Partners in Practice

Attached, detached, or new recruits?

Constance Martin

This is the third of a series of articles focusing on the current tasks and functions of the primary health care team

East Sussex Family Health Services, Lewes, East Sussex BN7 2PB
Constance Martin, *nurse adviser*

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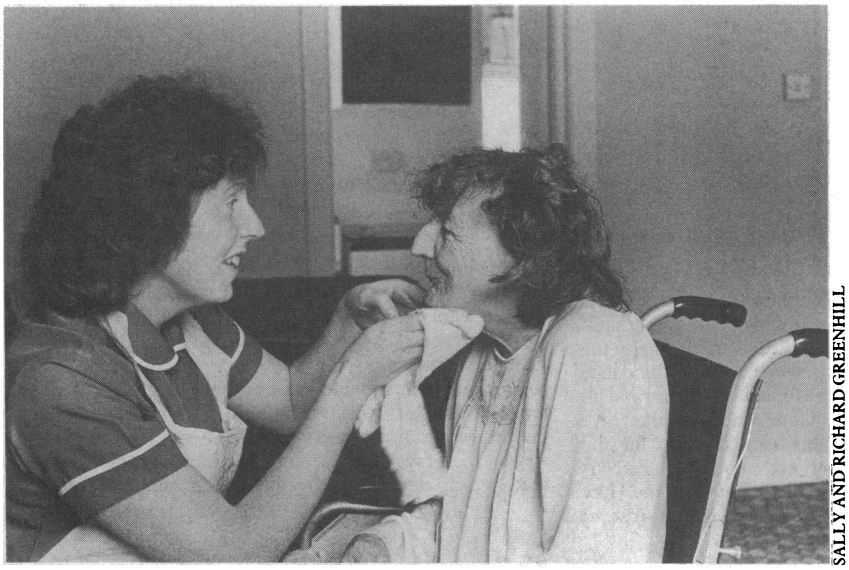
In 1986 community health services were defined by the Department of Health and Social Security as "front line ... services provided outside hospitals ... by community nurses, midwives and health visitors and other professions allied to medicine."[1] The part played by community nursing in those front line services has been shaped by many influences over the years. In this article I look at some of them and at where community nursing is bound for in future.

Where has community nursing been?

Up until the 1970s district nurses and health visitors were detached from general practice. They worked from a centre and were employed either directly by the local authority or by an association contracted to the local authority to provide nursing and health visiting services. The service was managed by a superintendent who had community nursing qualifications. But because most of the contact between the service and general practitioners was through the superintendent there was often little direct communication between the general practitioner and the nurse.

As early as the 1950s some health districts had recognised that this could create difficulties and were taking steps to overcome them. By 1965 Oxford health district had attached all its district nurses and health visitors to practices; by early 1970, 75% of health visitors and 68% of district nurses in England and Wales were attached.[2]



SALLY AND RICHARD GREENHILL

From now on community nurses will have more specialist preparation to meet particular health care needs

Community psychiatric nurses were becoming a more familiar part of the community nursing service too, so that by 1980 only six districts did not have a service. The spread of community nursing services, however, left a lot to be desired. Often areas where there was clearly a need for such services, because there was either a high proportion of elderly people or insufficient institutional care, were also those lacking adequate community nursing services. Some health authorities employed three times as many district nurses per 1000 population as others while urban areas tended to have fewer attached staff because of lack of accommodation and a larger proportion of single handed general practitioners. The 1974 reorganisation of the NHS, with its emphasis on an integrated approach to health care, obviously made an impact on such inconsistencies.

Differences in training between district nurses and health visitors also threatened to trip up the smooth running of the community nursing services. Since 1948 there had been a statutory obligation to provide health visiting from "qualified women," and their qualifications could be interpreted quite narrowly. In 1962, however, the Council for the Training of Health Visitors was set up, heralding a much broader approach to education and a better understanding of the health visitor's role. This body later became the Council for the Education and Training of Health Visitors. Mandatory education for district nurses was not introduced until 1981. Although their training was separate from that of health visitors, it was run by the same body, helping to reduce the differences between the two groups.

Attaching district nurses and health visitors to practices provided a neat solution to some problems and led to better communications—for instance, it inevitably triggered other occupational groups to deal with leadership, the handling of team decision making, and mutual trust and confidence.

Social workers, for instance, who were also becoming attached, wanted to establish their independence, having removed themselves from dominance by doctors in hospitals. Midwives were anxious to maintain their professional freedom, particularly with home deliveries, where the general practitioner could be less experienced than themselves. Health visitors also did not want their autonomy to be undermined and they were concerned that some of their counselling and preventive work did not fit "conveniently" with general practitioners' more curative approach.

So, while the concept of team care was accepted, worries about guarding occupational boundaries and the increasing trend towards specialisation was making it unworkable. Practice nurses were also increasing in numbers.

Where is community nursing now?

REVIEW OF SERVICES

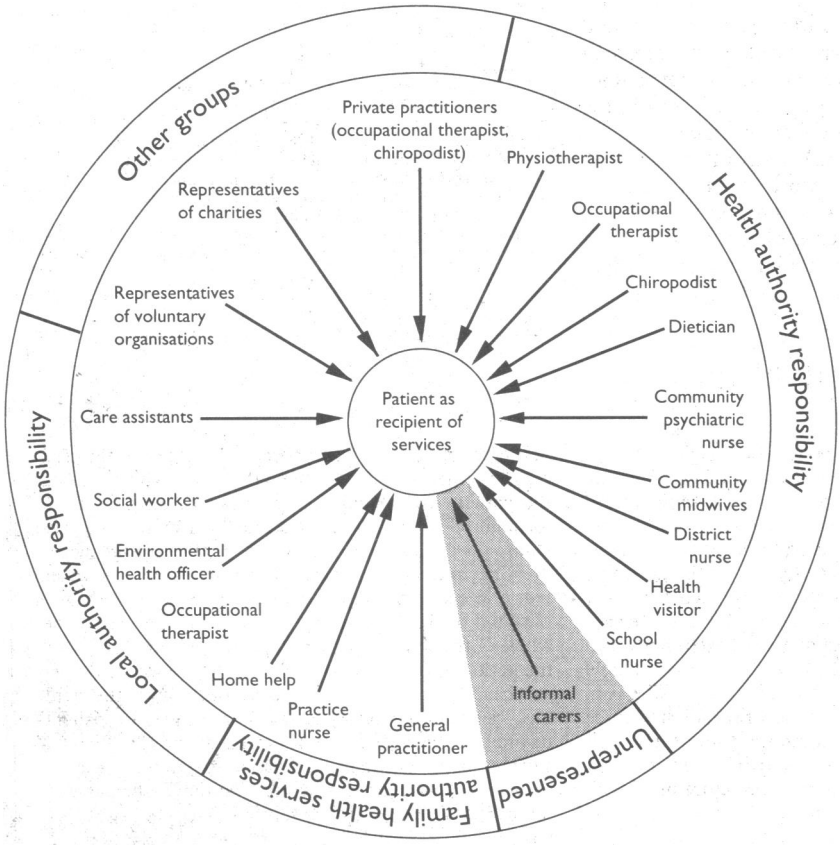
By 1986 the secretary of state for health in England and Wales commissioned Julia Cumberlege to "study the nursing services provided outside hospital by Health Authorities and to report to the Secretary of State on how resources can be used more effectively, so as to improve the services available to client groups. The input from nurses employed by General Practitioners will be taken into account."[3] The review found a number of weak points and commented particularly on the "separate, traditional ways of working in which health visitors and district nurses appear to be trapped." It took as its focus "the consumer," highlighting three areas of need: people who are dependent want to stay at home; people who prefer to be at home when sick need access 24 hours a day to professional help and support; and people want information about health care and what they can do to prevent ill health and promote good health.

The review challenged the perception of the supremacy of the general practitioner and offered an alternative approach based on giving nurses professional equality and shared responsibility. Overall general practitioners responded negatively, expressing particular concern over the issue of practice nurses and their employment status. The concept of neighbourhood nursing teams and the decentralisation of community nursing services, however, was accepted, and this gathered momentum. By 1988, 36 of 128 district health authorities had developed neighbourhood nursing and 41 were planning to do so. Today community nursing managers are increasingly being involved in the appointment of practice nurses and there are more and more joint initiatives to bring together general practice and health authority staff.

SYSTEMS OF CARE

Ninety per cent of contact with patients takes place in the community and it is clear that most people want to remain in their own home and environment. But for the patient community care is a "wheel of misfortune," stuck in a rut of organisational and professional structures (figure). The patient is seen as a recipient of care, and it is very likely that "an endless procession of professionals can enter the patient's home under the guise of quality care."[4]

On the one hand, then, we have the general practitioner, with her or his contractual responsibilities for patients, seeming to be the natural leader of the primary health care team, while on the other is the question of how to make that work when everyone reports back to different organisations.



Wheel of misfortune

Where is community nursing going?

JOINT WORKING

It is clear that finding the right basis on which to run community health services in general, and nursing services in particular, will be central to the successful implementation of the three government papers *Promoting Better Health*, the government's programme for improving primary health care[5]; *Working for Patients*, the health service in the 1990s[6]; and *Care in the Community: a Consultative Document on Moving Resources for Care in England*.[7] The report of the working group on nursing in the community 1990[8] came at a particularly appropriate time. It emphasises the need for joint working between the district health authority, the family health services authority, and the local social services department as purchaser and provider units. For successful joint working, says the report, we will need a shared vision of care; a commitment to joint working and putting patients first; joint assessments of population health needs; joint strategies; effective communications; and a commitment to quality.

MODELS FOR COMMUNITY NURSING

The report invites discussion at local level around five different models for organising community nursing services with the aim of achieving "the best possible nursing care—within available resources and in the way most suited to the needs of individuals and users and carers."

The "stand alone" community trust or directly managed unit—This model comes closest to achieving good communication and stability among professional staff and would encourage community nursing services to develop marketing and business skills. It could, however, isolate general practice and nursing.

Locality management or neighbourhood nursing—In this model mixed teams of staff are managed in a locality around a geographical patch or a consortium of general practices. This would depend on good networking among team members, who would still report back to different employers—either to the practice or to the health authority. General practitioners could find this confusing, particularly where practice boundaries did not correspond.

Expanded family health services authority—Relationships between family health services authorities and community units with their district purchasing and providing roles would need to be sorted out. In some cases formal links between family health services authorities and community units would be established for the first time. East Sussex family health services authority was in the forefront of the move to build closer working links with community units when it appointed the first nurse adviser in the country in 1988, a practice subsequently followed by others. The obvious outcome of this model is the primary health care authority.

Vertical integration or outreach—This model has a variety of forms including a version that combines

Requirements for effective community services

- Joint working and strategies between district health authorities, family health services authorities, and social services
- A commitment to putting patients' and carers' needs first
- Assessments of population health needs
- Preparation and practice so that community nursing, midwifery, and health visiting are responsive to health needs
- Effective communications

acute and community units—for example, mental health units and maternity units might provide inpatient, outpatient, and community services in one provider unit. This model offers "seamless care" for the patient and could shift the emphasis of care to the community, but this could become fragmented. Health promotion and education would need to be established as the focus could be on those already requiring health care.

The primary health care team—The primary health care team model is centred around a general practice or health centre, with the general practitioner managing all the community services. Its success would depend on skilful team building and setting of clear objectives. The historical divisions among the professional members of the team would have to be broken down and close links forged with secondary care and specialist services.

The report does not champion any one model; rather it leaves it to community nurses and their managers to decide what is right for their own populations.

CURRENT POLICY AND SCHEMES

Current policy on the future of nursing, and particularly community nursing, recognises the need for more flexibility.[9] A new unified discipline of community health care nursing is identified with shared common core preparation for practice and specialist modules to prepare for discrete areas of practice, resulting in greater flexibility of choice for practitioners and employers. In the main the profession has welcomed this development.

The Community Care Act has already had a profound impact on our effort to work along interagency lines. From 1 April 1992 local authorities have had to publish annual community care plans showing what arrangements they are making for community services and community care. In East Sussex the development of care management has a high priority. Six experimental care management pilot schemes have been established, all but one based in general practices and focusing particularly on elderly people and those with physical or sensory disabilities. They are being run initially for one year as a partnership between the primary health care team, East Sussex Family Health Services Carers, and the social services, with the social services as the lead agency. Care management offers the client worthwhile benefits: a single contact point, an assessment of all their health and social care needs, and an overall individual review with regular monitoring. Because the overall amount of questioning and assessing are reduced it is also far less of an ordeal for the client.

CONCLUSION

Increasingly there is a recognition that although the management and professional issues remain, concentrating first and foremost on what the patient needs is what is helping to break down barriers. Whether a member of staff is attached, detached, or a new recruit is no longer really the critical question. Attitudes, greater clarity about corporate identities, and joining forces to set goals that meet health needs are what count now. It is sharing not protecting, collaboration not isolation, and proaction to health needs not reaction that will make the wheel of misfortune become the wheel of fortune and the patient and carer as involved in setting goals for their own care as are the professionals and managers.

I thank Miss S Mackie-Bailey, proprietor, Gateway Enterprises; Miss D Millward, chief nurse and director of quality assurance, Hastings and Rother NHS Trust; and Mrs P Sinkins, consumer services manager, East Sussex family health services for their help.

1 Department of Health and Social Services. *Primary health care: an agenda for discussion.* London: HMSO, 1986.
2 Ottewill R, Wall A. *The growth and development of community health services.* London: Business Education Publishers Ltd, 1990.
3 Department of Health. *Neighbourhood nursing—a focus for care report of the community nursing review October.* London: HMSO, 1986.
4 Griffiths J. *FHSAs: the junior partners? NHS training directorate bulletin.* London: NHS, 1991.
5 Secretaries of State for Social Services, Wales, Northern Ireland, and Scotland. *Promoting better health.* London: HMSO, 1987. (Cmnd 249.)
6 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients.* London: HMSO, 1989. (Cmnd 555.)
7 Department of Health and Social Services. *Care in the community: a consultative document on moving resources for care in England.* London: DHSS, 1981.
8 NHS Management Executive. *Nursing in the community.* London: North West Thames Regional Health Authority, 1990.
9 United Kingdom Central Council for Nursing, Midwifery and Health Visiting. *Report on proposals for the future of community education and practice.* London: UKCC, 1991, 1992.

ONE HUNDRED YEARS AGO

THE DANGERS OF HOT WATER BOTTLES

Dr A. W. Edis, F.R.C.P., writes to us: Judging from the experience recently gained, I think it well to enter a word of caution as to the employment of hot water bottles after operations, when the patient is still unconscious. In one case of abdominal section, owing to an india-rubber bottle, filled with boiling water, unprotected by any flannel or plush cover, being placed low down by the feet, a slough formed over the outer malleolus, extending down to the periosteum, which caused the patient considerably more inconvenience than the operation itself. The pain was so intense that morphine hypodermically had to be resorted to. At the end of a month the pain experienced was so severe that the patient was quite unable to put foot to ground, and it was over two months before the slough had separated and the wound healed. In another case the bottle was placed between the feet and a large blister raised on the inner surface of the great toe, which caused the patient much pain and inconvenience for nearly a fortnight. The foot swelled and the leg itself became very painful, necessitating the employment of a bandage, water dressing, and other measures. In a third case, a hot-water bottle placed at the side of a patient after oöphorectomy, blistered the back of the hand so severely that nearly the whole of the skin subsequently peeled off, and prevented the patient using the hand for nearly three weeks. In yet another case a large blister was produced over the right hip, causing so much pain as to preclude the patient turning on that side for some weeks afterwards. I would suggest the employment invariably of suitable covers to prevent these accidents, and also a caution to the nurse as to their possibility. (*BMJ* 1892;ii:204)