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REVIEW

Nurses' performance on primary care in the National Health Service in England

Atuação do enfermeiro na Atenção Primária no Serviço Nacional de Saúde da Inglaterra

Actuación del enfermero en la Atención Primaria en el Servicio Nacional de Salud de Inglaterra

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ABSTRACT

Objective: To analyze the expansion of nursing roles in primary care in the English National Health Service and the implications for professional practice. **Method:** qualitative research in case study format, held in London, England, in six primary care units. Data were obtained through interviews with nine nurses. After the thematic data analysis, two units emerged: the nurses' performance characteristics and effects of the expansion of nursing roles. **Results:** expansion of nurses' roles: consultation, diagnosis and drug therapy, case management and monitoring of chronic conditions. Repercussions: for the user, there was improved access, communication and comprehensive care, increased duration of consultations, resulting in greater adherence; for nurses, there was the expansion of professional skills, knowledge and professional recognition; to the health care system, it resulted in cost savings. **Conclusion:** benefits in expanding nursing roles, were visible, contributing to primary care quality.
Key words: Nurse; Primary Care; Role of Nursing Professional; Drug Prescriptions; Clinical Protocols.

RESUMO

Objetivo: analisar a ampliação das funções do enfermeiro na atenção primária no Serviço Nacional de Saúde inglês e as repercussões para a prática profissional. **Método:** pesquisa qualitativa em formato estudo de caso, realizada em Londres, Inglaterra, em seis unidades de atenção primária. Dados obtidos por meio de entrevista com nove enfermeiros. Feita análise temática de dados, emergiram duas unidades: características da atuação do enfermeiro e repercussões da ampliação de funções do enfermeiro. **Resultados:** funções ampliadas do enfermeiro: consultas, diagnóstico e terapêutica medicamentosa, gestão de casos e acompanhamento de condições crônicas. Repercussões: para o usuário, melhorou o acesso, a comunicação e o cuidado integral, aumentou o tempo de duração das consultas, resultando em maior adesão terapêutica; para o enfermeiro, houve a ampliação da competência profissional, do conhecimento e do reconhecimento profissional; para o sistema de saúde, acarretou na redução de custos. **Conclusão:** sobressaíram-se benefícios na ampliação de funções do enfermeiro, contribuindo para atenção primária de qualidade.
Descritores: Enfermeiro; Atenção Primária; Papel do Profissional de Enfermagem; Prescrições de Medicamentos; Protocolos Clínicos.

RESUMEN

Objetivo: analizar la ampliación de las funciones del enfermero en la atención primaria en el Servicio Nacional de Salud inglés y las repercusiones para la práctica profesional. **Método:** investigación cualitativa en formato estudio de caso, realizada en Londres, Inglaterra, en seis unidades de atención primaria. Datos obtenidos por medio de entrevista con nueve enfermeros. Hecho el análisis

temático de los datos, surgieron dos unidades: características de la actuación del enfermero y repercusiones de la ampliación de funciones del enfermero. **Resultados:** funciones ampliadas del enfermero: consultas, diagnóstico y terapéutica medicamentosa, gestión de casos y acompañamiento de condiciones crónicas. Repercusiones: para el usuario, mejoró el acceso, la comunicación y el cuidado integral, aumentó el tiempo de duración de las consultas, resultando en mayor adherencia terapéutica; para el enfermero, se dio la ampliación de la competencia profesional, del conocimiento y del reconocimiento profesional; para el sistema de salud, llevando para la reducción de costos. **Conclusión:** se sobresalieron los beneficios en la ampliación de funciones del enfermero, contribuyendo para la atención primaria de calidad.
Palabras clave: Enfermero; Atención Primaria; Papel del Profesional de Enfermería; Prescripciones de Medicamentos; Protocolos Clínicos.

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INTRODUCTION

In countries with universal healthcare systems, like England, there has been the expansion of nurses' role in primary health care (PHC). Since the 1990s, there has been expansion of the functions of nonmedical health professionals in the English National Health Service (NHS), especially the nurse's roles, with the gradual transfer of some functions previously carried out by doctors. Nurses of PHC started to act in the treatment of patients with minor illnesses and monitoring of chronic conditions such as asthma, diabetes and heart disease, for example, guided by care protocols[1].

The NHS is universal, with wide coverage and free access to citizens, financed by the State through tax resources. Access begins with the registration of users in GP practices/surgeries (primary care unit in which a group of doctors works together, in associated or contracted manner), in clinics of general practitioners (GP), who function as the gateway and the filter system (gatekeeper) and are responsible for a list of people registered in primary care unit, usually by geographic reference[2-3].

The GP practice is the main point of provision of PHC in England[4]. It includes services such as medical consultations, of both spontaneous demand and follow-up of chronic conditions, Pap smears, contraceptives, simple surgical procedures and immunizations. There is still PHC units that meet specific situations: drug users, mental health, or vulnerable groups such as the homeless[5].

Faced with the growing demand for health care due to a higher prevalence of chronic diseases, one of the solutions found in England was the expansion of nurses' roles in direct care to patients. In Brazil, however, the nurses' functions in primary care are still restricted, with predominantly technical and bureaucratic activities, in times of universal coverage and access to health care [6]. Knowledge of different realities from the Brazilian one, in which the nurse has an expanded clinical function, motivated this research and led to the analytical observation of this reality. It is expected to contribute to the necessary debate on nursing in this country.

The objective of this study was to analyze the expansion of nursing roles in primary care in the English National Health Service and the implications for professional practice.

METHOD

This is a case study[7], aided by literature review and documentary analysis, whose empirical data collection occurred in PHC units (GP practices) in London, England, from interviews with nurses, considered key informants.

The literature review[8-9] provided synthesis of knowledge and incorporation of the applicability of the results of studies in everyday practice. The guiding questions of the study were: "What are the nurse's roles in primary health care in the English National Health Service described in the scientific literature? What are the repercussions of the expansion of the nurse's role in primary health care in the English National Health Service?".

Articles were searched in online databases PubMed and BIREME, with descriptors: a) National Health Service; b) Primary Health Care; c) Nursing. The inclusion criteria considered articles published between 2008 and 2014, in Portuguese, English and Spanish, indexed in Virtual Health Library, available online in its entirety. Studies that addressed the work of nurses in other levels of care than the primary and in other countries than England were excluded. In the search, 22 articles met the inclusion criteria and were part of this study. Regarding the included documents, they were all obtained online, in the websites of the English National Health Service, the English National Nursing Council and of the English National Nursing Association.

The empirical data collection occurred in two distinct units of primary care in the health area of Hackney, belonging to three Clinical Commisioning Groups - CCGs (NHS City and Hackney CCG, NHS Haringey CCG e NHS Tower Hamlets CCG), in the Eastern and North regions of London, from July 30 to August 17, 2014. The units were listed and the research subjects were recruited intentionally, through the global health unit from the Center for Primary Care and Hublic Health of University of London, through personal contact by the postdoctoral internship supervisor of this researcher, of which this activity was part, together with the National School of Public Health.

Interviews were scheduled a month in advance, via formal contact, by e-mail. Recorded interviews were held, with an average duration of one hour each, with seven nurses of different functions (general or clinical) in their workrooms in primary care settings, by following a previously structured

questionnaire with 30 open questions. Two nurses from services that guide professional practice were also interviewed, one from the National Nursing Association (Royal College of Nursing-RCN) and the other was a professor with Master's degree in primary care from the City of London University.

Both the data from literature review articles and the interviews with the nurses were investigated through thematic analysis, starting with horizontal mapping of material. The next step was an exhaustive and repeated reading of the texts for the seizure of relevant structures. This procedure, followed by cross-reading allowed performing a classification of themes. From the emerging structures of this analysis, relevant topics for discussion were regrouped[10].

Results were organized in two thematic units. The first, called *nursing activities in primary care in the English National Health Service*, covers the careers and roles of nurses, the management of chronic conditions cases and prescription of medications. The second, called *favorable and unfavorable aspects of the expansion of nurses' functions*, reports and discusses the expansion of the functions of nurses and their impact on primary care and professional practice.

The study follows the international ethical principles and guidelines of Brazilian National Health Council Resolution 466/12 and was approved by the ethics committee of research with human beings of UNIOESTE, under opinion number 699803. The interviewees signed an Informed Consent Form. To maintain the anonymity of the subjects, identifying acronyms were used for testimonials with abbreviation of the main functions - Nurse Practitioner (NP), Practice Nurse (PN), an association representative nurse (RCN) and professor (PROF) - followed by the number of order of interviews (e.g. NP1, NP2 and so on).

RESULTS

Regarding the characterization of study subjects, there was predominance of graduate nurses because as this is new at the graduation level, some professionals working for longer were nursing technicians and attended other graduations after the change in legislation, such as psychology, anthropology or obstetrics, whose formation is separated from nursing. Their duties included practice as general nurses, clinical nurses, advanced nurse, teacher and consultant in primary care. It was perceived focus on continuity of training, as all professionals attended specialization and / or master's degree in primary care. The time after the training was, on average, 30 years. It was evident also long stay in the same unit of primary care, ranging from 5 to 15 years.

Nursing activities in primary care in the English National Health Service

In England, nursing education occurs at graduation, lasting at least three years or 4600 hours in four main areas: Adult, Children, Mental Health and Learning Disabilities. After graduation, one must register on the category's specific council, the Nursing and Midwifery Council (NMC)[2,11].

In this article, the focus is on nursing careers and activities in primary care. These, nurses graduated in the adult area, differing by additional training in short courses on clinical management of several chronic diseases and for prescription of medications. It is noteworthy that the performance in clinical and therapeutic functions occurs only after specific training for each case and registration in the NMC and the NHS.

Nurses' careers and roles in primary health care

Specifically in primary health care, nurses with different functions are called nurse practitioner, practice nurse, health visitor and district nurse. They exert various clinical and non-clinical activities, with extended professional skills and emphasis on management of clinical cases, especially of chronic conditions and prescription of drugs. Their functions are summarized in Box 1.

Box 1 - Nurses' roles in Primary Health Care in General Practices or Community Health Services, in the English National Health Service (NHS)

Roles	Nurses' testimonials
General Practice Nurse or Practice Nurse	
• Clinical practice procedures (blood count, electrocardiogram, wound care); • Child and adult immunization; • Family planning; • Men's and women's health; • Sexual health; • Smoking handling clinic; • Supervision of health workers; • Health guidelines for travel as vaccinations and general care. **Practice site:** GP practice	*Seeing people for routine, minor things like health checks, dressings, syringing, check-ups on minor or long term conditions, diabetes, respiratory problems, acute things. So triaging on minor illness, access to GPs. So that'll be probably the first line of contact for outer people in some surgeries. So it could be very basic stuff, just doing dressing and maybe health checks, to really follow more of a long term care …* (RCN6) […] *in some GP surgeries, a health care assistant can do some of these, in some GP practices, the practice nurse will do it.* (NP2)

Continues

Box 1 (cont.)

(Advanced) Nurse Practitioner	
• Physical examamination; • Choice and implementation of clinical / drug treatment; • Reference to specialist; • Diagnostic hypothesis and final (clinical) diagnosis; • Multidisciplinary plan of continuing care, considering social needs and use of home (and return) visits; • Leadership of the clinical team and adequacy of individualized care practices. **Practice site:** GP practice	*What really defines a nurse practitioner is that they are prescribers … so they'll be able to prescribe within a competence, but from the entire, the same as the GP could, so we don't have any limitations on what you can prescribe. So prescribing is something that defines it and they would usually see, as other big thing* […]. *And seeing patients under differentiate illnesses, treatments, formulating plans, doing the follow up*. (NP3)
Health Visitor	
• Community Health Promotion; • Monitoring of child development (birth to five years old); • Family health care and minor injuries; • Breastfeeding, weaning and postpartum guidelines; • Oral Health Promotion; • Child violence and neglect prevention; • Referral of cases of neglect or family abandonment to specialized services. **Practice site:** Community Health Centre and homes	[…] *The health visitors will do the developmental checks on children up to the age of 5*. (PN8) *So, health visiting tends to be more around safe guarding, child protection issues, that's one of their biggest roles really. And they also do some routine checks on children, so they'll be the ones who's see them at 6-weeks, and measure their heads circumference, and length and weight, review if the parents have a concern about feeding, or weaning, or sleeping, or behavioral issues, anything along those lines tend to be the health visitors*. (NP3)
District Nurses	
• Home Visits (in the home or health care facilities and nursing/ elderly homes); • Support to elderly family or patients with exacerbated chronic conditions; • Promotion of individual self-care; • Aim to avoid multiple hospitalizations and avoidable hospitalizations. **Practice site:** Community Health Centre, Nursing Homes and homes	*So district nurses visit patients in their home. So if the patient is not able to come outside their home, district nurses go to their house. And they'll do wound care, catheter care, it's usually a task. So, they don't nurse the patient at their home, they go and do a task, so maybe go and do wound care and then come out*. (NP7)

Source: Adapted from NHS[11].
*Note: * The title advanced is given to clinical nurses with master's degree.*

Nurses' performance on management of chronic conditions cases

The practice of nurses in case management in English PHC is guided by the use of care protocols based on diagnostic evidence, procedures, drug treatment, guidelines for changes in lifestyle and individual monitoring. Case management (clinical case management) is defined as the effective and efficient approach to adults with chronic diseases or complex health care needs[12].

Case management, in addition to clinics, extends care to the social demands of the patient. Keeping the person with chronic disease outside the hospital, safe and in their home requires partnership with social service and other staff members, constant evaluation of health, hygiene, nutrition and capacity for self-care.

> […] *they'd be looking at both health and social needs of the patient. So, to try to keep the patient out of the hospital, so they'd be working close to the social services, social worker, and be looking at other needs that somebody might have in their own home, and keep them safe and keep them well at home if they can't come to the clinic*. […] *So, there's basic living: good wash, bath, eating food and all the rest of it, so they could be supported in their own home*. […] *That's a very simplified of what case management is*. (NP2)

Case management is not a specific skill of the profession, but a response to the complex individual health needs, perceived from the nursing consultation. Such clinical leadership is usually not formalized, however, finds fertile ground from the fragmentation of the care process and from a most often contact of the nurse with the community in relation to other members of the health team:

> *So, case management is not taught as a specific skill but when you have a relationship with the patient and that patient has complex needs and you are the one who sees him more often and has the best knowledge of his condition and needs, you by default will become the case manager. And it's not always very formal*. (PN1)

The care of people with prevalent chronic conditions like asthma, diabetes, chronic obstructive pulmonary disease, hypertension and heart problems is guided by clinical

protocols, developed by the National Institute for Health and Care Excellence (NICE) and by goals set in Quality Outcomes Framework (QOF).

> *Ashtma, Diabetes, COPD* [Chronic Obstructive Pulmonary Disease]*, Heart Problems, Cardiac Problems, post MI* [Miocardic Infart]. [...] *National Institute for Health and Care Excellence has guidelines, which recommend, and then we've got things called Quality Outcomes Framework, which all the GPs practices in England have to work towards and that's how we get our income.* (NP2)

Nurses' performance as drug prescriber

In the UK, since 1992, nurses with special training have prescribed medications. In 2006, this responsibility was legally expanded, seeking to increase the efficiency of services provided from the flexibility of the division of labor between doctors and nurses[13]. Box 3 summarizes the law progression of nurse's role in prescribing medicines in the UK.

Nurses represent 43% of professionals with qualifications to prescribe, registered in the NHS[13]. A study on the national database of PHC prescriptions from 2006 to 2010 and on the national database of the NHS workforce in 2010 indicated that the number of nurses prescribing more than once annually in the PHC increased by 18% in the period, from 13,391 in 2006 to 15,841 in 2010[13].

> *So I prescribe … if I have a diabetic patient, who needs medication, or is already on some medication, but needs to go on to insulin, I'll prescribe that. Someone wants to stop smoking, I'll prescribe nicotine replacement therapy or tablets to help them to stop smoking. Contraception, any of the contraceptives. Blood pressure tablets and cholesterol tablets.* [...] *So I prescribe for things that I am very familiar with, it's not that there's any legal restriction on my prescribing or other things, but professionally it's up to me to make sure that I am completely familiar with what I do prescribe.* (PN8)

Legally, the nurse is registered in the category board as prescriber and also in the NHS and, as well as medical professionals, they have their practice supported by insurance.

> *So, once you've done your university course, your exams, your portfolio past, you have to wait a while until you are on the NMC registered and you sign in there as a prescriber, so it's like a supplementary extended role and most practices would wait until that is all in place before asking you to prescribe. I waited until it's all done, so it's not that you need that once you pass your exam than you have to be accepted for the NHS as a prescriber. And then you have to have your insurance and your things in place.* (NP9)

In the following statement, it becomes clear that the nurse acts clinically by prescribing drugs for patient care just like the general practitioner would do.

Box 2 - Legal authority and mechanisms of the National Health Service (NHS) for nurses prescribing medicinal products in the UK since 1992

Year	Role assignment by legislation	Legislation
1992	Specialist qualified community nurses started prescribing medicines from a limited list.	Great Britain. Medicinal products: Prescription by Nurses etc Act (C.28). London: Her Majesty's Stationary Office; 1992.
1996	It was created a limited form for nurses' prescriptions, for district nurses and health visitors, which included medicines for healing, skin problems and handling of catheters.	Great Britain. Medicinal products: Prescription by Nurses et Act 1992: (C.1). London: Her Majesty's Stationary Office; 1996.
1998	The NHS has expanded the list of drugs, creating the Nurse Prescribers' Formulary for district nurses and health visitors with additional qualification to prescribe.	National Health Service Executive: Nurse prescribing: implementation the scheme across England. Health Service Circular 1998/233. Leeds: National Health Service Executive, 1998.
2001	The scope of nurses authorized to prescribe was expanded for all nurses, midwives and health visitors, with additional qualification, naming them independent and supplementary prescribers.	Great Britain. The health and social care Act 2001, Section 63. London: The Stationary Office; 2001.
2002	The NHS introduces the Nurse Prescribers Extended Formulary (NF), including 140 drugs that were previously prescribed only by physicians, for the use of nurses.	Department of Health: Extending independent nurse prescribing within the NHS in England: A guide for implementation. Edition 1. London: The Stationery Office; 2002.
2006	Legislation for the independent nurse prescriber to prescribe all medications, including controlled medications, for any medical condition within their clinical competence.	DH/Medicines, Pharmacy & Industry/clinical & Cost Effectiveness: improving patients' access to medicines: a guide to implementing nurse and pharmacist independent prescribing within the NHS in England. London: Department of Health; 2006.

Source: translated[13] and adapted by the author.

> […] *so they'll be able to prescribe within a competence, but from the entire, the same as the GP could, so we don't have any limitations on what you can prescribe* […]. (NP3)

Favorable and unfavorable aspects of the expansion of nurses' roles

Nurses interviewed demonstrated a positive outlook towards expansion of functions in the PHC, which is convergent with the results of the literature review on the nurses' working reality. With larger clinical functions, these professionals perform consultations for diagnosis and drug therapy of patients with chronic conditions. The follow-up of these cases in the unit makes the nurse assume functions that were exclusively medical, such as prescription of medicines, requesting and interpretation of tests and case management, in a practice guided by care protocols and supported by staff.

> *So, the introduction of that really led to the biggest expansion of practice nursing, because it made it economically viable, so let's say appealing for practices to employ more nurses. And then over time* [some practices] *having introduced this networking, and what we call the care packages, so that was to produce enhanced care packages with patients, who have long term conditions. So, was very much based around nurses working with patients, probably increasing in nurses locally*. (ANP3)

> *No, I mean it's totally good model, clearly there's a nurse, and you could see that it's up to the person to extend role to the advance practice. So here, I'm a clinical leader, so I've got to some leading practice, for the GPs to work and manager so, it was the role reversal, but it's given me the opportunity to work in an advanced standard role, which, so yeah it's good*. (NP2)

> *I think it makes it more interesting jobs for nurse, because you can, as well as nurse, assessment and realistic assessment, in your medication review, you can look up at, you have the time to look up at how's someone been taking the medication, whether they understand it, you have more time and can bring them back.* […] *As a bad thing, that would pressure on salaries, that would bring more opportunities, so good things and bad things really. The regulated pay is now starting to break up into, so the practice nurses don't have the same terms and regulations as the NHS nurses*. (PN9)

DISCUSSION

Nursing activities in primary care in the English National Health Service

Nurses in England have suffered pressure from both government policies formulated for primary care and from their employers, in primary care settings, to increase their area of expertise, expanding their functions, in order to contribute more effectively in care of patients, especially those with chronic conditions. Studies analyzed [12-27] refers to the expansion of the nurses' functions in prescribing medications, replacing medical consultations to patients with chronic conditions. In these cases, they are responsible for case management in chronic conditions, as reported in the statements of study subjects.

Nurses' careers and roles in Primary Health Care

The reality of the health professionals here focused was not always as depicted in the previous paragraph, for the academic nursing education in England is quite recent, dating back to the 1990s. Before that time, nursing training occurred in practice spaces, usually hospitals, in the form of direct learning with a more experienced supervisor and they received a certification provided by the hospital. The first graduate degree in nursing began in September 1989, with a curriculum that blended theoretical and practical activities, with emphasis on health promotion and disease prevention, leaving aside the focus of the hospital[27].

There has been a new conception of the profession with a status of a graduation in the last twenty years. However, it has been said that a profession that was eminently practical, now has a predominantly theoretical training; the graduation does not correspond to the needs of health services[14,28].

Furthermore, when analyzing the work of nurses in the English primary care from the reformulation of health system occurred in 2012, it is worth mentioning that, with the changes in the organization of services, there was a change in the form of hiring these professionals, which initially hindered their inclusion in health facilities. On the other hand, with the consideration of health determinants in care, the demand for these professionals, who usually have the preparation to deal with the comprehensive patient care, has increased, converging with the social reality of the country[27].

Nurses' performance on case management of chronic conditions

From the expansion of functions demanded by the social and health environment, nurses have become reference for the management of chronic diseases in the PHC team in England, with the help of protocols for clinical trial, leading to specific decisions for each case according to that reported by the nurses interviewed in this study[16].

Study results[16] on the work of nurses as case manager in three most common chronic conditions in England have shown strong evidence of effectiveness of care by nurses as managers of clinical cases, since responsiveness to treatment and the patient's understanding of his condition were improved. Furthermore, nurses perceive themselves with more professional autonomy because they examine, evaluate and decide which the best patient care is[16].

Literature review showed that when the practice nurse became responsible for prevention of coronary artery disease in patients with clinically stable ischemic heart disease, this was well accepted by patients and nurses, leading to self-reported improvement on lifestyle and health conditions[24]. In secondary clinic prevention, there was decrease in the total number of deaths and probable coronary events, and care was more cost-effective. The same occurred in relation to diabetes, whose patients monitored by nurses reduced their HbA1c (glycosylated hemoglobin) and cholesterol and increased their adherence to therapy, compared to the results of medical care[24].

Nurses' performance as drugs prescriber

The percentage of prescriptions made by nurses in the PHC in England is small compared to doctors. Nurses' prescription happens when there appears to be relative advantage for all concerned, especially in areas with fewer medical professionals, in rural or low income areas. Another aspect that contributes to this not very significant number is that this practice has not yet been firmly established in PHC as routine[14]. Some professionals do not feel fully prepared for this function, report little time to study, need for continuing education on the subject, staff limitations, concern with the knowledge base required for practice[15]. There is need of professional competence with close clinical training to safeguard patient safety, together with the support of a professional to guide the practice (clinical mentorship)[26].

Nurses evaluate that their practice as prescribers offers significant benefits for the care of patients. They understand that prescribing within their scope of responsibilities has become an intrinsic part of the profession, and the practical experience brought increased confidence. They understand that to prescribe, one must have previous clinical experience, and the prescription by the nurse is important to improve access to health services[26].

It is noted, however, ambiguity regarding support to the activity of NP as prescribers. On the one hand, the NHS encourages this practice, on the other, in health services, the need for mentoring keeps the control of this practice with the medical profession, coupled with the attitude of some doctors who, exercising their position of power, restrict and control the time and opportunities for joint discussions[19].

Favorable and unfavorable aspects of the expansion of nursing roles

With the expansion of the functions of nurses, there has been improvements in care and continuity of care to patients. A study evaluating 35 scientific publications on the results of the consultant nurse practice in England observed positive impact in cases where nurses take care of patients, with improvement of physical and psychological symptoms such as reduction of anxiety, waiting time and rate mortality, better care, better understanding of their health problem and increased confidence[23]. In addition, the greater autonomy of the practice nurse in primary care staff increased the feeling of satisfaction of nurses at work[24].

The literature review[17] analyzed 25 articles related to 16 research and focused on the 1966-2002 period, to assess the impact of the replacement of doctors by nurses in caring for patients in the PHC in relation to the results, care process, resource and use, including costs. The nurse has replaced the medical professional in health care in two modalities, as supplementary and as substitute of physician's work. In seven studies, the nurse assumed responsibility for the first contact and continuity of care for patients seen. In five, the nurse assumed responsibility for the first contact for patients waiting for urgent consultation. In four studies, the nurse assumes responsibility for the segment in the management of patients with chronic conditions. In all, the results showed equal quality care, with no significant differences in care among doctors or nurses. In addition, patient satisfaction was higher for nursing care, related to longer visits, more information and return of patients more frequently[17]. Authors conclude that "appropriately trained nurses can produce as high quality care as primary care doctors and achieve as good health outcomes for patients". However, they point to the need to consider the results with caution, since only one study safely affirmed the equivalence of care between doctors and nurses[17].

Another study[20] typified the benefits and limitations of nurses assuming clinical functions in primary care in three themes: impact for patients, nurse's competence and evidence to support the NHS policy. The impact for patients was positive, because they considered the nursing consultation as longer and more comprehensive. As for nurses' competence, many do not feel empowered and prefer referring the patient to the doctor. Regarding support of NHS policy, it was realized the need to improve the training of nurses on the diagnosis and therapy for the expansion of their practice.

The increase of the functions of nurses in GP practices is related to the fact that they take over the possible workload of doctors. The expansion of nurses' roles can increase the quality of primary care, but this is only possible from the intensification of the nursing team work[24,29]. These expansion policies are regarded as an economic strategy to reduce costs since, by taking part of the medical work, the nurse is not necessarily paid in accordance with that responsibility[14]. In Box 4, it is developed the synthesis of favorable and unfavorable aspects of the expansion of nursing roles in the English NHS.

Box 3 - Summary of the results of the expansion of nurses' roles in primary care in the English National Health Service (NHS)

Changes for patients	
Favorable Aspects - Improved access to health services (reduction of organizational barriers); - Increased quality of professional-patient relationship[17]; - Better communication between patients and nurses[20]; - Greater length of consultation[17]; - Better adherence to treatment[22]; - Improved referral /follow-up of patients[16-24].	**Unfavorable Aspects** - Reduction of the patient's freedom to choose the professional who will serve him, as the first contact becomes the responsibility of the nurse[20]; - Patient's insecurity to follow the nurses' prescription[20].

Continues

Box 3 (cont.)

Changes for nurses	
Favorable Aspects - Better professional recognition of nurses by patients and other professionals[13]; - Increased technical powero[25]; - Increased professional body of knowledge[22]; - Greater job satisfaction, due to the increase of resoluteness of their practice[24].	**Unfavorable Aspects** - Work overload, because the nurse continues to exercise his traditional routine activities added to the additional clinical practices[20,24]; - Work increase does not corresponds to equivalent salary increase[13]; - Labor conflicts with doctors who are reluctant to recognize the clinical practice of nurses in the workplace[13]; - Labor conflicts with other nursing professionals not qualified for the expanded practice[18]; - Reluctance of nurses to delegate functions for healthcare assistants[18]; - Ill-prepared nurses to take on extended roles[24].
Results for NHS	
- Reducing the cost of care due to lower remuneration of nurses in comparison to the doctor[17]; - Cost savings with prescription of medications, which is more cost-effective when the nurse prescribes[20]; - Greater adherence of nurses to clinical guidelines for the rational use of medicines[20,22]; - Better effectiveness of the monitoring of chronic conditions, preventing hospitalizations[16]; - Greater adherence to guidelines for changes in lifestyle, reducing government spending on social care[18].	

FINAL CONSIDERATIONS

The study identified and analyzed the nurse's functions in the PHC in the English NHS by addressing their contributions to the quality of service provided, highlighting the nurse's role as health team member, describing the activities routinely performed by them in different functions and relating the difficulties and facilities inherent to nurses' practice in these different functions.

It stands out as a study limitation the focus in review articles and essays, with few publications resulting from research on the impacts of the expansion of nurses' roles in PHC of the English NHS. The clipping adopted in the case study is the point of view of nurses. Thus, it is suggested further research with other PHC team members and users of this service, with a view to an expanded evaluation the nurses' work, covering all involved.

For patients, the expansion of nurses' clinical practice has resulted in better access to services, in consultation with longer duration, in more efficient communication and improved adherence to treatment. For nurses, there is the achievement of an utmost respected professional status, expanding the profession's body of knowledge. For the NHS, it has resulted in cost savings, for it is more advantageous in the context of the actual cost, plus the fact that, socially, nurses' work has less pay. At the same time, it has expanded the attendances, which is a goal in times of more contingent budgets, as currently experienced.

It is expected that this article can contribute to the debate on the extension of the scope of work of advanced practice nurses in the Brazilian reality. This can be a path to universal coverage and access to PHC, granting comprehensive care to the user by qualified health professionals, trained to accompany him continuously in prevention, promotion, treatment and rehabilitation, providing meaning to the relationship of health services with community individuals.

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