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PRACTICE OBSERVED

Practice Research

Facilitating prevention in primary care

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Abstract

We believe that many general practitioners would practise preventive medicine if they had the opportunity to organise their practice to do this. We therefore provided a "facilitator," who understands the work of a general practice, to help practices that were interested in prevention to set up programmes. She, for example, helped the primary care team to set up objectives, trained practice nurses to measure blood pressure, and set up a system to measure the progress of the programme.

Introduction

The scope for prevention in general practice has been described recently, the priorities being the prevention of vascular disease and cancer.[1-3] A recent report concluded that "about half of all strokes and a quarter of all deaths from coronary heart disease in people under the age 70 are probably preventable by the application of existing knowledge."[2] Because measures to prevent vascular disease include helping people to stop smoking there is also scope for preventing the one third of cases of cancer caused by cigarette smoking.[4]

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Potential of the primary care team

Primary care is uniquely placed for carrying out prevention because: (*i*) it has extensive access to the population[5]; (*ii*) contacts are largely patient initiated and fear of disease may motivate

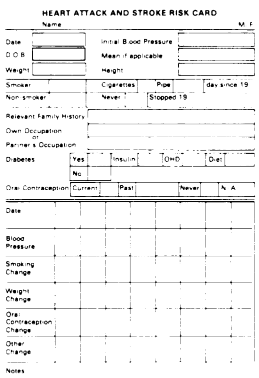

FIG 1—Heart attack and stroke risk card.

changes in behaviour; (*iii*) consultations in primary care offer educational opportunities[6]; (*iv*) primary care doctors are credible and trusted (R McCron, J Budd. Communication and health education. University of Leicester Centre for Mass Communication Research); (*v*) there is evidence of effectiveness.[7,8] The opportunities arising from the one million daily contacts in general practice in Britain may be exploited not only by doctors but by other members of the primary care team, notably practice nurses.

General practitioners have been overwhelmed with exhortations to practise prevention. They have been urged to counsel smokers, identify people with high blood pressure, detect those at risk of cancer, prevent child abuse, give dietary advice, measure blood lipids, care better for people with diabetes, and do many other preventive activities. There has been some response but there is need for more activity.[9]

We believe that general practitioners are committed to the principles of prevention. Some have shown their interest by developing preventive programmes but most have not managed to do so.[10-13]

Primary care teams are busy, and few have slack time during the week when members sit around wondering what to do. Nor is it possible for general practitioners to identify areas of work that could easily be discontinued. What primary care teams need is not more exhortations, or even more knowledge, but practical help to reorientate their activity and, by effective use of "reimbursable" staff, to practise preventive medicine. We therefore decided to offer primary care teams that were interested in prevention practical help to develop anticipatory care. This help was in the person of a "facilitator."

Facilitator

An individual with experience of primary care who could acquire the necessary preventive skills and help practices to learn the "tricks of the trade" seemed to be needed. The facilitator's job is to: (*i*) help the primary care team to discuss prevention and set objectives; (*ii*) help the general practitioners to recruit a practice nurse or increase existing nursing time; (*iii*) train the nurse in methods of prevention, including measuring blood pressure and giving advice on smoking and diet; (*iv*) help other practice staff to learn how to ensure that individuals at risk may be opportunistically recruited to see the practice nurse; (*v*) help the practice to prepare, design, and print risk cards (fig 1), reminder labels (fig 2), and explanatory letters, establish simple recall systems, and maintain supplies of health education materials; (*vi*) organise meetings of doctors, nurses, receptionists, and other staff; and (*vii*) set up a system of audit to measure progress.

The facilitator does not provide a service commitment by seeing patients, except when demonstrating skills. The primary care team do the work; the facilitator simply provides the additional energy required to change working patterns and is a source of information.

The emphasis throughout has been to give practical help to general practitioners, practice nurses, health visitors, district nurses, practice managers, secretaries, receptionists, and any other member of primary care teams in changing patterns of work.

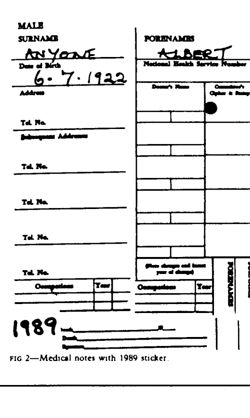

FIG 2—Medical notes with 1989 sticker.

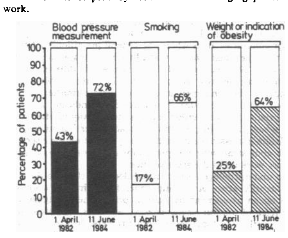

FIG 3—Results of 10% audits of recordings in the preceding five years conducted at practice A on 1 April 1982 and 11 June 1984.

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The basic measures adopted are inquiring and giving advice about smoking, recording blood pressure, weighing, and giving dietary advice. These are carried out by a practice nurse and offered opportunistically and at appropriate intervals to patients aged 35-64 years who attend the practice for any reason.

Information recorded on patients' notes about cigarette smoking, blood pressure, and weight is the "outcome" measurement. This is, of course, a proxy measurement, far removed from reduction in morbidity and mortality, which are the real objectives of preventive medicine. But identifying risk is the essential first step.

The initial results from the first practice that implemented this type of screening, based on a 10% random sample of records (validated by complete audit in some practices), are encouraging (fig 3). Over 3000 people have so far been screened, but detailed analysis and comparison with control practices must await completion of the study.

Implications for health authorities

We believe that many general practitioners and primary care teams are committed to and would like to practise preventive medicine, but they need more than exhortation if they are to change their pattern of work. Only about 15% of general practitioners currently employ their full quota of staff for which they are reimbursed. The cost of employing a practice nurse to

do the work described can be covered by reimbursement by the family practitioner committee, tax relief, and fees received for only one cervical smear and one tetanus injection per doctor each week. In a practice of two doctors the cost after reimbursement and tax relief for the 10 hours required to implement the prevention programme was only £7 a week (table).

Health authorities can help to change work patterns in general practice. We suggest that the most cost effective way of doing this is to employ a facilitator. Our facilitator is a trained health visitor and health education officer employed on the senior administrative officer grade. She has visited others in the United Kingdom who are concerned in similar work, as well as local practices that have prevention programmes, and has acquired the necessary skills to pass on to primary care teams.

The expected independence of family practitioner committees, which will result from enactment of the Health and Social Security Bill, emphasises the importance of collaboration between the district health authority and family practitioner committee services in providing health care. Patient care and health promotion are vitally dependent on such collaboration, and this project is an example of how rhetoric may be transformed into action.[14]

Cost of a practice nurse

Practice nurse employed for 10 hours per week:
Nursing sister scale II (mid-point of the scale)
at £3·98 per hour = £39·80 per week
less 70% family practitioner committee reimbursement = £11·94
less 40% tax relief on the remaining 30% = £7·16 per week
= £372·32 a year.

We thank the Chest, Heart, and Stroke Association for funding the project. We also thank all the members of the primary care teams that collaborated in our project, as well as Brenda Dry, Elizabeth Hagen, Claire Henry, Ginnie Herbert, Stella Mayers, Carolyne McKinlay, and Angela Mowforth for help with audit, analysis, and typing.

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Underprivileged areas: validation and distribution of scores

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Abstract

Underprivileged areas were identified by weighting several census variables that relate to social conditions, by using weights determined by means of a questionnaire sent to one in 10 of the general practitioners in the United Kingdom. The weighted variables were added (after statistical manipulation) to give a score for each of the 9265 electoral wards in England and Wales.

Blank ward maps were sent to general practitioners in five family practitioner committee areas and they were asked to shade the wards according to the degree to which the population increased their workload or the pressure on their services. Maps of these same areas were then prepared by using the calculated scores with the cut off points between the worst, the intermediate, and the best areas as on those used by the general practitioners. The two sets of maps were then compared to determine how well the maps that were based on scores agreed with the general practitioners' maps showing their assessment of the variation of workload in their areas.

Overall, 6·3% of the wards differed in shading in any way between the two sets of maps. In the three areas where the general practitioners shaded complete wards and did not report having difficulties with shading only 1·2% of the wards differed.

It may be possible to use these "underprivileged area" scores to indicate where problems occur for general practitioners and to extend this work to other primary health care workers.

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Introduction and method

Underprivileged area scores were calculated for each of the 98 family practitioner committee areas in England (90) and Wales (eight) using eight census variables from the 1981 census. Each variable was weighted according to the degree to which general practitioners nationally considered that each factor—for example, proportion of elderly people living alone—increases their workload or pressure on their services when present in their area. The weightings were determined by means of a questionnaire sent to one in 10 of all general practitioners in the UK as described previously.[1]

To find out how accurately these underprivileged area scores actually agreed with the opinions of general practitioners in various areas blank ward maps were sent to the local medical committees that represented general practitioners in five family practitioner committee areas. The local medical committees were thought to be the most suitable groups to represent the views of general practitioners in these areas but they could seek the views of non-committee members if they wished. The family practitioner committee areas were chosen by the underprivileged areas subcommittee of the General Medical Services Committee of the BMA, based on the criteria that they

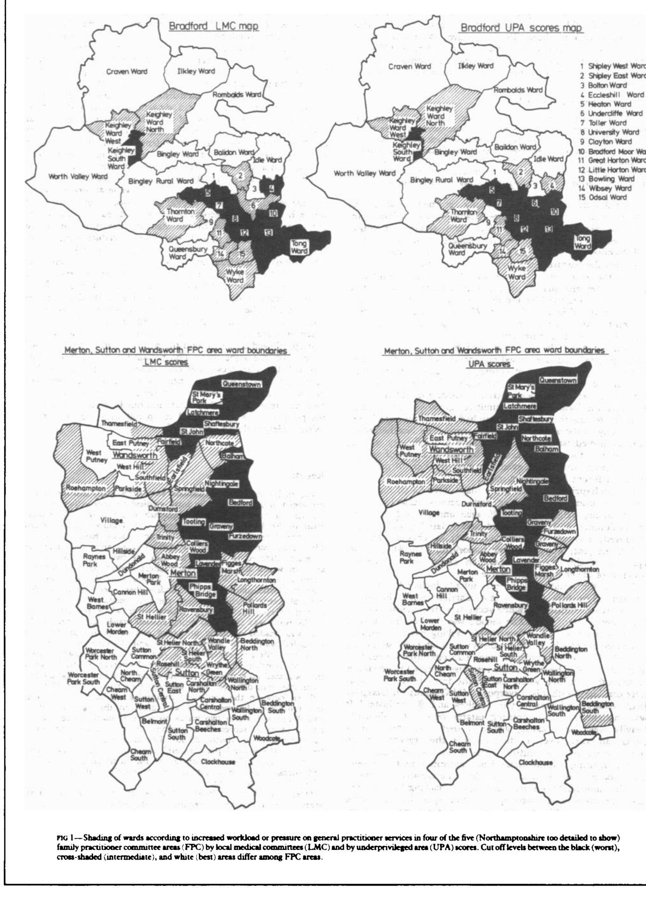

FIG 1—Shading of wards according to increased workload or pressure on general practitioner services in four of the five (Northamptonshire too detailed to show) family practitioner committee areas (FPC) by local medical committees (LMC) and by underprivileged area (UPA) scores. Cut off levels between the black (worst), cross-shaded (intermediate), and white (best) areas differ among FPC areas.

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