Practice nurse workload before and after the introduction of the 1990 contract for general practitioners

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SUMMARY

Background. *A study of practice nurse workload in 1989 by the East Anglian reporting system revealed that nurses were undertaking a wide range of activities, with 12% of nursing time being spent on administration. The 1990 contract for general practitioners emphasized the role of general practice in health promotion.*

Aim. *The 1989 study was repeated by the East Anglian reporting system in 1992 to investigate changes in practice nurse workload.*

Method. *Nurses in 22 practices recorded all the procedures they performed and their duration, over a two week period.*

Results. *The number of practice nurses in each practice had increased from 0.7 full time equivalents in 1989 to 1.2 in 1992. The proportion of time spent on administration had increased to 19%. The number of different procedures performed by practice nurses had risen from 36 in 1989 to 54 in 1992, with most new activity in well person and new patient clinics.*

Conclusion. *Changes have taken place in the volume and range of work undertaken by practice nurses. There is potential for practice nurses to use the results both for negotiation and for education.*

Keywords: workload; conditions of service; practice organization; practice nurses.

Introduction

THE role of the practice nurse has been evolving since the general practitioner charter in 1965. In 1984 the Royal College of Nursing produced a broad definition of the role of the practice nurse: 'A practice nurse is a registered general nurse who is employed by a general practitioner to work within the treatment room and is a member of the team responsible for the clinical nursing care of the practice population together with the district nursing team of the health authority.'[1] Since then there have been two major developments, first the development within the nursing profession of the nurse practitioner and secondly the introduction of the 1990 contract for general practitioners with its emphasis on health promotion. The latter encouraged the formation of practice-based health promotion clinics, often organized and run by nurses.

The studies of Reedy and colleagues[2] and Bowling[3] documented the areas of practice nurse work using nurses' recall of their work. Waters and colleagues described the range of work undertaken by practice nurses from treatment room records.[4]

In 1985 the East Anglian reporting system conducted a questionnaire survey of practices, enquiring about the type of work undertaken by practice and attached nurses.[5] In March and April 1989, 22 out of 82 practices in the East Anglian reporting system (representing 6.7% of the 330 practices in the region) undertook a workload study in which nurses were asked to document the tasks undertaken and time of starting and finishing the tasks. It was hoped this would help the recording practices to organize their workload. The study found that practice nurses were performing a wide range of activities, with marked differences between practices. Twelve per cent of total nursing time was spent on administration.

With the widespread introduction of nurse-run health promotion clinics, both the amount and range of work undertaken by practice nurses is likely to have changed. The East Anglian reporting system therefore decided to repeat the 1989 study in 1992 in order to define the range of tasks and procedures being undertaken by practice nurses; to determine whether the proportion of practice nurse workload on administration had changed since 1989; and to identify the changes in practice nurse activity since the introduction of the 1990 contract.

Method

The same 22 practices which had taken part in 1989 were recruited into the 1992 study. While the practices were the same, there had been changes in terms of partners and partnership sizes. The 22 practices represented 170 568 patients. Practice nurses were asked to record the type of procedure undertaken and the time the consultation with a patient began and ended. Thirty six procedures had been coded from the 1989 study, but the nurses were encouraged to write in additional information if the given list was insufficient. No checks were made on the validity of the recording.

The recording period was two weeks, chosen by the practice, between September and December 1992. Completed forms were returned to the East Anglian reporting system office and the data were analysed using *SUPER CALC 5*. Afterwards, practices were sent their own and aggregated data thus enabling them to see their own range of procedures and timings as well as to make comparisons with the aggregated data.

Results

Of the practices 15 (68%) were training practices. The number of principals ranged from two to nine with a mode of four. Practice list size ranged from 2858 patients to 18 600, with a mean of 8459 patients and a mean of 1843 patients per principal. Total practice list size had increased by 12.6% since 1989.

No practices dropped out of the study and all nursing hours and clinics were said to have been recorded by all practices.

A total of 1934 hours of nursing time were recorded in 1992 compared with 1104 hours in 1989, an increase of 75.2%. Assuming a full time nursing week of 36 hours this represents 1.2 full time equivalents per practice compared with 0.7 in 1989.

The time taken to do administrative work had risen from 11.8% of total nursing time in 1989 to 18.7% in 1992. The duties included in this classification were call and recall to clinics, form

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filling and organizing clinics. The number of different procedures had risen from 36 in 1989 to 54 in 1992, with most of the new activity in health promotion and new patient clinics.

The proportion of total nursing time spent performing the various procedures, both in 1989 and 1992, is shown in Table 1. Although a direct comparison between the two years is difficult because of the increase in number of different procedures undertaken and increase in total number of nursing hours in 1992, it is interesting to note the increase in the areas of administration and health promotion, and the decrease in general advice giving. For the number of procedures recorded in both studies, there was a significant increase in activity between 1989 and 1992 at the $P<0.001$ level for all immunizations (974 procedures in 1989 and 1195 in 1992), blood sampling (866 in 1989 and 1062 in 1992), dressings (842 and 1020), counselling (five and 49) and breast examinations (eight and 61). There was a significant decrease ($P<0.001$) in both ante-natal (187 in 1989 and 106 in 1992) and post-natal care (26 and 12), swab taking (115 and 33) and wart/verruca treatments (81 and 18). All the other areas were unchanged or the difference did not reach statistical significance.

Table 1. Proportion of total nursing time spent undertaking procedures, in 1989 and 1992.

Procedure	% of total nursing time spent on procedure in 1992 (n = 1934)	1989 (n = 1104)
Administration	18.7	11.8
Advice (general)	2.4	5.8
Antenatal care	0.8	1.9
Assisting doctor	1.7	4.4
Blood pressure check	1.6	1.1
Blood sample	6.5	9.0
Breast examination	0.4	0.1
Cautery	0.1	0.2
Cervical collar	0.1	0.3
Cervical smear	2.9	2.9
Chiropody	0.1	0.1
Contraception plus advice	0.8	1.3
Counselling	0.6	0.2
Clinics (non-approved HPC)	12.7	7.2
Diabetes check	1.9	2.8
Dispensing	0.6	5.0
Dressing	8.8	14.3
Ear syringing	3.6	4.8
Electrocardiograph	1.4	1.7
Foreign body removal (eye)	0.3	0.4
Health promotion clinic (approved)	10.4	0
Hearing test	0.2	0.9
Home visit[a]	0.1	0
Blood taking	0.1	0
Diabetes	0.1	0
Elderly	1.0	0
Immunization (adult)	3.4	0
Immunization (child)	2.2	10.5[b]
Immunization (travel)	2.5	0
Ingrowing toenail	0.1	0.1
Injection (other)	1.5	2.6
Injury/trauma/wound	2.0	3.4
Minor surgery	2.9	0
Nebulizer	0.3	0.5
Other (specify)	1.0	0
Postnatal care	0.2	0.7
Practice meeting/teaching	0.8	0
Pregnancy test	0.2	0
Removal of sutures	1.2	1.8
Restocking/tidying	2.3	0
Ring change of pessary	0.1	0.3
Suturing	0.1	0
Swab	0.2	0.8
TPR/BP	0.3	0.2
Urine check	0.9	2.1
Verruca/wart treatment	0.1	1.1

n = total number of nursing hours. HPC = health promotion clinic. TPR/BP = temperature, pulse rate, respiration rate, blood pressure. [a]Unspecified, including travel time. [b]10.5% includes all adults, child and travel immunizations.

Some practices recorded clinics as family health services authority recognized health promotion clinics, others as independent activity. A breakdown of health promotion clinic activity, both approved and not approved for health promotion payments by the family health services authority is shown in Table 2. The new, approved, health promotion clinics accounted for 10.4% of nursing time. The most common approved clinics were those for blood pressure, health promotion, diabetes, weight control, well person, asthma, hormone replacement therapy, and elderly people. Health promotion clinics, new patient clinics, minor surgery and health checks for elderly people were new items of work and accounted for 9.2% of nursing time.

There was a bimodal distribution of nursing time per 100 patients on the practice list, the lower modal point being in the 40 to 49 minutes range and the higher point being in the 80 to 89 minutes range. Attempts to correlate this finding with the time taken in health promotion clinic or well person clinic activity, or both, failed to show any relationship.

Discussion

The proportion of practices which were training practices (68%) was well above the national average (10%).[6] Although the two studies ran for the same length of time and the practices were largely the same, there were differences in the time of the year

Table 2. Health promotion clinic activity in 1992, both approved and not approved for health promotion payments by the family health services authority.

	% of health promotion clinic time spent by nurses
Approved clinic for:	(n = 200.5)
Asthma	28.3
Blood sampling	0.1
Blood pressure check	10.4
Breast examination	0.1
Cervical smear	0.2
Coronary heart disease	0.8
Cholesterol	0.2
Diabetes	16.6
Elderly people (75+ years)	5.0
Health promotion	9.0
Hormone replacement therapy	1.9
School leavers	0.1
Weight/diet control	12.6
Well person	14.8
Non-approved clinic for:	(n = 246.4)
Asthma	5.0
Cholesterol	2.5
Elderly people (75+ years)	2.0
Hormone replacement therapy	0.6
New patient	35.7
Travel	2.8
Weight check/diet	14.0
Well person clinic	37.1
Contraception clinic (well person)	0.1
Travel (well person)	0.3

n = number of hours of health promotion clinic activity.

when the data were collected. None of the nurses in the practices recorded special influenza immunization clinics. However, between 1989 and 1992 there was a rise in the number of all immunizations which could be explained by influenza immunizations being undertaken during the autumn study period, but could also reflect an increased number being undertaken by practices to fulfil targets.

In the time between the two studies the total nursing time had increased by 75% while the population being served had increased by 13%. There was an increase in full time equivalent nurses per practice from 0.7 in 1989 to 1.2 in 1992. Much of this increase can be attributed to the introduction of the 1990 contract for general practitioners, with its emphasis on health promotion, new patient and elderly patient checks, all tasks that could and had been delegated to practice nurses.

The new area of family health services authority approved health promotion clinics represented 10.4% of the total nursing time. The practices participating in the study were from three family health services authority areas and the rules governing health promotion payments were different in each area; this might explain the wide range of health promotion activity and the fact that similar named clinics were both approved and not approved. Nurses had been asked to ensure that the clinics described as health promotion were recognized as such by their family health services authority.

Minor surgery was another new area involving 2.9% of nursing time. The decrease in the amount of time spent on verruca and wart treatment might reflect the fact the general practitioners, aided by practice nurses, were taking on this activity in order to claim minor surgery payment.

Much clinic work requires call and recall arrangements and the completing of forms; this fact alone might explain the increase in administrative time from 12% to 19% of total time between 1989 and 1992. Like doctors, nurses are not trained for much of the administration that they have to do, and it is neither economical nor efficient to tie up expensive skilled time in this way.

In the 1989 study no home visits were recorded by practice nurses while in the 1992 study home visits were recorded. This raises the question of the geographical as well as the professional limits of responsibility.

Much, if not all, of the work of the practice nurse is governed by protocols, often generated by the practice but which also can be adopted from the literature or from colleagues. It is important that there is an assessment of competence and supervision of the nurse when new areas of work are undertaken, for the nurse's professional esteem and confidence, the doctor's satisfaction and, above all, for the patient's assurance.[7] The reasons for a fall in the amount of time spent taking swabs could reflect nurses working to protocols, the influence of financial pressures or a transfer to doctor activity.

The data collected from the study were reported back to the participating practices. In this way, practices were able to determine their own performance in relation to the whole group. This has enabled the practices to refine their nursing timetables and has empowered the nurses in their negotiations within the team.

The results highlight the issue of education and training. It is only by knowing the range of competencies expected that the nurses themselves can define their role, and their employers and the educational authorities can provide the educational opportunities appropriate to their needs.

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Acknowledgements

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Food for thought...

'The probability of a man seeking medical advice [for urinary symptoms] increased with increasing symptom severity. In contrast, the decision to refer was independent of symptom severity.'

Hunter DJW, McKee CM, Black NA, Sanderson CFB. Health care sought and received by men with urinary symptoms, and their views of prostatectomy. January *Journal,* p.27.