had carried out such assessment in the Nuffield research, the majority had been involved in initiatives led by the local department of public health.

While such collaboration may bring about the transfer of appropriate knowledge and skills, it deals less with the problem of the lack of time and other resources identified by practices. The availability of such resources would therefore seem to be an essential consideration if primary care professionals are to be asked to undertake work that they currently consider both extra to, and different from, routine primary care activity. Greater efforts could therefore be made to integrate support for health needs assessment with that currently available for audit activity and postgraduate education. In addition, the examples of successful collaboration between primary care and public health departments at a district level might usefully be applied in the context of collaboration between practices in a locality. Whatever the scale, a team approach within individual practices, and a sharing of workload and resources between practices, will help in achieving a feasible approach to health needs assessment within primary care.

If the results of needs assessment are to lead to changes in services to address the needs identified, then adequate attention must be given to planning and implementation. This includes the need for setting clear objectives, the involvement of relevant stakeholders, and the agreement of criteria for prioritizing needs. However, the problems associated with such planning and implementation in relation to health needs assessment in primary care have been exposed.¹⁷ Current funding arrangements for primary care not only fail to acknowledge the resource implications, but also make response through service development initiatives difficult. If needs assessment is to be effective, then the responsiveness of these funding arrangements must be improved, and the development of local health services more explicitly based on local needs.

Few would argue with the fundamental aims of health needs assessment in helping to ensure the provision of equitable and effective health care. The challenge in pursuing these aims in primary care is twofold: first, to increase the practical understanding of how needs assessments can be undertaken, what support is needed, and what benefits can follow; secondly, to ensure that the results of health needs assessments are sufficiently integrated into the planning and commissioning of local services for them to produce effective change.

JOANNE JORDAN

Senior research fellow, Centre for Primary Care Research,
University of Leeds

JOHN WRIGHT

Consultant in Epidemiology and Public Health Medicine,
Bradford Royal Infirmary

References

1. Department of Health and Social Security. *Public health in England: the report of the committee of inquiry into the future development of the public health function*. London: HMSO, 1988.
2. Department of Health. *Working for patients*. London: HMSO, 1989.
3. Department of Health. *The NHS and community care act*. London: HMSO, 1990.
4. National Health Service Executive. *An accountability framework for GP fundholding: towards a primary care-led NHS*. [EI (94) 54.] Leeds: NHSE, 1994.
5. National Health Service Management Executive. *Local voices, the views of local people in purchasing for health*. London: Department of Health, 1992.
6. Shakespeare G, Lawrence P. GP choices: will GPs choose a primary care led NHS? *British Journal of Health Care Management* 1996; **2**: 434-443.
7. Warden J. Spot the difference? *BMJ* 1997; **314**: 1068-1069.
8. Robinson J, Elkan R. *Health needs assessment, theory and practice*. London: Churchill Livingstone, 1996.
9. Gillam S, Murray S. *Needs assessment in general practice*. [Occasional Paper 73.] London: Royal College of General Practitioners, 1996.
10. Smith R. Rationing: the search for sunlight. *BMJ* 1992; **304**: 716-717.
11. Townsend P, Davidson N (eds). *Inequalities in health: The Black report and the health divide*. London: Penguin, 1992.
12. Peckham S. Local voices and primary health care. *Critical Public Health* 1994; **5**: 36-40.
13. Colin-Thome D. Practice population commissioning - a fundholder's perspective. *The Fundholding Summary* 1994; **August**: 8-10.
14. Murray S, Graham LJC. Practice bases health needs assessment: use of four methods in a small neighbourhood. *BMJ* 1995; **310**: 1443-1448.
15. Jordan J, Wright J, Wilkinson J, Williams DRR. *Health needs assessment in primary care: a study of understanding and experience in three districts*. Leeds: Nuffield Institute for Health, 1996.
16. Audit Commission. *What the doctor ordered. Fundholding: the main report*. London: HMSO, 1996.
17. Ruta DA, Duffy MC, Farquharson A, et al. Determining priorities for change in primary care: the value of practice-based needs assessment. *Br J Gen Pract* 1997; **47**: 353-357.

Address for correspondence

Dr J Wright, Consultant in Epidemiology and Public Health Medicine,
Bradford Royal Infirmary, Bradford BD9 6RJ.

Nurse practitioners in general practice — an inevitable progression?

GENERAL practitioners (GPs) are used to working alongside nurses whose roles overlap with their own. Indeed, there has been a huge expansion in the number of practice nurses over the past 10 years,¹ and the role of the practice nurse has expanded into areas that were previously managed solely by GPs.² Practice nurses have made an essential contribution to increasing the range and quality of services offered to patients,² and have helped primary care keep up with ever-increasing demands and expectations. General practice must now begin to examine addi-

tional options in order to cope with the increasing workload from hospital closures and the 'primary care led' National Health Service.

In *Primary care: the future*,³ it is argued that the role of nursing in primary care should continue to expand, with nursing staff increasingly sharing the case load of the GP. Some have interpreted such statements as a green light for the development of the nurse practitioner (NP) role, and others as a warning that it is time for GPs to defend their territory.

In a recent review of the literature, we identified a range of activities that had been carried out by NPs in primary care. While NPs have dealt with a narrower range of problems than those dealt with by doctors,^{4,5} studies have demonstrated that they carry out their activities safely and effectively.^{6,7,8} They are popular with patients^{6,8,10} and good at listening, explaining, and understanding.^{5,10} They are more likely than doctors to abide by protocols¹¹ and to use a drug formulary,¹² and are less likely to prescribe.¹³ They are also more likely to emphasize non-prescriptive approaches and prevention.¹² Yet their cost (on grade H) is only slightly more than a G grade practice nurse. They are not however a cheap alternative to doctors.^{6,14}

In a series of case studies carried out by one of the authors (MK), it was clear that many NPs were engaged in a process of 'defining themselves' in the general practice setting — not so much seeking to mimic GP services, but rather seeking opportunities for providing something new to patients. NPs' flexibility allows them to fill the care gaps⁶ that can occur outside practices; for example, providing care for the homeless, or within practices.⁶ Examples of the latter include triage and telephone advice,¹⁵ 'same day appointments',⁷ and home visits.⁹ Some, but not all,^{4,6} GPs have noted that NPs reduce their workload.^{6,7,9} GPs consistently suggest they have more job satisfaction, offer a higher standard of care, and see more patients as a result of employing a nurse practitioner.^{7,9}

Koperski has suggested that attention to the practical aspects discussed below is essential to the successful employment of an NP.⁵ This is particularly important for larger practices, as these seem to find success more difficult than practices with one or two partners.⁶ Successful development depends on the practice preparing before the NP's arrival, and a formal 'in-practice subgroup' could help to avoid or resolve many administrative, clinical, and personal problems. This group could clarify role responsibilities and develop a job description prior to employment. Written role descriptions will identify important issues of responsibility, accountability, and liability. This does not preclude developing the work as the NP settles into the practice. It does, however, lay the foundation for the other pieces of practical work, including a written drug formulary and agreed protocols. The written role descriptions can form the basis of education for reception staff, who are critical in directing patients appropriately to the NP. Patients themselves will also need education.

Mechanisms of support, supervision, professional development, and problem resolution need to be in place from day one. NPs working in primary care can be isolated and may feel vulnerable. An identified mentor will help the NP to know their limits and to cope with the uncertainty and anxiety that comes with increased responsibility. Training and professional development plans need to be identified and carried out in protected time. Training can include attendance at courses as well as in-house observation (e.g. the use of video recording and 'sitting in' on consultations).

The employment of NPs could increase GPs' administrative and managerial roles, dilute 'continuity of care' and 'personal care', and edge the GP towards 'specialism'. However, GPs can develop strategies to minimize these effects. NPs could play a part in the administration and management of primary care nursing. GPs and NPs can confer regularly about their mutual patients; for example, through 'unified primary care records' where NPs' and GPs' notes lie side by side (computerized records are ideal for this and can include notes from other members of the primary care team).

Attention also needs to be given to the supporting infrastructures at Health Authority and national level. The case studies⁵ revealed a lack of structured training programmes and 'quality-

of-care' monitoring for NPs in primary care similar to that described for practice nurses.¹⁶ Developing a pool of accredited mentors for NPs is important and should ideally include GPs and NPs. Formal in-practice support, training, and development plans could be requirements for continued funding for NPs from Health Authorities, and would help to maintain quality of care.

The case studies⁵ indicated a need for an accreditation scheme in addition to achievement of the NP degree (currently only offered by the RCN). This suggests the need for an 'NP registrar' training scheme similar to that which exists for the training of GP registrars and for district nurses and health visitors. Local Education Consortia need to give serious consideration to funding the education of NPs in a comparable way to district nursing and health visiting. This would need close cooperation between medical and nursing bodies as well as substantial funding. Such cooperation was advocated in *Primary care: the future*.³

Present prescribing restrictions make NPs less cost-effective and waste patients', NPs', and doctors' time.^{5,6} A limited national formulary also reduces effectiveness.¹⁷ The new-government is still considering full implementation of the existing scheme for nurse prescribing. Extending prescribing to all specialist community nurses (after appropriate training) and creating a more flexible formulary are issues that the Department of Health and the Prescribing Review Team led by Dr June Crown should seriously consider.

The development of the NP role is being hampered by finance (unlike GPs' funding, money for NPs presently comes from cash-limited funds), by the lack of a clear role definition and legal status, and by their inability to prescribe even over-the-counter preparations. A significant minority of practices have already managed to successfully accommodate NPs but more pilot schemes are needed, including those that focus on accreditation and continuing education. The recent primary care bill¹⁸ offers an opportunity to bypass many of the above problems through its funded pilot schemes and we would be foolish to miss this unique opportunity.

MAREK KOPERSKI

Senior Fulbright scholar, visiting professor,
Department of Family and Community Medicine,
University of California, San Francisco

STEVE ROGERS

Senior lecturer, Department of Primary care and Population
Sciences, University College London and Royal Free Hospital
Schools of Medicine

VARI DRENNAN

Senior lecturer in primary care nursing, Department of Primary
care and Population Sciences, University College London and
Royal Free Hospital Schools of Medicine

References

1. Department of Health. *Statistical bulletin on non-medical staff, 1985-1995*. London: Department of Health, 1996.
2. Jeffreys LA, Clark A, Koperski M. Practice nurses' workload and consultation patterns. *Br J Gen Pract* 1995; **45**: 415-418.
3. Secretaries of State for Health, Scotland and Wales. *Choice and opportunity. Primary care: the future*. (Cm 3390). London: Stationery Office, 1996.
4. Salisbury CJ, Tattersell MJ. Comparison of the work of a nurse practitioner with that of a general practitioner. *J R Coll Gen Pract* 1988; **38**: 314-316.
5. Koperski M. *Nurse practitioners in general practice: Strategies for success*. London: Camden and Islington Health Authority/London Implementation Zone Educational Initiative, 1997.
6. NHS Executive South Thames. *Evaluation of nurse practitioner pilot*

projects. *SETRHA*. London: Touche Ross, 1994.

7. Marsh GN, Dawes ML. Establishing a minor illness nurse in a busy general practice. *BMJ* 1995; **310**: 778-780.
8. Spitzer WO, Sackett DL, et al. The Burlington randomized trial of the nurse practitioner. *N Engl J Med* 1974; **290**(5): 251-256.
9. Weston-Smith J, O'Donovan JB. The practice nurse - a new look. *BMJ* 1970; **4**: 673-677.
10. Drury M, Greenfield S, Stilwell B, Hull FM. A nurse practitioner in general practice: patient perceptions and expectations. *J R Coll Gen Pract* 1988; **38**: 503-505.
11. Molde S, Diers D. Nurse practitioner research: selected literature review and research agenda. *Nurs Res* 1985; **34**: 362-367.
12. Buppert CK. Justifying nurse practitioner existence: hard facts to hard figures. *Nurse Practitioner* 1995; **20**: 43-48.
13. Rosenaur J, Stanford D, Morgan W, Curtin B. Prescribing behaviours of primary care nurse practitioners. *Am J Pub Health* 1984; **74**: 10-13.
14. Richardson G, Maynard A. *Fewer doctors? More nurses? A review of the knowledge base of doctor-nurse substitution*. [Discussion Paper 135.] York: University of York, 1995.
15. Dale J, Crouch R. Telephone advice. It's good to talk. *Health Service Journal* 1997; **107**: 24-26.
16. Jewell D, Turton P. What's happening to practice nursing? *BMJ* 1994; **308**: 735-736.
17. Luker K, Lynn A. Nurse prescribing: Study findings and GP views. *Prescriber* 1997; **8**: 31-34.
18. Department of Health. *National Health Service (Primary Care) Act* 1997. London: HMSO, 1997.

Address for correspondence

Dr Marek Koperski, Department of Family and Community Medicine, UCSF, 500 Parnassus Avenue, San Francisco 94143-0900, USA.
Email: Koperski@itsa.ucsf.edu

University of Wales College of Medicine
School of Postgraduate Medical and Dental Education
Department of Postgraduate Education for General Practice

Training for General Practice in Wales

Vocational training opportunities exist in all parts of Wales. Schemes are based both in the rural areas of the country and in the busy developing cities of the Principality. All parts of Wales have good access to wonderful countryside, and there are many vibrant, artistic and cultural activities in the cities and towns.

Applications are now being invited for rotational posts commencing 4 February 1998 in all twelve Vocational Training Schemes in Wales. The schemes are run under the auspices of the School of Postgraduate Medical and Dental Education; the SHO posts are all located in hospitals and are linked to the College of Medicine for teaching purposes. There are over a hundred training practices in Wales, ranging from large city-centre practices to practices in rural areas with access to Community hospital beds.

Individual training schemes in Wales are located in the following areas:

| | | | |
|----------------|---------------|-------------|------------|
| Cardiff | Aberystwyth | Bridgend | Carmarthen |
| East Glamorgan | Haverfordwest | Swansea Bay | Rhyl |
| Newport | Wrexham | Abergavenny | Bangor |

For further information about Vocational Training Schemes in Wales, and for details of application procedures, write to: Dr David Wood, Senior Lecturer in Postgraduate Education for General Practice, Llys Meddyg, 23 Castle St., Conwy, Gwynedd, LL32 8AY. Please indicate which scheme/s are of interest to you.

Experienced Doctors
Prescribe yourself a revitalising tonic



You're a dedicated professional. But, these days, you're beginning to lose that old enthusiasm you had at the start. It's time to give your career a boost. And we know a better course of treatment: the NSO experience.

By joining us you'll be able to find world-wide opportunities, you'll have access to all the latest medical journals, and you'll be able to work in a variety of different settings.

We have a number of opportunities for GPs all over the world. But, despite the distance, we'll make sure you are able to keep up with developments at home by sending you the professional journal of your choice. We'll also make sure your NHS pension payments are well protected, with a return air ticket, travel insurance, and a modest but generous gratuity on leaving.

To keep your mind sharp, you'll have at least one day a week planned for extended visits to interesting sites, for placements, for meetings with people close to the community, and for the results of your work. However, we can also offer a limited number of 12-month assignments.

But before you apply, please check the following questions. Are you aged 23-65, with a least two years' post-graduate experience?

Could you travel to a new and unfamiliar environment on a regular basis? Are you flexible and adaptable to a new team in a relationship? Are you a non-dependant and entitled to unrestricted entry to the UK?

If you can answer 'yes' to all these questions, please contact our Enquiries Unit, who will be happy to send you information and answer any queries you may have on 01 780 7500 (24-hour quoting system). FAX: VSO, 27 Yarnley Bridge Road, London SW19 2PN.

Alternatively, contact us online at <http://www.vso.co.uk>



© 1997 VSO Limited