DEVELOPMENTS IN COMMUNITY NURSING WITHIN PRIMARY HEALTH CARE TEAMS

PART II A review of the literature 1974 - 1982

by

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CONTENTS

SUMMARY

In this part of the Report on developments in community nursing, published material (in the period 1974 - December 1982 inclusive) and in particular those involving health visitors, district nurses and practice nurses, were examined with the aim of forming a view on areas or innovations where research is called for. (In other parts of the report this view is augmented by information obtained from professional bodies and chief nursing officers of districts.)

In this literature search, which included published registers of research in progress, we identified several areas where developments do not appear so far to have been sufficiently evaluated or alternatives explored. These areas are:-

1. Organisation of community nursing.
2. Community evening and night nursing services.
3. Provision of primary care aides (i.e. persons providing both domestic and personal help to patients).
4. The roles of health visitors and district nurses.
5. Nurses working in the treatment rooms/surgery premises.
6. Schemes to keep patients in the community as much as possible.
7. Regular screening of the elderly by community nursing staff.
8. The consumer viewpoint.

Generally whilst the literature search suggested that a wide variety of schemes had been tried out, formal evaluations were uncommon. Most commonly schemes were described and impressions about their effects were reported; anything approaching a controlled trial was extremely rare.

The literature revealed little evidence of attempts to appraise standards of care in schemes implemented. Also there was no evidence of a concerted attack directed at particular issues; most studies and schemes seemed to take place in isolation from those of other innovators.

INTRODUCTION

The terms of reference of this project as a whole are as follows:- 'The purpose of the proposed project is to identify, describe, and assess schemes involving developments in community nursing services, including in particular new approaches to co-operation between general practitioners and nurses in the provision of primary health care. The emphasis would be on schemes arising since 1974 or not already covered in existing reviews such as 'Primary Health Care: a review' by Donald Hicks (1976) and would aim to cover all schemes within the above terms of reference, not only published work or those which were (or are) the subject of some research investigation.'

In this report we confine our attention to developments concerning health visitors, district nurses and practice nurses. We concentrate on published material on developments which were either within the primary care team or sufficiently closely associated with primary health care teams in our judgement to justify inclusion. We have also included a few 'unpublished' items where these seemed especially relevant.

METHODS USED FOR LITERATURE SEARCH

Several methods were used to try to obtain a comprehensive survey of the literature from the beginning of 1974. This report reviews literature published up until the end of December 1982.

1. Certain journals and magazines were searched issue by issue from the beginning of 1974. These journals are listed below. A few issues were missing from the libraries used and needed to be searched for further afield.

   British Medical Journal
   Community Development Journal
   Family Practitioner Services
   General Practitioner
   Health and Social Service Journal
   Health Bulletin
   Health Visitor
   Lancet
   Journal of Advanced Nursing
   Journal of Community Nursing (now Journal of District Nursing)
   Journal of Epidemiology and Community Health - formerly
   British Journal of Preventive and Social Medicine
   Journal of the Royal College of General Practitioners
   Midwife, Health Visitor and Community Nurse
   Midwives Chronicle
   Nursing
   Nursing Focus
   Nursing Mirror
   Nursing Times
   Public Health
   Pulse
   The Practitioner
   Practice Team
   Royal Society of Health Journal
   Update

2. Lists of current literature were searched from 1981 onwards, including Nursing Research Abstracts, Health Services, and General Medical Practice (which are all produced by the D.H.S.S.), the R.C.N. Nursing Bibliography, and the King's Fund list of additions to the library.

3. Articles obtained in the above searches, and books and pamphlets acquired for the project have been in turn searched for any references they gave. This 'trawl' produced relevant items not found in earlier searches.

4. A search using 'Medline' was made and yielded a number of relevant items but only a few were not already in our lists, in particular those in foreign journals.

5. Representatives of professional organisations who were consulted in connection with the project made suggestions about items to include.

THE CONTEXT IN WHICH PRIMARY HEALTH CARE TEAM DEVELOPMENT TOOK PLACE IN THE PERIOD 1974-1982

Introduction

This period largely coincides with that which began with the coming into being of the reorganised National Health Service in April 1st. 1974, extending to the same date eight years later when the 1982 restructuring of the National Health Service took effect. However, primary health care team developments in this period need to be seen in the context both of what happened in the years before 1974 as well as in subsequent years.

Attachment of the community nursing staff to general practitioners

Hicks (1976) reported that by 1973 about 75% of community nurses in the National Health Service were attached to general practitioners and that the number of district nurses and health visitors so organised was increasing steadily. Although there was an apparent absence of scientific evaluation of attachment schemes and some reservations about its costs and benefits especially for health visitors, the assumption was that attachment was here to stay and was desirable. However by 1981, the report of the Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (The Harding Report, 1981) of the primary health care team stated 'nurse attachment to general practices are increasingly being reviewed and in the last two years or so a number of health authorities particularly in urban areas have reverted to a geographical pattern of working'. The report suggests various reasons for an apparent growing disenchantment with attachment. These included:shortage of nursing staff; the need to provide a nursing service to the whole community, requiring a degree of geographical nurse cover, particularly in areas with a high mobility of population; and the fact that the success of earlier attachment schemes had much to do with their being implemented in areas particularly well suited to attachment by virtue of the existence of group practices serving geographical areas and enthusiastic about primary health care team work which obscured the fact that attachment could in other circumstances be less effective. Both this report and others in commending attachment, at least as an ideal, emphasise the importance as far as possible, of zoning general practice attachment areas so that matching geographical

areas for general practitioners and attached community nurses would exist. This would avoid the situation sometimes found in inner cities, whereby numerous practices and attached nurses served patients in the same tower block (see the report of the Study Group on Primary Health Care in Inner London (The Acheson Report, 1981) for example).

Hicks (1976) was able to offer a straightforward definition of attachment (namely 'schemes in which a health visitor or home nurse is responsible for providing services to all patients on lists of all specified general practitioners with whom she has regular consultations. She is not limited to working in a geographical district'). However by 1981 it was argued that attachment needed more precise definition and/or could take various forms with the result that it was sometimes no longer agreed by all the professional parties involved as to whether or not community nursing staff were in fact attached to some practices. (See e.g. Hughes & Roberts, 1981) The Harding Report on the Primary Health Care Team (1981) argued that more attachment for community nursing staff did not imply effective team work though it would probably help, while it was possible that in some circumstances effective team work could take place in the absence of attachment. Thus by the end of our period attachment was being questioned as the most effective means of organisation in some circumstances, both for district nurses and for health visitors.

The Appendix to Circular CNO(77)8, Nursing in Primary Health Care, sets out the conditions in which attachment schemes will lead to team work and also the adverse conditions where team work will not have the highest priority. The G.M.S.C. has supported attachment of health visitors and district nurses and has reservations about the zoning of practice catchment areas, (British Medical Journal, 1981, p.1557 and British Medical Journal, 1980 p.166).

From Home Nurse to District Nurse

The National Health Service and Public Health Act of 1968 had enabled District Nurses to work in clinics and not just in patients' homes. This opened the way to the development which Hicks (1976) noted, that by 1973 about half of the contacts recorded by the district nurse with patients took place in treatment rooms of health centres and other primary health care premises. In order for this development to take place, of course, it was necessary that there should be suitable clinical accommodation in which district nurses could work and one

consequence of the implementation of the Charter for the Family Doctor Service, (1965) was to encourage doctors to work in health centres and other similar premises where such accommodation could be provided. Indeed it seemed at this time that the district nurse would be a natural, if not the only (see below),provider of care in the treatment room of the health centre or general practitioner's premises.

Practice Nurses

The implementation of the Charter for the Family Doctor Service (1965) also facilitated the employment by general practitioners of practice nurses in that it allowed for 70% reimbursement of cost of salaries of up to two full-time staff to each practitioner and such staff might be those with nursing qualifications. However as the attachment of district nurses to general practitioners became wide-spread within the National Health Service and they were enabled to treat the patients elsewhere than in patients' homes, it seemed possible that district nurses might largely if not wholely replace practice nurses on the grounds that the general practitioner incurred no cost in the case of district nurses attached to his practice. However there is evidence that practice nurses were if anything becoming more numerous as time went on. (See page 13). Various reports expressed concern about relationships between practice nurses and health authority employed community nurses (see the Harding Report, 1981, for example) and tended to suggest that it would be desirable in the long run for practice nurses to be phased out while not going as far as to suggest that this ought to happen immediately. In contrast the G.M.S.C. was committed to the position that the direct employment of nurses by general practitioners themselves should be encouraged, (British Medical Journal, 1981, p.1557).

Management Arrangements for Nurses in the National Health Service

The Report of the Committee on Senior Nursing Staff Structure (Salmon) in 1968 had led to the establishment of a relatively elaborate nursing management structure in hospitals and this had been followed by the Report of the Working Party on Management Staff Structure in the Local Authority Nursing Service (Mayston, 1969), recommending a similar though simpler structure for community nurses. However it really needed the 1974 reorganisation of the National Health Service, as a result of which a unified management structure for all nurses came into being, to bring out the full implications of such a hierarchy for community nursing. This had significance for their professional autonomy and professional relationships within the primary

health care team. For better or worse, the Nursing Officer was an interested party in, but not a member of, the primary health care team. She had management responsibilities which included supervising the attachment of her subordinates to general practitioners in relation to the overall goals of the nursing services within the locality for which she was responsible. This sometimes led to difficulties as the Harding Report (1981) observed 'for example it was said that

i) senior nurses were on occasion redeploying nursing staff and in some cases had terminated attachments without consulting beforehand general practitioners and nurses involved;

ii) nursing staff were being redeployed on a temporary basis to provide for colleagues away sick, on holiday, or on training courses, at very short notice so that other members of the team had insufficient time to rearrange their working schedules to take account of their colleagues' absence;

iii) that there were sometimes difficulties arising out of conflict between health authority policy and the general practitioner's expectation of what a nurse should do; for example in the fields of vaccination and immunisation, and of family planning.'

Elsewhere the same report recommended that 'constraints that place limits on the range of duties which health authority employed nurses may undertake should be subject to periodic review by health authorities in consultation with local medical committees along with any other factors which might prevent attached nursing staff working alongside general practitioners in surgery-based treatment rooms.' Thus it appears for good or ill the existence of a managerial hierarchy within the community nursing service did enable health authorities to exercise a greater degree of control over attached community nursing staff than perhaps was the case prior to the reorganisation of the National Health Service in 1974. Though the quotations given tend to see this increased control in a negative light, it did also enable the community nursing service to negotiate with general practitioners on more equal terms than was perhaps previously the case when district nurses and health visitors were operating as more autonomous but isolated individuals.

The 1982 restructuring of the National Health Service, (see the Circular HC(80)8, entitled 'Health Service Development Structure and Management') endorsed and continued with the principles underlying the organisation of nursing established at the 1974 reorganisation. As far as primary health care services were concerned, however, there was some anxiety at the possibility that there would not be distinct community units, but rather that these services would be linked in with other services in units based on, for example, geographical territories. Thus for example, the British Medical Association Conference, July 1982, supported a motion that community services 'should be encompassed by a single community care unit on which the general practitioner should be represented as of right'. (Health & Social Service Journal, 1982), and the Royal College of Nursing in May 1982, drew the attention of family practitioner committees 'to the commitment of the major nursing organisations to a structure that has a separate unit for community nursing services in the reorganised National Health Service.' (British Medical Journal, 1982)

Higher and Further Education in Nursing

The management structure for nursing adopted in the 1974 reorganisation of the National Health Service was a sign and a means of giving practical effect to the enhanced status of nursing within the service - as an important function closely related to medicine but managerially and to a degree philosophically independent from it. Another sign of and factor promoting the enhancement of nursing status was the emergence of University and Polytechnic Departments of Nursing producing nurses who were graduates, in some cases possessors of higher degrees. The first University Department of Nursing Studies had been set up in 1956 in the University of Edinburgh offering courses leading to a degree in Social Science and Nursing and gradually other universities followed suit so that by 1979 there were ten schemes leading to a University degree in Nursing, (and others for a C.N.A.A. degree) plus registration. (Baly, 1980). It takes time for a sufficient number of nurses so trained to come off the production line and to form a 'critical mass' which was substantial enough to effect the way in which the profession perceived itself and was perceived. That such a critical mass was achieved in the years soon after 1974, was suggested by the founding of the Journal of Advanced Nursing in 1976 with a style and content which specifically proclaimed its intention to be numbered with the learned journals rather than with the professional magazines. The concept of the 'nursing process' though not new, was something that fitted in naturally

with the post-1974 nursing structure in the National Health Service and with the emergence of nursing as an academic discipline. For the nursing process is a practical realisation of the idea that nursing is a specialised and scientifically oriented activity which medicine must use in much the same way as it calls on the services of natural scientists to undertake laboratory tests.

A characteristic of science generally and manifested within medicine in particular is increasing specialisation and as nursing has emerged as a distinct discipline, so 'it is now accepted that some nurses by studying and research can develop special skills in aspects of nursing, for example, terminal care, stoma care and oncology, and that such nurses can be used to advise their colleagues both in hospital and community and to play a part in teaching other disciplines.' (Baly, 1980).

Evidence of developments in this direction included the setting up in 1970 'after much pressure from the Royal College of Nursing', the Joint Board of Clinical Nursing Studies (Baly, 1980) which 'has introduced a range of post basic clinical courses, of a nationally approved standard'. (R.C.N. 1976). Moreover the Royal College of Nursing put forward the concept of the clinical nurse specialist/consultant in its evidence to the Committee on Nursing (Briggs) in 1971. A working party of the Royal College of Nursing, set up for the purpose of identifying the role of the clinical nurse consultant, establishing its relationship with other persons in the health service, and preparation for this role, submitted its findings to the Committee on Nursing as supplementary evidence. A subsequent publication 'New Horizons in clinical nursing', (the report of a seminar held at Leeds Castle in 1975 under the auspices of the Royal College of Nursing, (R.C.N. 1976) ranged over a number of aspects of developments of the nursing role drawing a distinction between the clinical nurse specialist and the clinical nurse consultant - 'the clinical nurse consultant role was the ultimate in clinical nursing requiring knowledge in breadth as well as in depth even though clinical expertize might be related to one specialty. A clinical nurse specialist role could be identified, of a more limited nature but, nevertheless of significance in advancing the contribution of the nurse in the care of patients in a particular specialty or with particular needs. Other roles developed by nurses were of an even more specialist nature and might not necessarily require a nursing base on which to build, e.g. the nurse therapist role'. (See also page 20 of our Report)

The increasing complexity of primary health care, in the relevant clinical and social spheres has led to the conviction that personnel should be given appropriate training before they become fully accredited operators within this field. Thus in the case of medicine,a period of training has now become mandatory (in effect from February 1981) before a doctor can become a principal in general practice and likewise it has now become mandatory (in effect from autumn 1981) for district nurses to complete a period of training before they may enter this branch of their profession, as it is already in the case of health visiting.

Health service priorities and the limits and costs of medicine

Scientific medicine as a dominating and all conquering force in the restoration and preservation of health, came under attack from writers such as Illich (see e.g. Illich 1976). Nursing was largely exempt by its nature from such criticisms. Moreover as the seventies wore on, priorities within the National Health Service were increasingly centred on groups such as the frail elderly, the mentally ill and the mentally and physically handicapped (D.H.S.S. 1976 and 1977) - areas where medicine could offer relatively little by way of cure and where self evidentally the contribution of carefully planned and organized and compassionate nursing care was at least as important. Particularly in the case of the elderly, the priority rose largely because there was a steadily increasing need for care for such people as more and more of the population were aged 75 years or more.

There has also been a trend in policy towards 'community care' interpreted broadly as the shifting of care of patients where possible from hospitals to institutions in the community or to patient's homes (e.g. D.H.S.S. 1976 and 1981). Such a trend clearly has implications for caring professions in the community such as community nurses. This was explicitly recognised (in D.H.S.S. 1976) in recommending a fairly rapid increase in the numbers of district nurses and health visitors. (A growth rate of 6% per annum was proposed).

Scientific medicine came under attack as to its efficacy at a time when its costs were escalating to an extent which caused concern to even the wealthiest nations. Hence there has been a revived interest in health education and self care, the former being an area in which health visitors

have been particularly concerned. There is a paradox that the most highly trained and costly health service personnel (i.e. doctors), had a very limited opportunity for the provision of health education given their present roles and numbers within the National Health Service.

Questions of cost and availability of trained doctors have led to the emergence in developed and developing countries throughout the world of new types of health personnel intermediate in role between doctors and nurses, as traditionally viewed, but with a background arguably closer to that of the nurse as a rule. Hence for example the emergence of the 'bare foot' doctor in China on the one hand and the nurse practitioner/ physician's assistant in the United States of America. This development in the U.S.A. had received attention in the literature from the late 1960s onwards and Hicks (1976) drew attention to a model evaluative study comparing doctors in a group practice in Burlington with nurse practitioners (Spitzer et al., 1974). We shall return to this study in a later section of the Report and at this stage will only note that interest in these developments persisted in the United Kingdom (see for example Reedy, 1978), but as yet very few experiments with this kind of development have been noted in this country. (See page 79 referring to the work of Stilwell).

One of the central issues in the development of an extended role of this kind is whether, if at all, such practitioners could prescribe drugs etc. That it was reasonable for a nurse to do so, within appropriately defined limits, was suggested by the existing practice of midwives. (See also the Royal College of Nursing report of a working party of the R.C.N. Family Planning Nurses Forum, Nurse prescribers of oral contraceptives for the well-woman (R.C.N., 1980) where it was proposed that family planning nurses should so prescribe).

Membership of the E.E.C. and the World Health Organisation

The period covered by this review coincides with most of the period during which the United Kingdom has been a member of the E.E.C. There has been some direct impact from E.E.C. membership, for example as member nations move towards mutual acceptability of one anothers medical and nursing qualifications. One consequence of this has been the definition of a practising nurse which could exclude some practising health visitors (Nursing Directive 77/452/EEC). Membership of the E.E.C. has arguably had a more general effect of causing organisations in health services as in other spheres of life to adopt a European perspective. The World Health

Organisation offers another framework for discussions and planning of health services and health care problems at an international level and within this context issues relating to the community health services are the subject of certain of these activities. One report we discuss later (see page 38) serves to illustrate the arguably greater tendency for health care matters to be discussed at international level. It would be wrong to suggest that either the E.E.C. or W.H.O. were already exerting a profound effect on the day-to-day running of community nursing activities but it does offer the innovator in this field a rich and diverse range of experience upon which to draw for ideas and to which to appeal in justifying developments.

Care of the dying

In recent years, there has been a growing awareness of the particular needs of the dying patient and his family. Research has been done in this area and there have been developments in the provision of services for the dying, such as hospices and the funding of 'Macmillan' nurses. The provision of services for the dying in the National Health Service has been summarized by Ford & Pincherle (1978). Although the majority of deaths take place in hospital (about 59% in N.H.S. hospitals) inevitably much care of patients still takes place at home, and consequently places demands on the community nursing and medical services.

Apart from the general policy now current of keeping patients - of all categories - in the community and out of hospital wherever possible, it is felt that many dying patients would prefer to die at home, or to spend as long as possible at home even if hospital or hospice admission may be intermittently or finally necessary. This view - that patients probably prefer to be at home as much as possible - was held in the Report of a Working Group on Terminal Care of the Standing Sub-committee on Cancer (1980). The Group recommends that district general hospitals give expert advice in care, for instance by having teams which are hospital based or go into the community. Similar advice should be given from hospices where these exist; however there are currently only 60 or so hospices in existence which can provide at most about 7% of the beds needed for dying patients, (Lunt, 1982). If more patients are cared for at home, the Group recommends increasing community nursing establishments and involving voluntary organisations to help with supplying more specialist nurses and supporting services in the community.

Numbers (whole time equivalents) of community nurses and workload of district nurses and health visitors

Trends in the strength of the work force and the magnitude of the workload of community nurses must inevitably have some bearing on thinking about developments in their role in the primary health care team.

Superficially at least the numbers of whole time equivalents of district nurses and health visitors have both shown substantial increases in the period from 1974 to 1979 and for a number of years before that. Thus the Chief Nursing Officer in her report 'Nursing 1977-80 (1981)' reports a 17.8% increase in the number of whole time equivalents of district nurses (i.e. SRN and SEN with and without district training) from 11,665 to 13,738 in the period 1975 to 1979*. There was a 51.5% increase in the period 1971 to 1979*. The number of whole time equivalent health visitors increased by 17.3% in the period 1975 to 1979* from 7,655 to 8,983. (53.3% in the period 1971 to 1979*). These figures were for England only but those quoted in the report of the Royal Commission on the National Health Service (1979) for Great Britain over the period 1967-1977 reveal a very similar picture. The increase in district nursing numbers in the period 1975-1979 is almost entirely accounted for by increases in the number of SRNs and in particular SENs (in both cases whole time equivalents) with district training. Moreover the increase in the number of ancillary staff (w.t.e.) employed in support of district nursing services during this period was 50%, i.e. from just over 2,000 to just over 3,000. (D.H.S.S. Primary Health Care Service Statistical tables 1975-79). The 17% increase in the number (w.t.e.) of health visitors between 1975-1979* was of course by definition staff qualified in health visiting. However the number of supporting staff to health visitors in the community health services (as distinct from the school health services) was relatively small and static. The number of practice nurses was estimated as 650 (w.t.e.) in 1975 (D.H.S.S.,1975, see page 19 of our Report) and 1,100 in 1982 (D.H.S.S., 1982)

As to nurses entering training for community nursing, the Chief Nursing Officer (1981) expressed disappointment at the continuing decline in the number of candidates entering health visitor training. Entrants to district nurse training (SRN and SEN combined) were fewer in the years 1977-80 than in the preceding three years. (Harding Report, 1981). (However in this period major changes in the pattern of district nurse training were under discussion and such training was not at that time mandatory).

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* Numbers from 1975 onwards include senior grades at area/district level.

In discussing manpower levels in community nursing, account has to be taken of the reduction of the working week to 37½ hours from 40 hours with effect from April 1981.

The workload of district nurses and health visitors as measured by the number of cases attending, showed very different trends over the last decade (C.S.O. 1982). In the case of district nurses, the number of cases treated increased three-fold in the period 1971 to 1980 (from 1,265,000 in 1971 to 3,765,000 in 1980). The distribution of cases attended by age group had changed in the decade in that by 1980 the proportion of cases attended involving persons aged 65 and over was lower and that involving persons aged 5-64 years higher than in 1971. There was also a slight increase in the proportion of those aged under five, among cases attended by district nurses. The net effect was that in 1980 compared with 1971, district nurses were treating five times as many cases among those aged less than five years and twice as many cases among those aged 65 years and over.

. By contrast the workload in terms of cases attended by health visitors had declined from 5,158,000 in 1971 to 4,603,000 in 1980, though in fact the figures suggest a slow but steady increase from 1976 to 1980. The proportion of health visitors' cases that involved those aged less than five years was lower in 1980 than in 1971, but still made up 60% of their cases attended. The proportion of cases attended involving persons aged 65 years and over was 13% in 1980 compared with 10% in 1971, and it did appear that there was a steady increase in the proportion of persons attended in the age group 17-64, at least in the period 1976-1980. The net effect of this in terms of actual numbers of the cases attended is that health visitors were attending fewer cases involving patients aged 65 years and over in 1980 compared with 1971 and indeed 1976 and they were of course attending fewer children under five years. These trends have to be seen in the context of the falling birth rate and an increasing number of over 65 year olds in the population. The population overall of England remained virtually constant in the period 1971-81. (C.S.O. 1982).

D.H.S.S. AND PROFESSIONAL POLICY STATEMENTS, AND REPORTS CONCERNED WITH THE DEVELOPMENT OF COMMUNITY NURSING

Introduction

That primary health care teams are, or ought to be, the natural providers of primary health care and to be encouraged in normal circumstances is something almost universally agreed by the D.H.S.S. and the professions; and it is generally agreed that community nurses with general practitioners form the core of such teams. It is not in dispute either that greater demands will be continually placed on primary health care providers in the context of a growing population of frail elderly, the need to improve ante-natal care and care of the new-born together with a generally accepted policy of returning patients and clients from hospital acute or long-stay facilities as soon and as far as is practicable.

Thus we turn our attention to more detailed and specific statements which relate to the work of community nurses in the context of primary health care teams.

D.H.S.S. policy on the function of the health service as it affects primary health care services

Priorities for Health and Personal Social Services in England, (D.H.S.S. 1976)

This proposed that district nurses and health visitor numbers should increase at the rate of 6% per annum. In the case of district nurses this was to provide care for the increasing number of elderly people in the community and also to enable children to be treated as far as possible in their own homes rather than in hospital, and to look after the younger physically handicapped outside hospitals. In the case of health visitors the increase was to allow for improvements in child health and welfare and to give support to mothers and particularly to protect the health of the most vulnerable children in the community. (Health visitors were stated to have a crucial role in the prevention of non-accidental injury to children). It was also to assist in the care of the increasing number of elderly in the community.

The Way Forward - Priorities for Health and Social Services (D.H.S.S. 1977)

This restated the Government's intention to increase expenditure on health visiting and district nursing services by 6% per annum. In an Appendix on 'More effective uses of N.H.S. resources', examples among those quoted were

> 'the time that community nursing staff spend on professional duties can be increased where general practitioners practise within defined geographical areas'
>
> 'the introduction of a community night-nursing service allows patients who are terminally ill or might otherwise require hospital beds, to remain at home. Where such a service is operating it might be hospital based in order to fully utilise nursing time and improve communications.'

Care in Action (D.H.S.S. 1981)

This document was produced by the Conservative Government while the two above were the products of a Labour Administration. It reaffirmed Government support for a strong primary health care service to include early detection of illness, swifter treatment to prevent deterioration, care of people in the community rather than hospital and drawing on the resources of the family, neighbours and voluntary groups rather than over-reliance on the services of full-time professionals in hospitals. In particular it stated that more health visitors and district nurses were needed in many places and that authorities should aim to increase secondments for training. In an Appendix under the heading 'Early Discharge Schemes, Day Surgery and Other Developments', it stated that there was some evidence that more district nursing functions might be performed by less highly qualified members of the team and also that there may be some overlap between the services provided by the district nurse team (particularly the nurse auxiliaries) and the home helps provided by Social Services Departments. It suggested that these issues raised questions which merited further studies about the organisation and operation of the district nursing team and the lack of relationship between these teams and home help services.

Selected documents published by the Government, the D.H.S.S. or by professional bodies

Primary health care teams (B.M.A. 1974) - report of a Panel of the Board of Science and Education of the British Medical Association

This report saw the development of primary health care teams of a suitable size (facilitated also by the movement from single-handed to group practice by general practitioners) as allowing improved comprehensive care both by day and by night. Continuity of care was seen as care for the patient and the patient's family by one or other member of the same primary health care team, even though the choice of doctor would remain an essential right of the patient as between the general practitioners in the team. It saw the attachment of the community nurse to general practitioners as vital so that these staff would serve populations defined not by geographical district but by patients on the doctor's list. (However elsewhere the report does state that as far as possible overlap between neighbouring teams should be avoided). The report noted that the nursing functions formed three categories at present represented by the health visitor, the midwife and the district nurse (it did not consider practice nurses). The panel was divided as to whether curative and preventive functions could be combined in the same nurse. New training structures which were evolving were expected to reallocate functions between registered and enrolled nurses so that each would carry out the functions most appropriate to her abilities. Each should be trained more specifically for a community role. The panel considered that the general practitioner was, to some degree concerned in all aspects of primary health care and would therefore act in an advisory and consultative capacity when necessary within the team. In the clinical sphere he takes the ultimate responsibility, but all members of the team are free to initiate and are responsible for activities within their own fields.

In certain defined areas, the report concluded, that with appropriate training, registered nurses could undertake patient assessment and counselling and in certain circumstances the initiation of therapy. Further study in this area was recommended, in particular a controlled trial to compare primary health care teams where the nurse makes independent decisions in certain areas with those teams where she does not. It was noted that the midwife already took such independent decisions within her own sphere of competence. The report discussed the possible introduction of a 'non-professional grade - an assistant to the physician' under the general

heading of 'Medical Assistant (Feldscher, Medex, Nurse Practitioner, etc.)' but concluded that in the United Kingdom there was no immediate necessity for such a grade. The overlap between the duties and functions of the health visitor and those of the social worker was noted to be considerable and it was suggested that the training of both professions should reflect the complementary nature of their respective skills and functions so that harmonious relationships were built up within the team for the benefit of the patient.

Nursing in general practice in the reorganised National Health Service - the report of a Joint Working Party of the Royal College of Nursing and The Royal College of General Practitioners (1974)

This report confined itself to considering district nurses and enrolled nurses employed by Area Health Authorities who worked mainly in the homes of patients, and nurses employed by general practitioners. It noted that despite the widespread development of schemes of attachment of health authoritity employed nurses in general practice, practice employed nurses also appeared to be increasing, and it pressed for the integration of general practitioner employed nurses into the nursing team so that they shared cover as far as possible and were not seen as competing agencies; and also so that they had the same access to educational opportunities as health authority nurses.

The report specifically recommended the establishment of evening and night nursing services in the community as a means of ensuring continuity in the provision of nursing services. It gave guarded approval to the extending of the nurses' role by taking on some of the tasks seen hitherto to be in the province of the general practitioner. It emphasized the importance of such tasks being allocated only to suitably competent and mature nurses and the need for further training both for such work in the treatment room and for work in the patient's home which the committee thought had distinctive characteristics. The committee distinguished between the straightforward 'triage' function (sorting the patients into those whom the nurse can treat and those who should be referred to the doctor) and the process of 'differential diagnosis'. The need for the evaluation of any extension of the nurses' role was emphasized. The report urged that all nurses working in general practice should be able to recognize serious psychiatric morbidity and emotional disturbances and know how to deal most appropriately with this kind of problem. In several places the report drew attention to the importance of having a nursing perspective on the planning of premises and services and in the formation of practice policy.

Nurses employed privately by General Medical Practitioners (Practice Nurses), STM(75)13 (D.H.S.S. March 1975)

This contained the following information and advice on practice nurses:-

'1. As health authorities may be aware, a number of general medical practitioners providing general medical services employ qualified nurses to assist them in their work. They are usually referred to as 'practice nurses' and are employed mainly within the practice premises or health centres although they may visit their employers' patients in their homes as requested. They often work alongside district nurses and health visitors who form part of the primary health care team. The number of practice nurses in England at present is about 650 (WTE) compared with a total field force of 10,200 (WTE) home nurses. In addition there are some practice nurses who combine nursing with other duties, e.g. receptionist.

2. The effect which the development of primary health care teams will have on the role of the practice nurse and the numbers likely to be employed is not yet clear and consideration of long-term training arrangements required must depend on how the role develops. In the meantime it is desirable that facilities should be available for the refresher training and updating of professional knowledge of the practice nurses employed at present. As part of these arrangements area health authorities who provide in-service education and training for their own community based nurses are asked to consider inviting practice nurses in their area to participate, without charge, including visits of observation etc. to hospitals and other institutions. Suitable forms of education and training would include short courses on specialised topics or techniques, lectures, seminars, discussion groups and periodical staff conferences. Attendance of particular nurses would, of course, be subject to approval by their employers.

3. Travelling and other expenses would be the responsibility of the practice nurse and her employer and it is expected that she would continue to receive her normal salary during the short periods of absence. Area health authorities are asked to bring this Memorandum to the attention of their Family Practitioners Committees and notify them of what facilities are available so that they may in turn inform general medical practitioners in their area who employ practice nurses.'

New Horizons in Clinical Nursing, Royal College of Nursing of the United Kingdom (1976)

We have already mentioned this report on page 9 as being particularly concerned with the development of the clinical nurse specialist/consultant. In Appendix A of this report, relevant extracts of the Royal College of Nursing evidence to the Committee on Nursing (Briggs) are listed. This is concerned with post basic nursing education and career progression. Here there is a section of nursing in the community setting as follows:-

'The nurse who opted to work in the community setting would be required to obtain the post basic credit or credits relevant to community nursing, the course of training required for the health visitor and that required for the district nurse would both come under this head. The nurse would then be equipped to practise in the community as a member of the community health team. All those services at present provided within the community by persons required to hold a nursing qualification are included in the term 'community nursing', and all persons so qualified would be members of the 'community health team'. It is considered that the desirable organisation of community work is that of the group practice team and further that there is need for an increase in the number of health centres on which these teams would be based.

Specialisation is not the prerogative of institutional care; it applies also in the community service. Nurses working in the community not infrequently specialise in a particular type of work and are recognised as capable of advising their colleagues in relation to this specialty. This advanced expertize should be supported by further studies to be defined, and recognised posts should be created at a consultant level. These would parellel the development proposed in the institutional setting.' The development proposed was 'that the full contribution of the nurse/midwife as a clinical expert of a high order must be further exploited by identifying a career for her in clinical nursing. This would take the form of creating posts for 'clinical nurse consultants' who would work alongside medical consultants. The 'Cogwheel' division structure opens up the way for such appointments. Eligibility for these posts would require the possession of qualifications at an advanced level: the diploma in nursing would be an appropriate qualification and others might well become available. One of the avenues of progression to the post of 'clinical nurse consultant' in an institutional setting would be from the post of ward sister of a designated teaching area as described above. Needless to say the post of 'clinical nurse consultant' should attract salary recognition consistent with the level of responsibility and the high degree of expertize inherent in it.'

Health Services Management - Vaccination and immunisation - Involvement of Nursing Staff HC(76)26 (D.H.S.S. May 1976)

The purpose of this circular was to clarify the role of nurses in vaccination and immunisation programmes. It stated that authorities should aim to involve nursing staff and vaccination programmes to the extent which best promotes in their local circumstances the objectives of such programmes, vis. to achieve maximum acceptance of recommended vaccines at recommended intervals by those members of the population who would benefit while ensuring all necessary safety precautions such as the scrupulous observance of contra-indications.

A doctor engaged in clinical medicine is responsible for all vaccinations, i.e. for the decision as to the suitability of the patient, the appropriate vaccine and its safe administration. While retaining that responsibility, he may delegate all these aspects to a nurse who is willing to be professionally answerable for this work, and who has been approved for the purpose by the employing authority. The delegation may cover an individual patient or a specifically defined group of patients provided that suitable policies and definitions have been drawn up and agreed in advance.

Fit for the Future: the Report of the Committee on Child Health Services (The Court Report, D.H.S.S. 1976)

The report proposed that within the community nursing service, there should be a distinct group of nurses called child health visitors (C.H.Vs.) who would have preventive and curative responsibilities for children (under 16 years) and advisory responsibilities in respect of their parents, and who would work in close association with general practitioner paediatricians (general practitioners who would have a special interest in and training in paediatrics). C.H.Vs. would at least initially be drawn from the ranks of the existing health visitors but would however require additional training. The report envisaged that the C.H.Vs. would be assisted by child health nurses who would have paediatric training. Thus this report was in a sense adopting a McKeownist approach to nursing care identifying one group of nurses as being responsible for the preventive and curative nursing care of those under 16 years of age and (by implication, though this was not the function of the report) other groups of nurses similarly concerned with other age groups.

Nursing in primary health care. Appendix to CNO(77)8 (D.H.S.S. June 1977)

This paper represented an updating of guidance in the light of the report of the Court Committee (D.H.S.S., 1976) (see page 21 of our Report) and the consultative document 'Priorities for Health and Personal Social Services in England', (H.M.S.O. 1976) (see page 15 of our Report) which in particular gave emphasis to the encouragement of the development of primary health care teams.

It states that experience has shown that where health visiting and district nursing staff have been attached to general practice and have developed co-operative patterns of working, with each discipline providing its own specific skills, the quality of service to individual patients and to families has improved. It has been possible to develop preventive and educative services as well as meeting the clinical needs of the practice population. Communications between the various members of the primary health care team and between the primary health care services and other National Health Service and local authoritity and voluntary services have also been improved, it is asserted.

The attachment of nursing staff to general practice was seen as desirable but not of itself sufficient to create effective primary health care team work. The participants in the team have to be sufficiently knowledgeable and motivated if effective team work is to take place.

The paper identified certain circumstances where the development of primary health care teams does not assume the highest priority. Namely

'a. where the numbers of nursing staff employed (by the health authority) are insufficient;

b. where general practitioners do not accept this concept of care;

c. where there is a predominance of single handed general practitioners

d. where it is impossible to provide adequate accommodation to enable staff of different professions to work from the same premises;

e. where there is considerable overlap of the geographical areas covered by general practitioners;

f. in inner city areas where there are special health and social problems

Where these conditions apply, however, the development of appropriate patterns of co-operative working remains nevertheless a high priority.'

The roles of various kinds of community nurse are then defined and in particular we quote those on the nurses relevant to this report, namely the health visitor, the district nurse, treatment room nurse and practice nurse.

'The Health Visitor is a family visitor and an expert in child health care. She is trained to understand relationships within the family and the effects upon these relationships of the normal processes of growth and ageing and events such as marriages, births and deaths. She is concerned with the promotion of health and the prevention of ill health through giving education, advice and support, and by referring to the general practitioner or to other N.H.S. or statutory or voluntary services where special help is needed. The health visitor is a professional in her own right, and she initiates action on behalf of her clients and refers to other agencies as she considers appropriate. She makes a very special contribution by visiting families who may have no other regular contact with health services, or who may be visited by no other voluntary or statutory worker, so that she alone may be in a position to identify physical, mental or social illness or family breakdown, and to alert others as appropriate. She is the leader of a team which may include SRNs, SENs and nursing auxiliaries working in schools or clinics. The scope for the employment of supporting staff, and the nature of the tasks which the health visitor delegates to them, will vary according to the needs of the population she serves.'

'The District Nurse is a SRN who has received post basic training in order to enable her to give skilled nursing care to all persons living in the community including in residential homes. She is the leader of the district nursing team within the primary health care services. Working with her may be SRNs, SENs and nursing auxiliaries. It is the district nurse who is professionally accountable for assessing and re-assessing the needs of the patient and family, and for monitoring the quality of care. It is her responsibility to ensure that help, including financial and social, is made available as appropriate. The district nurse delegates tasks as appropriate to SENs, who can thus have their own caseload, but who remain wholly accountable to the district nurse for the care that they give to patients. The district nurses is accountable for the work undertaken by nursing auxiliaries who carry out such tasks as bathing, dressing frail ambulant patients, and helping other members of the team with patient care.'

'Treatment room nurses are employed by some A.H.As. These nurses undertake a wide variety of treatments in health centres or general practice premises. In other A.H.As. the district nursing team undertake these tasks as well as their domiciliary work.'

'Some general practitioners employ nurses on nursing and/or reception duties, and these are known as practice nurses. They may work alongside A.H.A. employed nurses who are attached to the practice, but seldom undertake work outside the surgery premises. They may be included in training programmes organised by the A.H.A.'

The paper states that 'developments such as early discharge from hospital or day surgery will have implications for primary health care, meaning for example the importance of establishing a 24-hour nursing service in order to provide continuity of care. They will also increase the need for more effective communications between the specialist and primary health care services. ..... in practical terms this could be achieved by developing direct channels of communication between health visitors and district nurses and the appropriate ward sisters in hospitals. ..... Where nurses with a special knowledge of the care of a particular illness or type of patient (e.g. the physically handicapped, chronically sick children, the mentally ill or the mentally handicapped) work with patients and families in the community and liaise with and advise members of the primary health care team, it is essential that they maintain their expertise, and therefore desirable that they should be based within their specialist field.'

Residential homes for the elderly. Arrangements for health care. A memorandum of guidance. (D.H.S.S. and Welsh Office 1977)

The following items in this memorandum relate to the role of primary health care services, in relation to persons living in residential homes for the elderly:-

'Responsibility for the provision of health care rests in the first instance on the primary health care services which can also contribute to improving the quality of life in old people's homes by way of advice and guidance to residence and staff.'

'When in the opinion of their general practitioners residents require professional nursing care within the home, this should wherever possible be provided by nurses employed by the A.H.A. The nurses will normally be those working with the doctors who attend the residents unless some other local arrangement appears appropriate. In some areas district nurses are already helping care staff towards an understanding of the ageing process and illnesses associated with old age, and where resources permit health visitors may also be involved.'

'Caring for dying residents places extra strain on the staff, and the head of the home should be encouraged to call on the primary health care service for help..... The AHA should endeavour to provide night nurses if necessary either from its own resources or, for patients suffering from cancer, through the Marie Curie Memorial Foundations day and night nursing service. The S.S.D. might also, in suitable circumstances, provide sitters from its own night sitter service.'

In discussing training for residential care staff, it is observed that 'for instance some care staff might join training programmes already been run by the AHA for nursing auxiliaries. Staff of the hospital departments of geriatric medicine and psychiatry, as well as members of primary health care teams ..... might be able to assist in providing the instruction required.....'

'..... it is anticipated that all professional nursing needed in residential homes will eventually be provided by primary health care nurses employed by the AHA. Some health authorities may be hard pressed in attempting to stretch their nursing resources to cover entirely their statutory responsibility to the residents in local authority homes ..... The provision of professional nursing facilities to local authority homes should be regarded by AHAs as a high priority when planning the current deployment of nursing services.'

First Report from the Expenditure Committee 1976-1977. House of Commons Preventive Medicine, Volume 1, Report 1977, HC 169-i

The D.H.S.S. and others, it was reported, approve of health visitors concerning themselves with the old as well as with the young; the Society of Community Medicine felt that people's inclination to seek medical advice from available 'experts' who were not actually doctors, should be turned to account by using health visitors to advise the whole family. Our impression, says the report, from evidence given by the profession, is that informally they already do.

The committee felt that most health visitors still regarded their work with babies and young children as their first priority but 'I find pressures on me to spend time visiting elderly people and I find that more of my time is taken up in clinical sessions, but since those clinical sessions are in the main devoted to the developmental examinations of pre-school children, it is perhaps a proper part of it. I regret the time I cannot spend in people's homes.' Dr. Steiner suggested that one benefit of the lower birth-rate in Aberdeen was an improved service for the elderly by health visitors.

In discussing the fact that most health visitors are now attached to general practice, it was pointed out that this means that the health visitor may no longer have a well-defined area to practice in so that she is no longer a well-known neighbourhood figure. This situation may be alleviated if the health visitor works from a health centre within a well-defined geographical area as the Sub-Committee saw at Thamesmead and generally the Sub-Committee were much in favour of health centres as the best way of accommodating and promoting primary health care teams.

It was suggested by B.U.P.A. that nurses could carry out certain types of screening as effectively as doctors and that other auxiliary staff could also be used more effectively. It was understood from the F.P.A. that there were schemes to use nurses to fit intra-uterine devices. It was pointed out by Dr. Murray, speaking on behalf of the Royal College of Physicians, however, that the employment of auxiliary staff was not necessarily much cheaper than the employment of more highly trained people. This was particularly where the auxiliary could only practice with the fully trained person on hand. This could lead to one or both of the fully trained and auxiliary person being only partially employed.

The report suggests that certain routine screening or checking should be undertaken by the primary health care team. The Sub-Commitee were told that it was very much cheaper to discover say 90% of deafness in children by the use of health visitors than to detect 100% by the use of expensive specialists who had no other functions.

Prevention and Health (D.H.S.S., D.E.S., Scottish Office, Welsh Office, 1977)

This White Paper was the Government's formal response to the report of the Expenditure Committee (1977) referred to above. It endorsed the role of the primary health care team in preventive care. In addition to health visitors' crucial role in relation to babies and young children, the Government also referred to their role (with district nurses) in preventive care of the elderly.

'Health visitors and district nurses can help with advice to the elderly about remaining active and about ways of safeguarding health. Many general practices have record systems which make it possible to identify elderly persons most at risk, for example, those living alone, the recently bereaved, those recently discharged from hospital and the over-75s. Members of the primary health care team can observe the environment as well as the general condition of individuals identified in this way; and it is possible,

without the need for a formal screening service, to detect potential impairments which, if not corrected, could prove difficult to manage later on. Poor vision, impaired hearing, bad dentition, difficulty in walking, mental confusion, depression and incontinence need to be investigated and may require early referral to the appropriate services.'

Health Services Management - The Extending Role of the Clinical Nurse - Legal Implications and Training Requirements, HC(77)22 (D.H.S.S. June 1977)

In the letter accompanying this circular when issued, (CNO(77)9), the point is made that the role of the nurse was continually developing, and that nurses were constantly acquiring new skills to meet new needs. The working party which produced the circular, HC(77)22 was aware that this extension could be in several ways, for example by development within the traditional nursing role, in response to an emergency and by delegation by doctors. However it is where the nursing role is extended by delegation that there was felt to be a need for clarification and this explains the emphasis on this aspect in HC(77)22.

The circular took as its starting point the report of the Committee on Nursing (Briggs, 1972). This report had considered the question of the overlapping functions of doctors and nurses. The circular HC(77)22, stated that the Briggs Report had emphasized the central differences between the caring role of nurses and the diagnostic and curative functions of doctors. It had recognized that some of the differences and functions were becoming less distinguishable and emphasized the need for closer co-operation between the two professions in the best interests of the patient. The report had concluded that though there were no apparent legal objections to continuing the existing practice of dividing work between the professions, nurses should be required to undertake only those duties for which they had been educated and trained.

As to legal implications, the circular HC(77)22 states that 'work that has hitherto been carried out by doctors ought therefore to be delegated to nurses only when:-

a. The nurse has been specifically and adequately trained for the performance of the new task and she agrees to undertake it;

b. this training has been recognised as satisfactory by the employing Authority;

c. the new task has been recognised by the professions and by the employing authority as a task which may be properly delegated to a nurse;

d. the delegating doctor has been assured of the competence of the individual nurse concerned.'

Health Authorities were asked to review areas where delegation to nurses would be desirable. The importance was stressed of Health Authorities having a clearly defined policy based on prior local discussion and agreement between those responsible for providing nursing and medical facilities and made known in writing to all staff who were likely to be involved. In particular the policy should specify:-

'a. What tasks may be delegated;

b. what qualifications and training are necessary before a nurse may accept particular delegated tasks and

c. what safeguards must accompany the delegation of particular tasks in order that the safety of the patient is not jeopardized.'

An investigation into the principles of health visiting (C.E.T.H.V. 1977)

This was a report produced by a working party set up by the Council for the Education and Training of Health Visitors 'to examine the principles and practice of health visiting' as a pre-requisite to revision of the training curriculum. The working party after consultation with practising health visitors identified and discussed four key 'principles' - 'the search for health needs, the stimulation of the awareness of health needs, the influence on policy affecting health and the facilitation of health enhancing activities.' The report also included a definition of health visiting as follows:-

'The professional practice of health visiting consists of planned activities aimed at the promotion of health and prevention of ill health. It thereby contributes substantially to the individual and social well being by focussing attention at various times on either an individual, a social group or a community. It has three unique functions.

1) Identifying and fulfilling self declared and recognised, as well as unacknowledged and unrecognised health needs of individuals and social groups;

2) Providing a generalist health agent service in an era of increasing specialisation in the health care available to individuals and communities;

3) Monitoring simultaneously the health needs and demands of individuals and communities, contributing to the fulfilment of these needs, and facilitating appropriate care, and service by other professional health care groups.'

This report was influential and was the start of work which continued with two further reports, The Investigation Debate (C.E.T.H.V. 1980) and Health Visiting Principles in Practice (C.E.T.H.V. 1982) - the latter of these is discussed later in the present report.

The importance of the principles enunciated in 'An investigation into the principles of health visiting' was acknowledged in two other reports referred to in our Report, namely Primary Health Care in Europe, The Role of the Health Visitor (North East London Polytechnic, 1981) and Thinking About Health Visiting (R.C.N., 1983). (See pages 38-40 and 43-45)

A Happier Old Age - a discussion document on elderly people in our society (D.H.S.S. 1978)

This document had the following to say about community nurses:-

'At present just under 50% of cases dealt with by district nurses and about 15% of those of health visitors involved elderly people. Both the health visiting and district nursing services have responsibilities to other priority groups, such as young children and it can be argued that health visitors should spend proportionately less time with elderly people and district nurses proportionately more. Nursing auxiliaries with suitable supervision and in-service training, can often provide the kind of care needed by many elderly people. Personal tasks that many elderly people find difficult include bathing and cutting toe nails.' The report asked 'What is the scope for adjusting the role of community nurses and for expanding the help provided by auxiliary staff within the district nursing service '.

Collaboration in Community Care - A Discussion Document. The Report of a Working Party set up by the Central Health Services Council and the Personal Social Services Council (Chairman, Dame Albertine Winner, H.M.S.O. 1978)

This document is predominantly concerned with relationships between the Social Services on the one hand and general practitioners and Health Authorities on the other hand; but there are some references to community nurses in the field and some observations about the nature of team work.

In speaking of the primary health care team, the report refers to a confusion between the roles of health visitor and social worker with some overlap and more generally points to the fact that problems of collaboration could be partly overcome if Health and Social Services staff, particularly those in charge, were better informed about each other. The report goes on to say that one of the ways that such knowledge could be obtained would be through inter-personal exchanges during training both before and after qualifying. Shared training between nursing and social work should be encouraged, in particular between health visitors and social workers.

By attachment, the report means an arrangement whereby a member of one profession has a formalized means of working with another professional group within the latter's own territory. Note that this definition on attachment allows various degrees of attachment with the attached member of staff working within the other professional's territory 'for any time between a half day a week and a whole week with freedom in the former case to deal with other clients on another basis.'

In referring to schemes of attachment for Health Authority personnel to Social Service Departments, the following examples were cited as arising from the survey which was undertaken in connection with this report 'a district nurse attached to a day centre, a district nurses seconded to a home for the elderly, and the attachment of a health visitor to a day nursery and play group.'

Report of the Royal Commission on the National Health Service (H.M.S.O. July 1979)

The report drew attention to the shortage of nurses working in the community which placed a strain on them and reduced the effectiveness of other members of the primary care teams. The importance was stressed of the health visitor having an identifiable geographical area for case finding. It was also mentioned that where the general practitioner's list is widely dispersed, this may mean additional travelling for attached district nurses compared with the situation where they were responsible for a geographical patch. Mention was made of the possible conflict of loyalties of the nurse between the team of which she was a part and her superiors in nursing management.

In examining the possibility of extending the role of nurses in primary care, it was stated that the role of the midwife may serve as a model of the separate role and clinical responsibilities which nurses could carry. It was noted that the midwife makes her own judgements about the supervision, care and advice for and after childbirth and that in 75% of deliveries, according to the Royal College of Midwives, the midwife was the senior person present. It was also pointed out that community health visitors have long had a considerable degree of independence.

The Commission thought it was possible that district nurses could undertake more first visits to patients in their homes - quoting the experiment carried out at the Woodside Health Centre in Glasgow (Moore, M.S. et al., First contact decisions in general practice, The Lancet, 14 April 1973) and pointing out that nurse practitioners were providing perfectly acceptable care to patients in America and indeed were often felt to be more accessible than the doctor. The involvement of nurses in the screening both of the very young and the very elderly was already well established but it was not yet routine in all practice settings for nurses to be the main contact for elderly patients. In many cases the nurses were effectively making first contact decisions anyway, though this may not always be recognised for what it was.

More generally, the Royal Commission endorsed the view of Regional Nursing Officers in England that examination should be given to the possibility of extending the role of the nurse to enable them to undertake tasks traditionally in the province of medical staff particularly in the context of long-stay care. Nurses, it was recommended, should be enabled and encouraged to prescribe a nursing care programme including the mobilisation of other services such as physiotherapy. It was felt that any move towards extending the role of the nurse should not be at the expense of their caring role and also quoted the concern of the Royal College of Nursing about some extensions of the role of the nurse in respect of the legal liability of nurses involved and their ability to cope in relation to their training.

It was considered that there was an increasingly important role ahead for community nurses, not just in the treatment room but in health surveillance for vulnerable groups and in screening procedures, health education and preventive programmes and as a point of first contact, particularly for the young and the elderly. Research was recommended into the following aspects of the work of community nurses:-

'the workload of the district nurse and the competing demands for domiciliary care and treatment room work;

respective roles of district nurse, treatment room nurse, and practice nurse vis-a-vis the general practitioner;

their training and lines of responsibility;

the use of aides in community nursing;

standards of care.'

The Extended Clinical Role of the Nurse (Royal College of Nursing, United Kingdom, 1979)

This guidance to members in effect endorsed that of the D.H.S.S. health circular HC(77)22, The Extending Role of the Clinical Nurse - Legal Implications and Training Requirements, mentioned earlier, in the limited area with which that was concerned (that is the delegation to nurses of tasks hitherto regarded as being in the field of work of the doctor). It did, however, seek to take a rather wider view free from concentration on identification of specific tasks which constitute the extension or development of the clinical nursing role. Indeed the R.C.N. considered that it should not provide lists of examples of the extended role, but that the matter should be discussed in general philosophical terms. 'Lists are, by nature, limiting'.

It was considered that 'as nursing was an independent profession, the independent practitioner should have freedom to plan care'. In searching for an appropriate definition of the word 'care' it was suggested that 'nursing care means meeting the individual patient's self-care potential in all dimensions of his activities of daily living without usurping the patient's/client's own role. Nurses should establish their own parameters of care and then discuss them with the medical and remedial professions'.

'Clinical Nurses have tended to look to others for guidance and direction rather than making their own decisions about planning and developing care'. But some nurses are ready to develop a more independent approach given the autonomy to do so. The nursing profession has the responsibility to see that nurses are encouraged and not inhibited, safeguarding at the same time against a decline in essential nursing care (and the rights of nurses who do not wish to extend their role to include a greater degree of autonomy of practice). The autonomy of the nurse must involve an extension of her professional managerial discretion in relation to the doctor and her superiors. One of the major problem areas (within the management of nursing) seems to be the formulation and implementation of nursing policy. This can produce constraints for the clinical nurse in that it can have a restrictive effect on clinical practice. In order to minimise these constraints, a more effective working relationship needs to be established between senior nurse managers and clinical (nursing) practitioners.

The philosophy then of the R.C.N. in the context of development of the role of the nurse, is to develop the role of nurses whose prime commitment is nursing care, who can provide clinical leadership, define the nursing needs of patients, identify and analyse nursing problems and priorities, seek solutions using any relevant knowledge available in nursing or other sciences, administer and when necessary provide effective care, and very importantly, still help other staff to develop their ability to undertake this activity.

Primary Health Care Nursing - a team approach. Report of a working party of the Royal College of Nursing, Society of Primary Health Care Nursing (Royal College of Nursing, 1980)

This working party was set up to produce a document setting out the independent and inter-dependent roles of primary care nurses in the United Kingdom. The term 'nurse' was used in this report as a generic term to include district nurse and health visitor (and midwife, but we shall not consider her role). The report considered the role and functions of the various primary care nurses, noting that there are areas of overlap in these roles. Thus for example, it is within the competence of the health visitor and the district nurse to provide certain advice to patients and their families.

Accordingly in their discussion of the inter-dependent roles of primary care nurses, two points are made. First of all knowledge, not only of the formal disciplinary capabilities of team members, but also of the particular interests of team members is important. If there is this knowledge, then appropriate people can be brought in to give care. 'Appropriate' being used in a way that partly transcends disciplinary boundaries. Secondly the point is made that the question of who does what as for example between the district nurse and the health visitor, or between the district nurse and a doctor, depends in part on context. Thus for example, if a procedure like an injection is needed in the case of a patient already being visited by a district nurse, then provided that this was within her competence she should do it. If on the other hand there is not this particular established contact, then it makes sense for the doctor not to delegate it but to do it himself at the time when it is recommended. It is observed that there are considerable advantages in this approach to the patient. They receive a service from whichever member of the team can best help them at that time. There are no duplicated visits, they are being cared for by a united group who work together in their best interests.

In discussing future developments of primary care nursing, several difficulties are mentioned which may prevent the nursing members of the team from attaining the role, both independent and inter-dependent, described in the earlier part of the report. One of these is the absence of attachment or other suitable links with general practitioners. If the district nursing and health visiting services operate on a geographical basis, and if the geographic areas are co-terminus, it is still possible for there to be a team approach between these two services.

Another difficulty may be the proliferation of specialist nurses (as distinct from general workers within the primary health care team who develop a special interest, for example in the problems of adolescence). The working party was not in principle opposed to the development of specialist nurses. It may be that specialist nurses 'provide the kind of nursing skill which, either because it is based on training of a different specialty or because it is rarely required, cannot appropriately be acquired by all district nurses. On the other hand specialist nurses may be used to give a type of care which it should be possible for every district nursing team to give' provided the caseload is not too large. This could take the interest out of district nursing, the working party observed. They also noted the development of specialist health visitor posts, for example for the handicapped and elderly where the same problem would arise. With each development of an additional group of specialist nurses, it was thought, another area of work, often a challenging area, would be lost to the ordinary primary health care staff.

Two points are made on the professional aspects of the primary health care nurses' work. Because in certain circumstances an employer can be held responsible for the acts of an employee, employers are able to specify the range of duties which may be performed by their staff. Given an increasing tendency to resort to litigation, this has led employing authorities to restrict the duties that may be carried out to a point at which staff (usually nurses) are unable to fulfil their role, or to exercise their professional judgement. An example of this is that community nurses have always suggested 'over the counter' remedies for common complaints, but some health authorities have been suggesting that they should stop doing this. The working party argues that nurses should continue doing this and take the consequences if they are at fault in their judgement, as ordinary accountable professionals.

The second point made is that restrictions are sometimes placed on activities for nursing members of the primary health care team, because of an imperfect appreciation of their role and functions by their superiors. This is more likely to occur when those managing services have little or no experience of the work involved. When these posts are held by those who do have such experience, it appears more likely that community nurses will receive support and guidance.

Health visitor training should equip the health visitor to define health care goals and subsequently to evaluate the effectiveness of the work. It is to be hoped that health care consumers will increasingly be involved in both the planning and evaluation of the health visiting services.

Two factors will continue to effect the kind of work undertaken in the future by district nurses. The first is that the demographic changes which have been predicted, may result in an increase in the number of patients with degenerative conditions requiring nursing care. The second is that as the period of post-operative care in hospitals becomes shorter, the amount of support and care required from community based staff will increase. This will require an efficient and effective system of communication between the district and hospital sister.

Finally the point is made that expanding or extending the role of the nurse can take place in two ways; 1) by a widening of the role to take over tasks formerly undertaken by other disciplines and 2) by increasing the depth of the attack on the problems, that is to say giving very comprehensive care to one patient or client in a more or less traditional nursing sense, seeing that person as an individual in a specific family and community and discovering health needs and problems beyond those which are immediately obvious. Possibly, the report concludes, both a broadening and a deepening of the roles is required, but breadth should not be achieved at the cost of depth.

Health Visiting in the 80's. (The Health Visitors' Association 1981)

This document states that the biggest challenge to the concentration of health visiting on its traditional function of caring for mothers and young children, has come from the development generally known as 'attachment' to general practitioners. One of the problems encountered in attachment schemes, was that too few general practitioners understood the independent responsibilities of the health visitor, 'she is thought to be useful for routine visiting of

of elderly patients, answering calls and selecting the doctors visits, giving immunisation injections and coping with over-persistant surgery attenders. She may be considered unco-operative if unwilling to fulfil these functions.'

The other main arguments of those who question the wisdom of attachment for health visiting, concern the effect on the service given by the health visitors and the cost of providing those services. It is contended that some of the people most in need of advice and support from health visitors tend to move frequently and do not register with the general practitioner at all unless they become ill. Thus the health visitor's attention is likely to be directed away from those most vulnerable and hence most in need, to those who make themselves most noticeable in the doctors' surgery. A health visitor regularly visiting the same geographical area becomes a well-known figure, easily approachable, for example, by a newly arrived young mother or neighbours worried about the well-being of a child who will not know where to turn if different health visitors make only rare appearances visiting their own 'practice patients'. Furthermore development of attachment arrangements tends towards disappearance of the conveniently located local clinic where health visitors are known to be readily available to all who need them, and the doctors surgery or even a new health centre would probably be both less conveniently situated and less welcoming.

The cost of providing health visitor services when each has to call at homes over a more widely scattered area and two or more may well be visiting in the same road, block or even house, is inevitably greater than when each one restricts her visiting to a prescribed section on the map.

On the other hand, arguments in support of attachment are that all members of the primary health care team benefit from regular contact with each other and hence are able to provide better overall service to the public with the avoidance of any conflicting advice and the advantage of discussion of problems and that it provides an opportunity for health visitors to interest general practitioners in preventive medicine.

Some if not all the arguments against the attachment of health visitors to general practices would clearly disappear if practice lists were restricted to defined geographic areas, all general practitioners were tidily grouped into conveniently situated local health centres and there were enough health visitors to go round. In the meantime however, the Health Visitors' Association suggests that a great deal more careful study is required before the setting of all health visiting within primary health care teams can be fully confirmed as beneficial for the people for whom the service is designed and maintained.

Health visitors are now also part of a vast hierarchical structure of nursing management. However since the integration of the health services on the 1st. April 1974, and in the new nursing management structure, despite vigorous protestation and regular representation by the Health Visitors' Association, it is quite possible for a health visitor to find that no one above her has any experience of health visiting at all and quite probably that only the nursing officer will have health visiting experience and no one above middle management (senior nursing officer) will have any experience in any of the community services.

Other individuals and groups have envisaged health visitors as the ideal adjuncts to their own particular enthusiasms. For example medical consultants and voluntary organisations would like health visitors to specialise with them. Committees of enquiry into various aspects of care, regularly conclude that the health visitor's further involvement is essential. Recent examples are the Court Report on child health services, the Warnock Report on services for handicapped children and the Snowdon Report on integrating the disabled. At the same time some social workers seem to have as much difficulty as some general practitioners do in understanding health visiting.

The paper then goes on to list the functions of health visitors, classified according to three levels of priority:-

1) Recommended selection of work for health visitors working within severe staff shortages

This included urgent home visiting, to new births, to newly arrived families with small children, actual or suspected cases of non-accidental injury to children; in response to requests from families; to handicapped children; to newly reported T.B. cases, to ante-natal mothers, especially primiparaes.

Urgent referrals from other agencies which are properly within the health visitor's province

Efficient record keeping

Involvement in the training of student health visitors

Child health clinics

2) Recommended additional work for health visitors working under only average pressure

Routine visiting of all children up to school age

Visits to all ante-natal mothers

Supportive visits to families under temporary stress

Follow up of immunisation failures

Paediatric development testing at home on non-clinic attenders

Health teaching to groups of adults and in schools

Further liaison with hospitals and professional colleagues

Involvement with the training of medical students, student nurses and social workers

3) Recommended additions for health visitors who may one day have really small caseloads

Routine visiting of all children up to school leaving age with time to attend to the needs of all members of the family

Support for families under stress from e.g. psychiatric problems, chronic illness and handicap

Counselling and health education and family planning and psychology sessions and other appropriate clinics

Visits to play groups and nurseries

Involvement in research projects

Regular visits to schools and hospital wards

Primary Health Care in Europe. The Role of the Health Visitor. Report of a Conference held July 1981 (North East London Polytechnic, 1981)

The Conference was attended by 140 health visitors/public health nurses from fifteen countries in Europe and was jointly organised by the Council for the Education and Training of Health Visitors, the Health Visitors' Association, The Royal College of Nursing, The National Standing Conference of Representatives of Health Visitor Education and Training Centres (U.K.), North East London Polytechnic and the World Health Organisation Regional Office for Europe.

It was thought that this Conference was the first meeting concerned with primary health care to be organised by health visitors/public health nurses in the European region.

The thinking of Conference delegates was summed up in the final group report prepared by Charlotte Kratz and Gabrielle Markes, some sections of which are quoted below:-

'Moving towards primary health care'

'The idea of health visitors/public health nurses deciding their priorities and in community involvement by health visitors/public health nurses, rather than continuing to provide one to one services to which health visitors in the U.K. were used' was discussed, given the shortage of resources.

'The client should be paramount in all decisions pertaining to his own health care.'

'One major obstacle to moving towards primary health care is the growth of specialist services which in many cases take over the work of health visitors. This is undesirable in every way. Whilst specialist advice should be readily available, specialists should not take over from existing general services. The example of France, where the variety of specialist services were such that people did not know any longer whom to consult loomed large.'

'The Role of the Health Visitor/Public Health Nurse Today'

'The role should change to meet the needs of the community which the health service served.'

'The care of mothers and young children seemed to be a universal charge on health visitors. There was discussion on whether it was more appropriate for health visitors to respond to all calls made on them, possibly at the expense of the quality of their care, or to concentrate on only a few groups.'

'Participants were in no doubt that health visitors/public health nurses in primary care should be generalists, though in countries at present separating the preventive and curative function, this separation should be maintained. They should be able to call on the services of specialists but should at all times be able to maintain control.'

'The difficulties in working in primary health care and other teams were spelled out. Nevertheless it was considered appropriate that health visitors should continue to function in such teams.'

'The Influence of the Environment on the Work of Health Visitors/ Public Health Nurses '

'The influence of the geographical environment and of the immediate environment such as living in urban or rural areas was talked about. All these affected the work situation, e.g. the need for a triple duty worker rather than three individuals.'

'The Relationship between Education and Practice in Health Visiting/ Public Health Nursing'

'There was much commendation of the 'Principles of Health Visiting' which people felt were universally applicable.'

'If health visitors are to be prepared to give a suitable and sensitive service to clients, then management had a responsibility to see that appropriate support for them was available.'

'The Way Forward'

'There was an urgent need to use existing research findings and to commission further research, particularly by nurses. There was a plea for just distribution of available research monies.'

'Clients and communities should be involved in evaluating the services available to them and the people providing the service.'

The Primary Health Care Team - Report of a joint working group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (The Harding Committee, May 1981)

The terms of reference of this Committee were 'to examine the problems associated with the establishment and operation of primary health care teams and to recommend solutions'. In its introduction, the report stated that the Committee was set up because of a growing awareness that in some areas belief in the concept of the primary health care team was waning. And indeed, in a number of areas particularly in inner city areas, nurse attachment arrangements had been or were being dismantled because of problems of providing adequate nursing care to the community as a whole, or for reasons of economy.

The Committee did find evidence of waning support for the attachment of community nurses to general practitioners. Among the reasons for this were diseconomies of attachment as compared with giving a nurse a geographical patch, which became exacerbated when there was a shortage of community nurses in that locality necessitating re-deployment often at short notice from one practice to another. Moreover, there were felt to be actual losses in departing from the geographical patch approach in that the nurse found it more difficult to be familiar with her clientele in the circumstances in which they lived when working with a doctor's list as distinct from the population within a defined geographical patch. Moreover, in certain areas such as those in inner cities, a number of patients were not on the lists of doctors and so failed to receive community nursing services. It was stated that in one area, one seventh of the children below the age of five, were not being visited by health visitors for this reason. Inadequate or unsuitable premises are another reason why attachment was disliked by some nursing authorities at least in that it reduced the possibility of effective team work. There was also a mention of problems in relationships between general practitioners and nursing officers in the community nursing services.

In particular there was sometimes difficulty arising out of conflict between health authority policy and the general practitioner's expectations of what a nurse should do, for example in the fields of vaccination, immunization and of family planning. Another difficulty was the way in which attached nurses were swopped around to cover the sickness or holidays of colleagues with the minimum of consultation with general practitioners. (See page 7)

In its conclusions and recommendations, the Committee continued to endorse attachment of community nursing staff to general practices as probably the best way of promoting primary health care team work but recommended the zoning of group practice areas, particularly in inner city areas, but also in rural areas, so as to make it easier for community nurses to operate more or less on a geographical patch basis.

Among more specific recommendations were the following:-

That research should be conducted into levels of patient dependence on nursing services in the community in relation to the various levels of nursing skills and experience available in the primary health care team (that is the mix of trained support staff within nursing teams from the community).

That the relevant organizations should consider the role of the practice nurse and her relationship with health authority employed nurses and her need for training.

That the constraints which place limits on the range of duties which health authority staff may undertake should be subject to periodic review by health authorities in consultation with local medical committees along with any other factors which might prevent attached nursing staff working alongside general practitioners in surgery based treatment rooms.

That the health authorities should, as soon as possible, make arrangements to provide night and weekend nursing services where these are not already in existence so as to match on the nursing side the commitment which must already exist on the part of the general practitioner to a 24-hour service.

Primary Health Care in Inner London - Report of a Study Group Commissioned by the London Health Planning Consortium. (The Acheson Report, May 1981)

This group, reporting at the same time as the Harding Committee, broadly speaking endorsed the findings in the Harding Committee's Report but elaborated on a number of issues specific to primary health care in inner London. They emphasized the importance which they attached to having common geographical areas for the various caring agencies, or at least of general practitioners and community nurses in London. They also discussed the distinction between attached health authority nurses and practice nurses and recommended that the D.H.S.S. should institute a review of the existing research on professional roles in primary health care and consider whether

further study is needed. They mentioned a suggestion that there was scope for the development of care-assistants 'to provide a combination of social, domestic and nursing care in order to maintain in the community patients who would otherwise have to be admitted to hospital more for social than medical reasons.' It was recommended that the D.H.S.S. should sponsor research for health visiting, district nursing and school nursing, to establish a more reliable and sensitive guideline for determining establish - ment levels according to particular local circumstances.

Another recommendation of the Acheson Committee was that an experiment should be established in a health district with a high percentage of elderly living alone to screen on a regular basis all those over the age of 75. It was not envisaged that this would necessarily involve medical screening in the full sense of the word, rather it would be a service run under the supervision of community nurses although not necessarily by them, to keep a watch on the general health and well being of the very elderly in the district, especially those living alone with no immediate family support. An important aim of such a project would be to identify the real costs of the service and whether screening by ensuring early detection might enable compensating savings to be made in direct services.

The Committee recommended that where child attendance rates at accident and emergency departments are sufficiently high, the appointment of liaison health visitors to these departments should be considered and that in any event that where children attend accident and emergency departments, a note of their attendance should be sent to their health visitor as well as to the general practitioner.

The British Association of Social Workers/Health Visitors' Association Joint Statement: The Role of the Health Visitor in Child Abuse (1982)

In this joint statement, it is recommended that a local authority social worker should usually be nominated as key worker in this context although in some cases this role may also be performed by a social worker from another setting, e.g. from the N.S.P.C.C. It was not believed that the health visitor should be nominated as a key worker since health visitors did not have the appropriate resources or appropriate training to carry out some of the tasks involved in acting as key worker. However the statement did recommend that where the health visitor was the professional most closely concerned with the case and was willing and in a position to undertake the responsibility for maintaining contact with the family, the role of key worker should be divided into that of 'prime worker' and 'case co-ordinator'.

The prime-worker would be responsible for maintaining regular contact with the parents and children appropriate to the health visiting needs of the family, the outcome of case meetings (including registration) and its implications, and keeping in regular contact and discussing appropriate action with the case co-ordinator who should be a social worker of level 3 status. The case co-ordinator would act as a central point of communication about the case, make administrative arrangements for case conferences and formally notify the family of decisions reached.

This statement therefore identified an appropriate role for the health visitor (namely prime-worker) whereas it had been agreed that where the role of key worker was not divided into one of prime worker and case co-ordinator, it should not be undertaken by a member of the nursing profession (including health visitors within this definition).

Thinking about Health Visiting. A discussion document produced by the Royal College of Nursing Health Visitors' Advisory Group of the Society of Primary Health Care Nursing of the Royal College of Nursing of the United Kingdom (1983)

Strictly speaking this is just outside our remit of reviewing the literature up to the end of 1982. The document was, however, under discussion within the Society in October 1982 and for that reason we have chosen to include it in our Report.

The following factors or trends which underlie many of the problems and dilemmas in health visiting today are identified namely -

The relationship between health visiting and maternity and child welfare;

the relationship between health visiting and local authority services;

the relationship between health visiting and primary medical care, in particular the effects of its organisational system;

the administrative demarkation between health and social services, and their increasing specialisation and fragmentation of care;

the struggle of health visiting to fit into structural and policy changes which profoundly affected it but were outside its control;

the problem of role definition in health visiting, particularly in relation to nursing and social work;

the low priority accorded to prevention including child health service within the health services.

In a chapter entitled 'Health Visiting is Nursing', the following problems were identified:-

The short-comings of the present system of basic nursing training for the the educational preparation of health visitors;

the allocation of resources between health visiting and other types of nursing services within the nurse budget;

the control of health visiting services by all managers who are not themselves experienced in health visiting;

the difficulties experienced by health visitors, who constitute a numerically small minority group within nursing in influencing nursing policies;

the salary differentials which result from the enhanced payments made for evening, night and week-end work and hospital based clinical teaching, which are not available for health visitors;

the unequal relationship between nurses and doctors especially in the acute hospital setting;

the exclusive concentration on individual care which may inhibit the health visitors' role in community development.

Nevertheless the Advisory Group concluded 'we believe that the advantages to health visiting of greater integration within the profession of nursing, greatly outway the disadvantages'.

Concerning 'Health Visiting and Primary Health Care', the following issues were mentioned which raised, the Advisory Group thought, a number of questions to which health visitors should address themselves;

a) How should the goals of primary health care and primary medical care be reconciled?

b) Is it possible to nurse (i.e. foster the growth and development of) a community within the concept of attachment, which defines the team's clientele as a list of individuals?

c) How can primary prevention be promoted within a system dedicated to cure or palliation of disease?

d) How can concepts such as 'development of community resources' or 'self reliance' be fostered within a model of care which depends on the concept of a professional/client relationship in which the professional may be seen by some to be dominant.

e) What alternative models of a primary health care team can be developed other than attachment, in order to meet the needs of areas where attachment is difficult to achieve?

f) How can the consumer of primary health care best participate in and contribute to, the primary health care services?

Concerning the heading 'Accountability and Standards of Practice', the following questions were identified which it was felt needed urgent consideration by health visitors themselves:-

To whom is the health visitor accountable and for what;

what exactly is the health visitors field of expertize within which she can be said to be competent and can therefore be held to be accountable?

how far is the health visitor an agent of social change or an agent of social control?

what constitutes an acceptable standard of health visiting service and health visiting practice?

how can health visitors individually and collectively ensure high standards of health visiting practice.

SCHEMES IMPLEMENTED AND STUDIES UNDERTAKEN

In this section we refer to schemes and studies which have been described in the literature within the period 1974 to December 1982 inclusive. The following points should be noted in reading this section:-

1. Although we are primarily concerned with developments in community nursing in England, schemes and studies from the United Kingdom as a whole have been included, particularly from Scotland.

2. The schemes and studies described aim to cover the range and variety we found, not necessarily every single example.

3. Many schemes and studies reflect ideas put forward or tried out in the period prior to 1974, and so in that sense are not completely 'new'. However they do show the development and popularity of these ideas since 1974.

4. Comment on and discussion of the ideas exemplified by the schemes and studies is taken up in the Discussion later in the Report.

5. This section is divided into five headings namely

   Health visiting
   District nursing
   Practice nurses
   Extending the role of the nurse
   General reviews of schemes and studies

Health Visiting

Organisational aspects of health visiting

The main change in the organisation of health visiting (and indeed in district nursing) which has occurred in recent years is the move to attachment schemes. Attachment to general practices, which was the subject of several studies before 1974, has become the norm, although it is being questioned. One study (Walsworth-Bell, 1979) compared the work of health visitors in two adjacent health districts. In one district, health visitors were all attached, in the other, most worked on a geographical basis. The work of the two groups was remarkably similar but some differences emerged. In the geographical district, the health visitors were more likely to make contacts with patients 'in the street or in houses which were not the home of the primary patient', they did more followip visits, and in particular they did more follow-ups to households without a registered general practitioner. It was planned to experiment with a mixed scheme, with attached health visitors having territorial responsibilities.

One part of the country which had health visitor shortages was Thanet, Kent, where a 'flexibank' of health visitors and SRN assistants was set up (Bolton, 1981). This system enabled a crisis service to be maintained, with priority for babies and young children. It is concluded that although the flexibank enabled the population to have basic health visitor services, it was only for use in a crisis, and was no substitute for routine visiting and record keeping and responsibility for a known caseload.

Clode (1978) referred to an experiment in Trafford Area Health Authority, health visitors are integrated into a 'preventive division rather than the usual community division, emphasizing their preventive role as opposed to the curative function of other community services. Finance for the 'preventive' division, which also includes health education, family planning, school and child health services, was achieved by transferring money from the hospitals, as assessed by their bed-occupancy. As a result of this, it is reported that the health visitor-to-population ratio has improved, with more visits being made, reduced case-loads and no problems filling vacancies. This arrangement is unusual in that health visitors came under a different division to the community nursing services.

Health visitors providing services out of normal hours

Some studies have described and/or evaluated health visitor services outside normal hours, usually for parents with young children.

A 'crying baby' advisory service for 'out-of-hours' times was introduced at Huddersfield in 1977 experimentally and kept on after evaluation. Some other places have followed suit. At Richmond (London) a scheme for telephone advice at weekends about crying babies was started and has been kept on as an 'essential' service (Beech, 1981). Another crying baby advice service was tried out at Plymouth (Bogie, 1981) but although the health visitors were convinced of its value, general practitioners and midwives were not and the future of the whole scheme was in the balance. In Preston a 24-hour service for telephone advice by health visitors on child health problems generally, was set up as a pilot scheme, (Metcalf, et al., 1981). This was judged as a success and kept on as part of the normal health visitor service.

The aims of such schemes are not only preventive (e.g. to prevent possible 'battering') but also cost-saving since it is reported that many patients would have called out a general practitioner if the advice service from health visitors had not been available. This latter aim is difficult to prove as it depends on what the client said they would do otherwise, and of course sometimes the general practitioner had to be called in anyway. However there seemed to be widespread approval of these schemes by the health visitors and families concerned.

Another variation on out-of-hours work is provided by Enfield health visitors (Haylock, 1981 and Anon, HSSJ 1982). They are not only on call out-of-hours for emergencies but also do some routine work in the evenings, which is more convenient for some families,e.g. if both parents are out during the day. The health visitors operating the scheme are specifically recruited for out-of-hours work and are provided with G.P.O. radiopaging devices so they can be 'bleeped' wherever they may be in the district. A child health clinic was tried on one Saturday morning for each month, but had to be discontinued owing to lack of clinical medical officer time.

Finally another variation on this theme - Sheffield local radio services (both B.B.C. and commercial) have put on 'phone-in' programmes for parents to put questions to health care professionals about child health problems. (Community Outlook, 1979).

Health visitors and the elderly

One continuing pre-occupation which is apparent from the literature is the role of the health visitor in relation to the elderly. The survey for the O.P.C.S. by Dunnell & Dobbs (1982) found only 9% of the health visitors' time was spent with those of 65 or over, but that health visitor assistants spent 57% of their time with the same age group.

A number of studies have been done in which the health visitor was involved in screening for problems among elderly patients. This is not a new idea - there are reports on this from pre-1974 - but it is still a subject for study, and all the more relevant now with increasing numbers of elderly in the population.

In one study in a general practice in Scotland, a health visitor, using a specially devised questionnaire, visited a randomly selected sample of those aged 70 and over and the information she obtained was compared to an assessment of the same patients by a geriatrician and an assessment by the General Practitioner using his knowledge of the patient (Powell and Crombie, 1974). There was mostly a good correlation between the health visitors assessments of the physical and mental state of the patients compared to that of the doctors. The authors felt that a community nurse could use such a questionnaire effectively for screening the elderly.

Another Scottish study (Gardiner, 1975) also used a questionnaire administered by health visitors, to assess medical and social needs of patients in a group practice aged 75 and over. In addition some basic clinical tests were made. The study found that 82% of the 237 elderly persons visited had 'some significant pathology' and calculated that to maintain the surveillance and meet the needs arising, there would have to be expansion in 'medical, nursing, dental, laboratory and social work' resources.

Health visitors and district nurses undertook a survey of the over 80 age group registered with an urban practice in Yorkshire (Heath and Fitton, 1975). The staff did this in addition to normal duties, using an interview to obtain information about the health, social state and environment of the patient. There was no 'urgent concealed medical need' found but the survey did find some health and social needs and felt that surveillance of the age group was essential.

Barber & Wallis (1976) describe a system introduced into a health centre in Glasgow where the health visitor in the practice made an assessment of the elderly (65 plus) patients already in contact with the general practitioner or health visitor. The carrying out of assessments did not need extra staff, although they did generate extra workload as a result of problems identified. Health visitors felt that visits based on these assessments were more useful than previous visits had been.

Later on they tested a postal questionnaire to screen a sample of the elderly (70 and over) not just those in contact already with the general practitioner and health visitor. They concluded that the questionnaire was acceptable to patients, it identified patients who could benefit from further assessment by the health visitor, and reduced the workload that would be needed for routine assessment by visiting, (Barber, Wallis and McKeating, 1980). The same team developed the questionnaire to use it on all patients of 65 or over in a practice which had used no screening procedures at all (Barber & Wallis, 1982). Two part time research health visitors carried out the screening and assessment, and the workload of the primary care team was monitored for the period before, during and after the period of 'intervention' by screening and assessment. It was found that workload with the elderly for doctors, nurses and health visitors rose substantially during the 'intervention' phase. After this phase the general practitioner workload dropped considerably, but although the district nurse and health visitor workload with the elderly decreased, it was still higher than before 'intervention'. As a result of the assessments made, 78% of elderly patients were found to have 'unrecognised or unreported problems or symptoms'. It was concluded that the extra work which would be needed for an attached health visitor to routinely undertake screening and assessment was worthwhile, and was most effective if done for patients aged 70 or 75 or more.

A survey of all the elderly registered with a practice was done in Glasgow, (Currie, et al., 1974) by a health visitor and a nurse, for patients aged 70-72. They visited the patients at home and the general practitioner subsequently examined them. It was concluded that an extra health visitor or nurse is needed by a practice of 3 or 4 general practitioners to do this type of work, and in fact little serious morbidity was uncovered.

A scheme in Reading, (Curnow et al, 1975) used specially appointed health visitors to identify those over 65 who had health or social needs, who would benefit from help. Unfortunately not all needs could be met with the resources available, and it was not a satisfying full-time occupation for the health visitors. Some improvements in local services were made as a result. This scheme does raise a basic problem about any survey for need, namely of caring agencies being able to cope with the demands that arise as a result.

One practice has undertaken a two month pilot scheme for visiting the 70 and over age group in which a health visitor makes a first assessment visit and an SEN does follow-up visits. The SEN does some basic clinical tests but subsequently is also involved with arranging social support for those in need (Neil, 1982). The scheme is described as a success and is being continued.

One scheme aiming at prevention of diseases in later life was set up in South Hammersmith. Those over 50 were invited to come to clinics, run by a clinic nurse and a health visitor, for some screening, and health advice (Figgins, 1979). This of course was not within a general practice context, but it was in an area with many single handed general practitioners where presumably it would be more difficult to set up this type of clinic with general practitioners.

However not all reported surveys of the elderly agree that the results of screening are worthwhile. Freedman et al. (1978) carried out a comprehensive screening of all patients over 65 in their practice. It was felt that because of the decline in home visiting by the general practitioner, health and social problems might be missed. They concluded that the screening procedure revealed 'little treatable but previously undiagnosed illness' and that the lack of visits to the elderly by the general practitioner was offset by more visiting from district nurses and health visitors.

Health visitor skills have also been used to give special attention to the needs of the elderly. In one London borough a health visitor has been appointed experimentally under a joint finance scheme between the area health authority and the borough, (Day & Mogridge, 1981). She was seconded to the social services department, with responsibilities for preventive care, health education and liaison (between health and social services staff), and has a particular responsibility for the elderly and handicapped. Again this scheme, which is being evaluated, is one where the health visitor is not in a primary health care team. It shows - as do other schemes which

will be referred to - that the particular training and skills of health visitors can be utilized in the community and not just within the primary health care team.

In a pilot scheme in Manchester, a geriatric care team is led by a health visitor (Halladay, 1981). The health visitor liaises between hospitals, community health services and social services, taking case referrals from these. The team provides support and nursing help for the elderly and aims to keep people in their own homes as far as possible. The funding for this scheme came from inner-city money.

A scheme at Kidderminster provides for a geriatric liaison health visitor leading a team to give continuing care for patients discharged from hospital, (Thursfield, 1979). The liaison health visitor is assisted by two SRNs with district nursing qualifications who in turn act as team leaders to 'clinical assistants' who are SRNs each attached to one general practice. The geriatric liaison health visitor is notified of admissions so that the home conditions of the elderly patient can be assessed by someone in the team. The information from this assessment is included in hospital case notes. Each patient is visited on discharge and also all known elderly are visited routinely by the 'clinical assistants'. The liaison between hospital and community care which the scheme provides aims to give support to patients to check on their progress and avoid duplication of visits by professional staff.

A psychogeriatric liaison health visitor has been attached to a psychogeriatric assessment unit in Southampton, (Griffiths & Eastwood, 1974). She liaises with community health and social services about discharged patients, handing over to the community health visitor immediately if the patient is already known to them, or establishing the link if this is missing.

One study, (Luker, 1981,1982) has attempted to evaluate the effect of 'focused health visitor intervention' on a group of elderly women in Scotland. Using two groups of elderly in a cross over study, it was found that up to 43% of health problems did improve with 'intervention' (an effect which lasted for 5 months), although there was no clear improvement in 'life satisfaction', and not all the cases wanted to continue being visited. The elderly in the study generally saw the health visitor as someone to call in when they were ill or had a particular need, rather than as an agent of preventive health who could give advice.

Health visitors and psycho-social problems

There is evidence that a substantial proportion of health visitors' cases involve a psycho social content, particularly in households without children under five years. (See e.g. Clark (1976) who reports this in her study of 2057 home visits by health visitors in Berkshire in 1969). The results of a pilot stage of a study recently reported on (Briscoe & Lindley, 1982) showed that in one week's visiting, a health visitor identified and/or managed two different types of psycho social problems in routine visits to 17 families. More problems were classified as potential rather than actual, emphasizing the preventive approach of health visiting in this field. Some articles have reported schemes in which the psychological skills of health visitors were developed and used.

Mottram (1980) describes group psychotherapy sessions being held in a practice with nurses or health visitors acting as group leaders together with general practitioners.

A psychiatrist (Clarke, 1980) describes a series of seminars held in a health centre, in which health visitors discussed 'principles of assessment and management' of cases with the psychiatrist. This developed skills in the health visitors, and brought the psychiatrist into contact with the primary health care team.

In Sussex, (Reavley, 1981), a clinical psychologist reported on shared clinic sessions held with the health visitors since 1979. Selected patients see the psychologist, who manages these cases together with the health visitor. The author concludes that 'working together has produced a better clinical service and a more effective use of our resources. Good communication about the cases..... has been made much easier by having a clinic at the same time and in the same place'.

A health visitor in Harrow describes how she helped young mothers to form home-based groups for mutual support. (Hiskins, 1981, 1982). The scheme has evolved since 1969. Each group of 6-8 mothers has a 'leader' who is one of the mothers, and they meet in each other's homes in the area. A 'unit' is formed by six groups, and 'large social events' are organised by the 'unit' which include husbands. There is a monthly newsletter with ideas and information and a library of relevant books bought by fund raising. As a result of a study by interview of five groups of 43 mothers, the author concludes that the existence of the groups prevents isolation and helps prevent psychosomatic illness, as families give mutual support and mothers have friends to turn to. In this scheme, the health visitors have facilitated self-help in order to prevent psycho-social problems developing.

Health visitors liaising between hospital and community services

A number of health visitor liaison schemes were investigated by Paxton (1974). The author found paediatric, maternity, geriatric, diabetic, orthopaedic and chest clinic health visitors liaising between hospital and community, and one for hospital/school for physically and mentally handicapped children. It was concluded that although liaison schemes were costly, the benefits to patients - as reported by staff - must be taken into account. The benefits included continuity of care, speedy transmission of information and better staff relationships.

Three schemes whereby a health visitor liaises between hospital and community in relation to elderly patients, are referred to in the section on health visitors and the elderly, (Halladay, 1981, Griffiths & Eastwood, 1974 and Thursfield, 1979). Some schemes relating to other groups of patients are described below.

In Leeds, a scheme operates whereby two health visitors are attached to the rehabilitation team in a hospital, (Firth et al, 1978). The health visitors, in addition to their normal duties, accompany the rehabilitation team on ward rounds and follow-up patients in the community after discharge. An assessment of the home conditions is made, if necessary, by the health visitor before discharge, and she provides support during the critical first week after discharge from hospital. This support includes liaison with the general practitioner, ensuring voluntary bodies and social services undertake services agreed and advising the patient and family on self-care at home. The patient is handed over to the usual health visitor when the patient is stabilised at home. The scheme was studied for its effect upon patients and it was concluded that it resulted in a lower re-admission rate.

A liaison health visitor works with an oncology outpatients department in Glasgow, (Trotter et al, 1981). The health visitor 'gathers information about patients, relatives, and their problems ..... co-ordinates the provision of support services, and .... is a counsellor'. By visiting patients in their homes she is able to uncover problems, e.g. of pain control, which patients find more difficult to raise in the ward or clinic. She is hospital-based and may visit patients without consulting the general practitioner first. Her work has been studied and it was concluded that she is 'an essential part of the oncology team'.

An example of diabetic liaison health visitors, based in the community but liaising with the hospital team, is found in Leeds, (Jackson, 1979). In this instance one health visitor works full-time with diabetic patients, the other still retains some normal health visiting caseload. It is felt that the scheme has enabled patients to be more often stabilized at home, or to spend less time in the ward for stabilization.

In Leicester, (Matheson & Tillson, 1978), a paediatric liaison health visitor has been long established, since 1968. She liaises between wards, out-patients and the home, supervising home nursing of ill children and giving advice to parents. It was felt that the health visitor's work there reduced out-patient visits and saved hospital beds.

Wallis (1982) described her work as a maternity and paediatric liaison health visitor. She visits paediatric and maternity wards and attends the relevant out-patient clinics, talking to staff and patients and passing on all relevant information to family health visitors. Based in a health centre, her time is entirely taken up with gathering and disseminating information.

In Preston a system operates whereby family health visitors are informed of any children up to five who have visited an A. & E. Department after an accident, so that the health visitor can go to the home and give advice on safety. (Ahamed 1978, 1982). The information obtained over time has demonstrated the advice on safety most needed at the different ages of children, and it is hoped that in the long term home accidents will be reduced.

Specialization in health visiting

Currently health visitors tend to be 'specialized' in the care of babies and young children, although they have a wider responsibility for preventive health care generally. There are some advocates of 'specialized' health visitors as such, and examples of a few types of specialized health visitors were found, apart from the 'liaison' health visitors, described in the preceding section.

One type of specialism advocated is for handicapped children. In Lancaster health district, five health visitors were trained in the Portage system in order to study the effectiveness of providing such a service (Holland, 1981). Each health visitor visited one family with a developmentally delayed child and after six months the service was evaluated. It was found that the health visitors had been able to acquire the skills necessary to provide the service, and they had been able to continue normal duties as well. The children had progressed and the parents were enthusiastic.

A study of specialized health visitors working with Down's Syndrome infants by Cunningham et al (1982) is summarized by them as follows:-

'A health visitor was seconded to a university based research team studying early intervention with families who have an infant with Down's syndrome. She was given a three week practical training and then provided a home-based service for 61 families, visiting every 6 weeks until 2 years of age. Infant development and parental satisfaction with the service were compared to previous findings of the research group. Parental satisfaction was found to be very high and the progress of the infants compared favourably to previous studies. Following this, two field health visitors were given the training and then provided a service in their local area. The progress of the infants was monitored at 6-month intervals until 2 years of age, and parents were interviewed. Again no differences were found in the developmental progress of the infants and previous groups and parental satisfaction was high'.

The importance of <u>early</u> intervention is stressed by the authors, who found that the short course of practical training for the health visitors involved was adequate for children up to 18 months, when more specialized training is needed to provide help for these children. The health visitors in the study were not carrying normal caseloads as well, however the authors report that several family health visitors had said they would prefer to visit the Down's Syndrome children themselves and that family health visitors

'often maintained a joint service with the specialist health visitor. Where this has happened, the comments of the parents, the family health visitor and the specialist health visitor strongly suggest that it is the most satisfactory approach.'

There is an example of a scheme involving a specialist health visitor with the disabled in Southampton, (Dawson, 1979), where she is employed in establishing and maintaining a 'register of dependent disabled adults' (up to 65 years). Detailed information about the disabled person, their family and circumstances, is obtained, and this is updated once every six months or more often if the situation is deteriorating. The names of persons who could be on the register are obtained from the general practitioners. It was hoped that by using the information, the health visitor could provide a supportive service to these persons and their families, forsee impending crises and avert them, thus maintaining persons in the community if possible.

Finally there are a couple of schemes described where the health visitor is concerned with the care of the dying. A system in Edinburgh in which hospital based health visitors contribute to 'the support and care of terminally ill patients and their relatives' was described by Murray et al (1974). The patients were those attending a hospital Respiratory Disease Unit for bronchial carcinoma. The health visitors in this scheme were geographically deployed, based at the hospital, and worked with the consultant physician. They visited patients regularly, obtaining information about social and economic conditions, and giving support and advice to the patient and his family before and after his death. It was felt that this support helped families to manage nursing by themselves without necessarily involving district nurses, and enabled patients to avoid going back into hospital.

In Brent, the health district employs a health visitor and an oncology nurse to give support and advice (not practical nursing) to patients who were dying and to their families, (Wilshaw & Aplin, 1981). Most referrals came from consultants, but general practitioners, district nurses, social workers and health visitors also refer. The service provides counselling for patients and relatives, and bereavement counselling after death.

Health visitors and 'screening'

Health visitors by definition are concerned with the prevention of ill-health and its early detection. This is particularly so in the work of the health visitor with babies and young children, the age group with which the health visitor is most concerned.

One Scottish study in a health board addressed itself to the problem of 'who should carry out developmental screening examinations?' (Lawrence and Sklaroff, 1978). Using the same developmental screening record, one group of young children were examined by general practitioners and health visitors, a second group by medical officers and health visitors, and a third group by health visitors alone. It was concluded that health visitors could use the screening record satisfactorily, in both clinic and home settings, although health visitors tended to take longer than the doctors to complete the test.

In another Scottish study health visitors, supervised by clinical medical officers, undertook neurodevelopmental screening of infants in a health district. (Morris and Hird, 1981). The authors concluded that this method of screening was practical, and that 'the percentage of children identified as requiring further investigation in the present cross sectional study compares favourably with other more doctor orientated schemes', although they considered a longitudinal study was necessary to corroborate these findings.

In a postal enquiry which obtained information from 88 out of 90 A.H.As. about their policies on child health surveillance, wide variations were found. (Connolly, 1982). Areas varied in the degree of health visitor involvement and in the assessment criteria used.

A small sample of health visitors questioned as part of the same study also showed some disagreement about assessment criteria, and 'that regardless of the A.H.A. child health assesment policy, health visitors made their own evaluations of childrens' well-being'. The author recommends that each region should set up a working party 'to examine the health visitors work in child assessment to identify where they can most effectively contribute in this work'.

Health visitors have also been involved in schemes to screen for ill-health among the elderly, and several of these schemes are described in the section on 'Health Visitors and the elderly'. In addition one scheme, described below, involved the health visitor in screening for a particular disease among a particular age group.

In this scheme the attached health visitor played a role in a feasibility study in Scotland which was set up to see if men could be screened for risk of coronary heart disease, and would take advice to reduce the risk factors, (Rankin et al, 1976). Men aged 35-44 were invited to contact the health visitor, who gave advice on diet, exercise and smoking, and she arranged for an examination and tests by the general practitioner at which she assisted. At a follow-up of the men some months later, tests showed an improvement in test results (e.g. weight, plasma, chloresterol etc.) and the men claimed that they had increased exercise taken and reduced smoking. It was concluded that advice could change habits, and that this scheme is feasible in a general practice with attached health visitors.

District Nursing

Community night nursing services

Several schemes for providing night nursing or night sitting services, which are becoming more widespread, were reported on. These services are an extension of community nursing provision, being under the direction of community nursing officers. The staff for them are recruited in addition to the day community nursing staff and are paid for from health authority funds (or joint health and social service funds in one instance). Nursing of patients dying from cancer is undertaken by the charitably funded Marie Curie nurses, but where not enough of these nurses were available, the night nursing services provided an alternative. Some examples of these schemes are described below.

In a scheme in Fife there is a service for short term cases, e.g. care of the dying, or for longer term cases but less intensively, e.g. one or two nights a week to relieve relatives. Patients are referred by general practitioners or district nurses and cases are allocated by the nursing officer (Gillespie, 1980). Fife also provides a 'tucking down' service for patients needing longer term care. One nurse can visit several patients in an evening to do this, whereas with the night nursing service one nurse is with the patient all night. Generally the nurses felt the scheme worked well, and although there was no proof, it was felt that these services kept patients at home and out of hospital for longer than would otherwise be the case. However the one-to-one ratio of night nursing is expensive, compared to the 'tucking down' service.

Aberdeen provides a night nursing service, (Jack, 1976) and also evening visits to psychogeriatric patients. Nurses from the psychiatric hospital visit patients referred to them by staff from the psychogeriatric day hospital, aiming to delay or prevent in-patient admissions.

In Lancaster a pilot scheme for night nursing was described by Hornby (1976). Day staff were already operating a rota scheme for night emergencies, and to relieve them of this work, two groups of extra part-time nursing staff were recruited. One group dealt with general nursing care, the other group with emergencies at night on a peripatetic basis. It was concluded that the need for, and possibility of, a 24-hour service had been demonstrated. The service provided care for patients waiting for admission to hospital, and it was said that bed usage improved. An unforeseen need was for a night

psychiatric service, to support relatives of dying patients, and it was felt that this would be valuable if it could be provided.

A study of the night and evening nursing services in Newham, (Martin & Ishino, 1981) concludes that the costs are less than hospital care and enabled patients to remain at home who would otherwise go into hospital and block beds. Patients for the night and evening services are referred by general practitioners, community nurses, hospital consultants and casualty departments. No study of quality of care was undertaken, although it was reported that patients were pleased to be at home still. The study estimated that only care in Part III accommodation was less costly than intensive home care, but the patients were too ill or handicapped to qualify for Part III.

A night nursing service in Southend, (Sims, 1981 and 1982) similarly reports that patients seem to have been kept at home rather than being taken into hospital care. Referrals came mainly from the community nursing services, general practitioners and the accident centre.

Another variation on the night nursing services is operated in Rochdale, (H.S.S.J. 1981). As the night nursing services is limited because of resources, a night sitting service is provided, the sitters being employees of the local authority. The night sitters are usually unqualified and given training by the district nursing staff who also are involved in their appointments. The sitters are supervised and managed by the district nursing staff. They enabled the night nursing service to be extended, and stay with patients in the night, with the night nurse visiting the home during that time.

District nurses and the elderly

Care of the elderly forms a substantial proportion of the district nurse's work, and with an increasing proportion of the population coming into this category, this increases the demand on the nurse. In 1980 43% of cases attended by district nurses were to those of 65 or more, (Social Trends, 1982), and a survey by the O.P.C.S. (Dunnell & Dobbs, 1982) showed that 75% of the district nurses' time was spent with patients over 65.

The services of the district nurse become all the more important given the policy of keeping people at home in the community for as long as possible and the shortage of beds for the elderly sick. Two studies on this problem give conflicting views on the economic cost of keeping the elderly sick at home. Opit (1977) estimated the cost of caring for a group of elderly sick who were receiving district nurse care. When nursing, home help and social worker times were added to equipment, laundry, meals and social security payments, he concluded that the cost of keeping these patients at home was comparable to keeping them in residential care. An even more serious consideration was the quality of care received by these patients. No objective assessment was available, but the district nurses estimated that nearly 30% of the patients at home were 'receiving either inadequate or inappropriate care'. Maintaining a satisfactory level of care (which may not be possible at home anyway for seriously disabled patients) requires more finance. Opit concludes that wihout this increase in funding then 'domiciliary care for the elderly sick will be increasingly 'economic' simply because the level of care provided becomes increasingly inadequate'.

On the other hand Gibbins et al (1982) in Cleveland describes a scheme were 'augmented home nursing' was used as an alternative to hospital care for chronic elderly invalids. Extra nursing and home help staff were recruited to provide extra care until if possible patients could be referred back to the usual, not 'augmented' level of service provided by district nursing staff and home helps. Gibbins et al argue that the costs of this are comparable to long-stay care - however they did not take into account the range of costs considered by Opit above.

A pilot study of 'augmented' home care for acutely or sub-acutely ill elderly patients was undertaken in Edinburgh, (Currie et al, 1980). Intensive community nursing and medical care (daily visits by a general practitioner or a geriatrician) was given to patients during an acute illness to avoid admission to hospital, and patients' recovery was assessed by tests of function in daily living. The results suggested that recovery was quicker at home than it would have been in hospital, and that the scheme was acceptable to the patients.

A scheme in Norfolk (Allibone, 1979) to provide care for the elderly in the community has involved local people as well as professionals. Apart from 'social' type services, such as transport, a luncheon club and social activities, the scheme also provides a volunteer nursing service, working to help the district nurse. The women providing this service do not necessarily have any nursing experience, so they are given some basic training in home nursing, and carry out for instance bathing and foot care, bed making and some night-sitting. The volunteer group have a trained nurse as their 'leader' who liaises with the district nurse about allocation of work. Of course the success of such a scheme depends on having women locally available and willing to do the work and is no substitute for trained nursing care. However, in the report of a research study into this scheme (Allibone & Coles, 1982), it was stated that the work of the volunteer nurses reduced by half the number of visits made by community nurses compared with similar areas where there was no volunteer service, and that professionals and volunteers could work together in harmony.

A joint care funded scheme for the elderly in East Sussex (H.S.S.J., 1981) provides health services, sheltered housing and Part III accommodation in purpose-built premises. The scheme brings the relevant professionals together on one site where the elderly can go for counselling, social activities and treatment. The scheme provides for an extra district nurse in the locality, so that the extra nurse time needed for the project can be allocated. The nurse is not acting in a new role here so much as in a different structure, involving much close collaboration - if the scheme works out as the planners hope - between staff in health, housing and social services departments.

Three studies have reported on the use of district nurses doing routine assessments of the elderly. One study in Scotland, (Wallace, 1975) reported on a general practice where the district nursing sister routinely did assessments of patients of 75 and over. She makes an assessment of their housing conditions, social contacts, mobility, self-care and health. The author feels that although this type of assessment is associated with health visitors, having a nurse visit ensures immediate treatment without delays due to referral. Assessment of the elderly is an area where it is not clear who is mot appropriate to undertake it. Wallace reported that the nursing sister aimed to educate the elderly to improve their health, and to detect early signs of abnormality.

Another study in Birmingham used nurses (including a research nurse as well as district nurses) to survey the medical and social needs of a sample of the elderly (70 plus) in a general practice. It was concluded that nurses could carry out this kind of screening, and that there was a need for it, judged by the problems which were uncovered, (Shaw, 1975). However these results raised the problem of how to undertake this work, given the manpower which was needed to go out and interview persons in their homes. The practice list was found to be inadequate as a basis for a survey, which required 'a total population register' so that all the elderly in a given geographical area could be contacted. Attachment schemes did not ensure that all the population groups were fully listed.

Gooding et al (1982) describe a scheme where a nurse visitor was employed part-time in a practice to visit patients of 75 years and over to undertake preventive visiting. She asked patients about their general health and mental state and provided some type of service for 81% of the 282 patients visited in one year. Little unknown major pathology was found, but the nurse visitor provided support for relatives and friends, helped in improving safety and conditions in homes, and tried to help in cases of loneliness,. It was hoped that the preventive visiting would have some effect on the use of geriatric beds. So far this had not resulted but the study of this is continuing.

Paediatric home nursing

A scheme 'to provide specialised nursing care for sick children in their own homes' has operated in Gateshead since 1974 (Hally et al,1977). The nursing care is provided by district nurses recruited from the existing general practitioner's attached nursing staff who were given training on the paediatric wards. Children enter the scheme either after discharge from hospital (when they come under the care of the general practitioner) of if requested by the general practitioner, in order to avoid admission to hospital. The scheme enabled children either to avoid admission or reduce their length of hospital stay, which quite apart from reducing pressure on hospital beds, was considered better for the children emotionally. Most of the mothers, who were questioned about their attitudes to the scheme, were satisfied with it.

Atwell (1975) in Southampton, describes paediatric day-case surgery which began there in 1969. Patients are cared for at home by a paediatric home nursing service, formed from district nurses who come on the weekly ward rounds and visit the hospital daily.

A later article about the scheme (Gow & Atwell, 1980) describes the further development of the paediatric nursing role. The nurses in the scheme 'are all district nurses with the additional qualification of the Registered Sick Children's Nurse', and they work in geographical areas. The paediatric home nurses have several functions. These include post-operative care of children admitted for day surgery, the nurse having the right to re-admit a patient if she feels it necessary; care of children discharged early after surgery; help with care of physically handicapped and mentally handicapped; regular medical treatment such as diabetes management or regular injections for certain conditions; care of dying children; and care of children at home for some conditions which would otherwise need hospital admission. The paediatric home nurses are also involved in nurse training in the community, and liaise between hospital and community health services.

Day surgery and early discharge

Day surgery has been adopted by hospitals in a number of areas and has a consequent effect upon community nursing services. Several articles described schemes where district nurses looked after day-surgery cases.

A scheme in Bedfordshire is described by Shepherd (1976) in which hernia patients are discharged 48 hours post-operatively. The district nurse visited the home pre-operatively to assess the feasiibility of early discharge, and visits after surgery, undertaking removal of sutures. It was said that this system reduced the waiting time for hernia repairs from up to a year down to six weeks.

Russell et al (1977), Stockton-on-Tees, reported on day surgery for hernias and haemorrhoids, concluding that it is clinically and socially acceptable for patients. However day-patients received 4.18 more visits from district nurses than patients kept in the normal length of time following surgery for these conditions. The general practitioners gave day-patients 0.50 more consultations than 'longer stay' patients, so the extra work fell mainly on district nurses.

In Kingston and Richmond Area Health Authority, a district nursing sister (Hart, 1982) has described the way community nursing staff cope with day surgery cases of hernias and varicose vein stripping. Nurses visit the patients pre-operatively, to check their condition (temperature, pulse, respiration, blood pressure), to give advice, and to assess the facilities in the home. If these facilities are not suitable, despite what the patient has previously said, the nurse will notify the hospital and the patient is referred for normal hospital surgery. The nurses routinely visit twice post-operatively, but may visit or be called for, again.

Ruckley et al (1978) compared systems of after-care for groups of patients who had had varicose veins or hernia operations. One group was managed in an acute ward post-operatively, another in a convalescent hospital and the third group at home in the care of the general practitioner and district nurse. Most post-operative complications were minor, and for the day surgery group, the district nurse managed most of these, the general practitioner the remainder. The day care system required an average of an extra eight minutes (including travelling time) per patient for the general practitioner than other systems did. For the district nurse, the day care system required over 120 minutes extra time per patient than the other systems. The authors report that patients like the day surgery

system and that nurses were able to undertake tasks currently done by doctors. As in the study by Russell et al, referred to above, the extra work with patients resulting from day surgery fell on the district nurses rather than the general practitioners.

In a later article, Ruckley et al (1980) in Edinburgh describe a survey of the views of district nurses caring for day-surgery patients who had had hernia and varicose vein operations. The nurses reported few problems in post-operative care, and felt the system was better for the patients. Most nurses found the work satisfying although it did involve extra work. (A scheme for day surgery for children with care by a paediatric home nursing service, has been described in the preceeding section).

District nurses in the treatment room

One trend in the work of the district nurse has been for an increasing proportion of 'first treatments' to be given by them at surgery premises, as opposed to patient's homes. Reedy et al (1980) quotes a figure of 55.2 first treatments being given by district nurses on surgery premises in 1976, compared to 40.5 in 1972. In Reedy's survey comparing the activities of health authority and practice nurses, it was found that - not surprisingly - health authority nurses spent more time working at surgery premises where a treatment room was available. Compared to practice nurses, however, Reedy found that the health authority nurses were less likely to perform more 'technical' procedures such as venepuncture, and likely to undertake more traditional 'caring' activities. Similar findings were reported in Cartwright and Anderson's survey (1981), by Bowling (1980) and by Dunnell & Dobbs (1982), in the O.P.C.S. Survey.

We found hardly any other items written about the district nurses' work in treatment rooms. Most of the detailed studies of work in treatment rooms we found have been of places where the practice nurse undertook all or almost all the work, and these are referred to below in the section on Practice Nurses working in the surgery. One small study (McIntosh, 1979) looked at the work of six district nurses at surgery premises, and found that they were doing traditional nursing tasks only. Nurses who undertook longer sessions, e.g. an afternoon in the treatment room, saw more patients per week than those nurses who mainly gave treatments in patient's homes or had short sessions at the surgery premises. This is a more efficient use of nurses' time but there was a limit apparently to the number of patients willing to travel to the surgery for traditional treatments - some were quite resistant to this.

The 'Hospital at home' scheme

The 'Hospital at Home' scheme has been operating in Peterborough since 1978, (Mowat, 1982). The pilot scheme, funded by the Sainsbury Trust and the Area Health Authority for an experimental period provides care for patients of all ages who would otherwise have to go into hospital for a short period. Administration of the staff, such as extra nurses, a social worker, physiotherapist, occupational therapist and patients aides ('a cross between a nursing auxiliary and a home help') is done by a senior nursing officer. The general practitioner is responsible for clinical management and the district nurse for nursing care - she can call upon the 'bank' of staff in the scheme for help as needed. Twenty-four hour cover is available, although usually less has been needed. The scheme is aimed at patients who need intensive care for a short period, for instance patients who are dying, fractures, acute infections in the elderly, and strokes. A survey of a small number of the patients and staff involved reported overall satisfaction with the scheme. It was felt that, although comparing costs of home and hospital care was difficult, the scheme provided the cheaper alternative. If adopted more generally, it was suggested that shorter waiting lists and fewer hospital beds could result.

This scheme is unusual in having a 'bank' of nursing, auxiliary, and paramedical staff upon which the primary care team can call. However there are other schemes which provide for intensive short-term care at the home of patients who would otherwise have to go into hospital. (See Currie, 1980 and Gibbins, 1982 under 'District Nursing and the elderly)

Nursing and related care - joint schemes with social services

Some schemes have been jointly funded by health and social services* to provide help to enable patients (or 'clients') to stay in their own homes. The elderly feature largely in these schemes of help but younger people needing support for short or long periods may also be included.

In Oxfordshire a scheme began in 1979 to provide help for the frail elderly, (Quelch, 1981). A project team is led by a senior social worker, and includes a district nurse and home care assistants. Referrals came from health and social services, and are assessed by a project team member to see what help is being given and what deficiences in help could be provided. The home care assistants, 'who combine personal and domestic caring activities for clients', provide help if necessary seven days a week and occasionally overnight, working in shifts. Apart from providing long term help for the frail elderly, the scheme also provides short term intensive help to restore elderly people who have suffered some form of 'crisis' (physical, mental or social) to a better level of functioning. The scheme aims to avoid or delay the admission of clients to long-term residential care, and to enable some elderly people to leave residential care and live again in the community.

Experimental schemes, started in 1979, to provide 'care attendants' for young disabled people and financed by the Hampshire Joint Care Planning Team have been described by Lovelock (1981). The care attendants are 'best described as a (paid) relative substitute' who do work similar to that done by a variety of persons including nursing auxiliaries and home helps. Evaluation of the schemes was carried out, and both carers and clients were very satisfied. It is concluded that the service improves quality of life, and helps to delay or even prevent 'entry into residential care' sometimes, and that it might be extended to other groups such as the elderly and mentally handicapped.

A scheme (set up in 1978) providing 'short-term intensive support and practical help to clients within their own homes' in Avon County is described by Dexter (1981). The scheme has been funded by the health authority and the county, and pays for 'home aides who are appointed for their previous experience in one of the caring professions'. They are based in a hospital and provide seven days a week, 24-hour cover, aimed

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* Other schemes jointly funded are mentioned on pages 51, 61 and 63

at rehabilitating clients, for instance after discharge from hospital, so that after a short period of support clients can manage with a less intensive amount of care. The elderly have been the main users of the scheme, and the home aides, apart from providing practical and personal care aim also to re-educate, stimulate and motivate clients. The scheme is reported to be successful and funding is continuing.

In Rochdale a 'home care scheme' has been instituted, which provides 'home care workers' for patients on their discharge from hospital - usually elderly patients. Referrals are made by hospital social workers, with district nurse liaison officers providing the link with primary care teams, (H.S.S.J., 1981). This joint care scheme began in 1977 and has expanded to weekend and evening care and long term care, having originally been intended to provide short term intensive care only.

Another example of co-operation between health and social services is also described for Rochdale. A geriatric care team has been set up to 'assist and improve the care of elderly residents of local authority homes', (H.S.S.J., 1981). The need has arisen because of the number of residents in Part III accommodation who now require nursing and medical care. The geriatric care team comprises two district trained nurses, who did some further training in geriatrics. They visit local authority homes 'to train and to advise as consultants in health care'. Training is directed at the care staff of the homes, who are social service employees, so that they can better manage problems such as incontinence, drug effects and confusional states. The geriatric care team, after an initial training and advisory visit to each home, revisit the home to monitor progress.

However a study of elderly people in residential homes in a London Borough, which found a substantial amount of physical dependency and mental confusion in the residents, concluded that skilled nurses should be employed in the homes, rather than depending on district nurses. (Bowling and Bleathman, 1982). Most of the community nurses interviewed in the study felt that homes should have their own skilled nurses, and they did not have positive feelings about the times they had spent in the homes in nursing tasks.

Support services for community nurses in the care of the dying

Numerous schemes for helping in the care of the dying at home have developed. A survey of health districts and single district areas in England and Wales and of Social Service departments, was carried out by Wells (1980) to find out what services they provided for the dying and the bereaved in the community. This revealed a variety of services provided by the National Health Service, Social Services and voluntary organisations, in particular many night nursing, night sitting, home care and counselling schemes. (These services do not of course necessarily apply only to the dying, and a number of schemes described in the literature are referred to in this report elsewhere in connection with district nursing services and general help for the sick and elderly).

In addition there are specialist advisory teams based in hospitals and hospices, whose medical and nursing staff can advise community nursing staff and general practitioners on problems which arise in the management of the dying patient, such as pain control and dealing with the unpleasant side effects of drugs.

A survey of services in England, Wales and Scotland for terminal care available in December 1980 is reported on by Lunt and Hillier (1981). In domiciliary services, the survey found 32 home care advisory teams (both N.H.S. and non-N.H.S.)and eight hospital support teams (two non-N.H.S.) with wide variations between health regions. These teams had almost all developed since 1975. The authors recommended that 'the regional inbalance in the provision of services should be redressed, particularly for home care teams where inequalities are greatest. Improvements could be achieved if the N.H.S. encouraged the voluntary sector to favour the regions at present worst provided'. They advocate giving priority to home care teams rather than to more inpatient units.

Two examples of advisory teams, one based in a hospital, the other in a hospice, which occur in the literature, are described below. In both examples the primary care team retains clinical and nursing care of the patient, working with the support of the specialist team.

A 'terminal care support team' has been set up at St. Thomas Hospital in London and their work is described by Bates et al,(1981). The original team comprised a nursing sister, social worker, two doctors (radiotherapists) and the hospital chaplain, and began seeing patients at the end of 1977. The team offers help in controlling symptoms to the hospital staff caring for the patient and to the general practitioner if the patient is discharged

home, and is available at nights and weekends. If the general practitioner agrees the team can offer advice to him and the community nursing staff involved. It is felt that by referring patients to the team earlier in the course of disease, and having their symptoms therefore better controlled, patients were able to be at home more, thus releasing hospital beds. The demand for the services of the team has grown over three years, and as a result the team has expanded, an outpatient clinic has started, and the team's work with patients in the community including bereavement counselling, has greatly expanded. The authors argue that providing such a team is cheaper than hospice care (although of course patients may occupy beds in hospital), has teaching potential, and 'can bring the principles of hospice care to patients at home and in the hospital.'

An advisory service on terminal care based at a hospice is described by Doyle (1980 and 1982). The service operates from a hospice at Edinburgh, and staff include nurses and doctors. It aims 'to give to the patients, their families and professional attendants specialist, professional advice and support', and to 'enable more patients to remain at home longer than might otherwise have been possible and even die at home if that is their wish.' The advisory service is provided by specialised nurses and the doctors in the hospice, and only becomes involved at the request or consent of the patient's general practitioner who remains in charge of the patient. The advisory team visits the patient, assesses his needs, and sends written recommendations on care and management to the general practitioner. Thereafter a nurse visits as necessary 'to monitor the drug regimen, guide the family, listen and explain, interpret what the doctors have said, and often to prepare them for possible admission to the hospice'. The team often found that the usual statutory support services - including district nursing - had not been mobilized for the patient, which suggested lack of assessment and monitoring of the needs of dying patients. It was felt the hospice advisory team enabled patients to spend a longer time at home before entering hospital or hospice care.

One study evaluating an advisory domiciliary service based in a hospice for patients dying of cancer is described by Parkes, C.M. (1980). Spouses of patients who had died of cancer were interviewed, comprising one group who were asked about the home care service generally, a matched pair of groups who had and had not received help from the home care service, and a group of whose spouses had died in the hospice. It was concluded that the domiciliary service enabled patients to stay longer at home than they did without the domiciliary service. The costs of the domiciliary service were much less than the cost of inpatient care to the hospice, but the greater length of stay at home put considerable stress upon the families and in turn therefore the patients. However generally the spouses felt

Practice Nurses

Numbers of practice nurses

By practice nurses we mean those nurses employed by general practitioners, who must therefore be taken into account in any consideration of the work of the general practitioner with nurses in primary health care. Since these nurses are employed by general practitioners (and reimbursed in part by Family Practitioner Committees) their exact numbers are not known. A number of surveys concerned with practice nurses, their prevalence, the work they undertake, their training and their characteristics, have been carried out, notably by Reedy and his colleagues at Newcastle. Various sample surveys of practices have given different proportions of practices or doctors with practice nurses. Reedy (1976) found 24% of practices with practice nurses, Dunnell & Dobbs (1982) in the O.P.C.S. survey found 27% and Cartwright & Anderson (1979) found that about 36% of doctors employed practice nurses. Reedy (1976) states that in 1974 there were 3,100 practice nurses in England, and a D.H.S.S. publication on nurse manpower (1982) stated that 'in whole time equivalent terms about 1,100 qualified nurses are employed by general practitioners in a nursing capacity.'

Training courses and associations for practice nurses

Training courses designed for the needs of practice nurses and associations for them have arisen ad hoc, since no organisation has been responsible for providing these needs, although it was stated in the Appendix to CNO 77(8) 'Nursing in Primary Health Care' that practice nurses could be included in the training programmes organised by health authorities. However Reedy et al (1980) in describing a survey of the characteristics of practice nurses and health authority employed nurses, found that 64% of the practice nurses had not 'received any continuing education during their present employment', compared to 29% of the health authority nurses. Also they report that 32% of practice nurses said they had access to continuing education, compared to 91% of the health authority nurses.

Courses specifically for practice nurses have been provided, Leiper (1975) describes such a course in Hampshire and Mourin (1980) one at Norwich, both being based at further education colleges. Both reported that the nurses attending wanted further courses.

A few associations of practice nurses are mentioned - Mourin (1980) refers to a Norfolk Practice Nurses Group, formed after the course held at Norwich mentioned above, and Wrightson (1975) describes the Hull Practice Nurses Association formed back in 1972. The Royal College of Nursing has established a Practice Nurses Forum and is planning training courses (Rankin, 1981)

The practice nurses work at the surgery

A number of studies have reported on the actual work undertaken by nurses - usually practice nurses - in the surgery as opposed to the home. Development of this type of work has been enabled not just by the employment of practice nurses who work under the direction of the general practitioner, but by the provision, particularly in health centres, of treatment rooms.

Bain & Haines (1974) reported on a survey (over 2,000 cases) of work undertaken in the treatment room of a Scottish health centre. Most of the work was done by a SEN practice nurse, who was said to have played a valuable role, in undertaking a large volume and variety of procedures, and dealing with a large number of self-referrals from patients, about half the cases being self-referrals. Further training for the nurse in other procedures, and the employment of another nurse, was planned.

A study of the work in a Yorkshire health centre treatment room provided data on over 61,000 procedures in four years, (Waters et al, 1980). Most procedures were carried out by the practice nurses*, and overall 30% of procedures needed training or initial supervision of the nurses, a category which increased over time. The writers argue that the extension of the nurses' work would not have been possible if they had not been general practitioner employees and subject to the area health authority approval. Over 30% of the patients made their initial contact with the practice nurse, who referred them if necessary to the general practitioner.

A later study was published by the same team, (Waters & Lunn, 1981) of treatment procedures in the same practice. Over a third of the procedures were of the type requiring 'initial assessment or training or both', but these were limited in variety. The practice nurses were authorized by the doctors to undertake these procedures, but the authors conclude that if an attached health authority nurse was to have an equal role in the treatment room, their extension of procedures would have to be agreed with the health authority, and that nurses should only be attached to a practice if they were willing to train for and undertake these procedures.

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* as these procedures were not part of usual nursing curricula

The O.P.C.S. survey (Dunnell & Dobbs, 1982) found that general practitioner employed nurses spent 30% of their time on technical tests and assessments, and 47% on technical procedures, compared to 2% and 40% respectively spent on these activities by district nurses.

Another study (Marriott, 1981) looked at the work of practice nurses in a group practice in Worcestershire, where the patients were allowed 'open access' to the nurse if they wished. Forty-six per cent of patients did in fact see the nurse first, out of a sample of 3,000 attendances. Marriott feels that with adequate safeguards - for instance observation of the nurses' work and regular meetings between doctors and nurses to discuss problems - the doctors could confidently delegate work to nurses. Marriott feels that the care of patients is improved by this system, although he also thinks that 'further research is required to audit the management of patients by nurses when patients have open access to them.

In one group practice in London, the practice nurses undertook a new role in the running of the general practitioners' surgery sessions, (Bevan et al, 1979). The nurse saw each patient in a consulting room before the doctor, took a brief history and did any preliminary examination she felt necessary. The doctor then came in to see the patient while the nurse went on to prepare the next patient for the doctor in another consulting room. The scheme as described utilized experimental surgery premises, but was originally implemented in conventional premises at times when rooms were available to enable each doctor and nurse team to have at least two consulting rooms in operation. Doctors, nurses and patients were generally pleased with the new arrangement. In particular the system enabled the doctors to spend a higher proportion of their time 'on tasks considered central to the doctor's role', and they found their work less fatiguing.

Extending the role of the nurse

An increasing number of published articles are discussing the pros and cons of the concept of the 'nurse practitioner', a nurse in primary care, who could be a point of first contact for patients and could take decisions about their management - including of course the decisions to refer to a doctor just as a general practitioner might refer to a specialist. It has been argued that this would be a more economic system, since nurse training is far less expensive than medical training (and nurses are paid less than doctors) and these nurses could take over part of the family doctor workload. (However if doctors need to be at hand to supervise or deal with problems arising, the system is not necessarily more economic. See Murray, J.J. quoted in Expenditure Committee, House of Commons, 1977).

MacGuire (1980) has argued that in the United Kingdom 'nurses... are quietly expanding their roles .... to meet new demands without an accompanying fanfare of new titles'. We refer below to some schemes and studies which illustrate possible 'extensions' of the nursing role in primary care in the last few years.

Two of these come from the same practice in the north-east of England. Marsh (1976) describes how practice nurses are employed in his practice to run family planning and well-woman clincs. In family planning provision, the nurse takes over routine follow-up of patients, makes home visits if necessary and gives advice on contraception and related problems. The nurse concerned with running the well-woman clinic does relevant examinations and takes cervical smears. The system frees the doctors for other work and is an example of what the nurse, given suitable training, can undertake in a general practice setting.

Marsh also (1977) describes how nurses and health visitors in his practice were involved in a primary health care team effort to deal with 'minor' illnesses' in his practice. The general practitioner referred follow-up of minor illness to the nurses, and patients then often take recurring episodes straight back to nurses. Nurses and health visitors gave advice about self-treatment of illness, avoiding prescriptions and encouraging patients to buy their own 'patent medicines' such as analgesics, if appropriate.

In one practice, a nurse (qualified also as a health visitor) employed by the practice undertook a survey of all those aged 65 years and over who were on long term drug treatment so that they could be reviewed. (Martys, 1982). The 'drug monitor' was trained by the general practitioner 'to evaluate problems associated with drug treatment and to identify drug-related morbidity occurring in elderly patients on long term treatment'. She visited and interviewed the patient and took a blood sample. Over a third of the patients who were taking long term drug treatment were thought to be experiencing some adverse effects and their regimens were corrected wherever possible. The 'drug monitor' nurse will be involved in regular follow-ups of patients on long term drug treatment.

A clinic which is 'staffed and entirely run by nurses' at Staines is described by Wilson (1977). The clinic, in a health centre, treats patients referred by the general practitioners of the various practices in the centre, and is staffed by the district nurses. It is felt that the clinic saves the time of many nurses' visits, and that by being referred at an earlier stage by their general practitioners, to nurses who have expertize in ulcer treatment, better results in healing are obtained.

Nurses have been employed in general practices as part of the M.R.C. study of the effects of treating hypertension (Bryan, 1982). They are trained to take blood pressures to a high degree of accuracy, take blood samples and spin them in a centigrige to obtain serum, to record and read E.C.Gs. and to give patients the appropriate hypertensive drugs, all according to the M.R.C. protocol. In addition to their work for the trials, it is reported that some of these nurses are undertaking further work in the practices, setting up clinics, e.g. in hypertension for patients not in the study, or for diabeties. One practice claims that their nurse's work has enabled the general practitioners to increase the time they spend on patient consultations.

In a small study (Whitehead, 1982) in which general practitioners and district nurses were questioned about their views of nurses undertaking hypertension clinics, response was generally favourable to the idea. The general practitioners felt it would give them more time for other patients and the SRN district nurses were keen to be involved in the prevention as well as the management of hypertension. SEN district nurses were not as enthusiastic about the idea.

A pilot study in Birmingham of a nurse practitioner in general practice was described by Stilwell (1981). The nurse practitioner (a qualified health visitor) held one surgery a week for six months which patients had the option of attending, or to which they had been referred by the general practitioner. The nurse practitioner referred patients to the general practitioner if this was felt to be appropriate, otherwise she gave advice about managing minor illnesses, prescribed from a limited range of drugs (the prescription being signed by the general practitioner), monitored certain conditions and gave general information about personal health care.

In a later article Stilwell (1982) describes the follow-up stage to the pilot scheme, in which the nurse practitioner provided a full-time service to patients. Consultations were kept as informal as possible, the nurse practitioner being known by her christian name. She worked with the supervision of one general practitioner in the practice with whom regular meetings were held to review tasks of both nurse practitioner and general practitioner in this system. The general practitioner suggested to patients he thought appropriate that they might see the nurse practitioner for routine follow-up consultations, an option which patients could decline. If patients saw the nurse practitioner twice about the same illness, they were requested to consult the general practitioner. The nurse practitioner used the normal medical records to record findings, she could recommend certain medications, and if these needed prescriptions, the general practitioner had to sign these (as in the pilot stage described above). Examination and treatments were based on protocols used for Family Nurse Practitioners in the University of North Carolina, Department of Family Medicine, and agreed with the supervising general practitioner. The role of this nurse practitioner has evolved and changed over time, for example at one stage she was sharing the on-call rota with the general practitioner, but this was stopped on the advice of the Medical Defence Union. Her work is to be evaluated by the General Practice Teaching and Research Unit at Birmingham Medical School.

In contrast an experiment using a person of quite different background and training is described by Reedy et al, (1980). A final year student from a physicians associate programme in the U.S.A. worked in a general practice for two months. His work included consultations in the surgery and on home visiting, and under supervision managed a representative sample of cases. It is suggested that this type of auxiliary could be useful in under-doctored areas.

Barber et al, (1976) compared in a study the decisions made by a nurse and the general practitioner of a practice about the urgency of requests for home visits. At first there was some discrepancy between the nurse and doctor assessments which potentially could put patients at risk. After actual visits and comparisons of decisions were made, it was felt that the nurse could, given suitable guidelines, assess the relative urgency of home visits and the appropriate action to take.

Some practices already use nurses to make home visits, but in one practice where this is done, a patient survey found that 41% of patients would not like the nurse to appear if they had requested a home visit from the doctor. Patients who had received home visits from the nurse were generally satisfied with their treatment although a quarter would still have preferred to see the doctor, (Marsh & Kaim Caudle, 1976).

Finally, two surveys have questioned staff about their attitudes towards more delegation to the nurse in general practice.

Bowling (1981) reports on a sample survey of doctors and nurses' attitudes towards delegation of tasks to nurses. Less than half the general practitioners regularly delegated minor clinical procedures. They were generally against the nurse being the first contact for the patient in the survey although more prepared to send the nurse on a home visit to assess if the patient needed to see the doctor. More nurses than doctors were in favour of nurses doing these 'decision-making' tasks such as seeing the patient for initial screening.

Miller & Backett (1980) in a larger survey of general practitioner opinions, found that 45% of general practitioners would permanently accept having a family practice nurse 'who would undertake after suitable training, tasks including history taking, examination, diagnosis and advice on treatment'. Nearly a third were against having such a person in the practice, the rest had no strong view or would accept such a person temporarily where there was a shortage of general practitioners. From these surveys it appears that nurse practitioners would have a mixed reception from general practitioners and nurses, but a considerable number of both groups would support such an innovation.

General reviews of schemes and studies

'Primary Care Nursing' edited by Lisbeth Hockey (1983)* includes chapters on health visiting and district nursing in the United Kingdom which give concise summaries of developments in these fields, with full lists of references.

In 'A Sourcebook of Initiatives in the Community, Care of the Elderly' (Ferlie, 1982) over 200 schemes in England in this area are described, most in some detail. Information for the sourcebook was obtained by approaching social service departments, health authorities, housing departments and voluntary organisations, and many of the schemes described are concerned with domiciliary care of the elderly.

A list of briefly described schemes in community nursing is included in a report on information obtained from chief nursing officers in England (Baker & Bevan, 1983).

A summary and discussion of 37 studies of the work of the health visitor in the period 1960-1980 in the United Kingdom has been written by Clark (1981). The studies include both published and unpublished research involving data collection.

Schemes to set up local support groups for parents and families in which health visitors have been involved are listed in an article by De'Ath (1982). References and addresses for information are given.

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* Two items published in 1983 are included here as they cover schemes within the period of this literature review.

DISCUSSION

Introduction

We have grouped this section under eight headings corresponding to areas where, at least as far as the literature goes, it appears that further research is required. After each heading, there follows a set of questions followed by a discussion elaborating on the issues raised.

1. Organisation of community nursing

Is attachment necessarily always the best way of organising community nurses - is it economic, does it provide the best service for patients, is it an efficient way of using trained staff?

Do the advantages of being attached and thus belonging to a primary health care team outweigh the disadvantages?

What modifications to organisational and management arrangements could be made to reduce problems of attachment?

Attachment (that is to say an arrangement whereby district nurses and health visitors are responsible for a population consisting of the patients of one or more general practitioners, rather than the residents in a geographical 'patch'), as a universally appropriate way of organising community nursing services is clearly under attack or at least critical review. (See for example pages 4, 35 and 36 of this report.)

Despite this disillusionment there appears to be a dearth of studies examining various forms of attachment schemes and other alternative means of deploying community nurses - nor do the published registers of ongoing research we consulted reveal much work in progress in this area.

Here we examine in particular the difficulties which can arise from the mismatch in their organisation and management to be found as between health authority employed staff and the general practitioners, and their staff, working within primary health care teams which seems to be at the heart of the problem and which merits study. (A matter to which Hart (1977) drew attention.)

Those who question the merits of attachment argue that this can be uneconomic compared with the 'geographical patch' approach especially in inner city areas where a large number of community nurses (using this

collectively to refer to health visitors and district nurses) may be working in the same locality and a particular nurse's travelling time is increased because her patients are scattered over a relatively large area, either viewed in horizontal terms or in the case of high-rise flats, vertically speaking. Attachment in these circumstances also means that no one community nurse has an overall responsibility (within her sphere of activities) for a given geographical patch, thus no one has a duty or indeed the capacity to know what is going on in the patch, e.g. to follow up unregistered patients or to build up a network of contacts which would enable her to get early warning of problems occurring within say some families. There is, it is argued, a great deal of difference between being a district nurse or health visitor for a particular small locality, in terms of identification, and having a similar role in respect of the patients of a couple of general practitioners, scattered over the community.

The question of whether scarce resources are being properly deployed clearly needs to be asked when a number of community nurses are all travelling about the same relatively large (or at least heavily populated) area, simply because a number of distinct practices all have patients scattered around that locality. The Acheson Report (1981) produces illustrative data as to how serious a problem this can be sometimes in inner London, for example 15-20 family doctors with patients in a single block of flats; with this number of doctors ascertained from only a total of about 40 families with whom community nurses were in contact. Equally it is not always the case that attachment leads to community nurses being inefficiently deployed in the sense that it reduces the proportion of their time which they are able to spend caring for patients or clients. For example, the study quoted by Hicks (1976) (Ambler et al., 1968) suggests that attached health visitors were spending more time per week with their clients than those who were partially attached or working on the traditional geographical patch basis - they certainly spent more time travelling but much less time on administration. Also they seemed to work longer hours than those who were partially attached or working a geographical patch. In effect this extra time they spent at work was being devoted to direct contact with patients both in the patient's home and in clinics. They also spent more time than the other categories of health visitor in liaison meetings.

Poulton (1977) comparing aligned and attached health visitors and district nurses in the Wandsworth and East Merton Health District concluded

that 'There is a significant difference in the working pattern of health visitors who are attached and those who are aligned. The main differences are:

1. The aligned* health visitors spend more time on client visits including routine visits.
2. The attached* health visitors spend more time in consultation with the general practitioner.

The home nurse also shows a significant variation of working patterns between schemes throughout almost all aspects of her work. The main differences are:

1. The attached nurse spends less time on visiting patients at home but compensates for it by carrying out care at the surgery.
2. The aligned nurse and nurses engaged on relief work, spend more time on travelling than their colleagues.'

Walsworth Bell (1979) compared the work of health visitors in two districts, Greenwich and Bexley. In the former nearly all health visitors worked on a geographical basis whilst in the latter all the health visitors were attached to general practices. The author concluded that 'there seems a common core of health visiting practice ... which is untouched by how the health visitor's work is organised. ... However the differences should not be minimized. The advantages for attached health visitors are that they seem more approachable to clients and their clinics are used more for informal consultations. The advantages for geographical health visitors are the higher number of 'no-one initiated' visits, and increased follow-up of families known not to have a G.P.'

Dunnell and Dobbs (1982) in their survey of Community Nurses in 24 health districts, also produced some information in relation to attachment. It was found that for district nurses, midwives and health visitors, that not being attached to general practice and working with a large number of practices were related to a less positive assessment on their part of relationships with general practice. However assessments in relation to patient-related aspects of their work, 'were not related to patterns of attachment and patchworking, nor to the number of practices worked with .... .

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*'The doctors whose patients are attended by an attached nurse all work in the same location, be it a health centre, health clinic or general practice. On the other hand an aligned nurse works for doctors located at various places. In addition to their G.P. caseload every health visitor has a geographical responsibility to cover those not registered with G.P. practices, e.g. Part III accommodation and gypsy encampments.' (Poulton, 1977).

There was a slight tendency for attached nurses to view the amount of travel they did as excessive. When information about actual travelling time from the diaries was compared, there were no differences between attached and not attached district nurses, midwives and health visitors.'

Clark (1981), who reviewed thirteen studies comparing characteristics of the work of health visitors organised on attached and geographical patch bases respectively, concluded that:-

'a) the differences reported are small, and

b) such differences as are found cannot be conclusively attributed to (the presence or absence of) attachment.'

However a study comparing district nurses working on attached and geographical bases respectively, in part of one Midlands area health authority (West Midlands Regional Health Authority, Management Services Division 1977) warned against the danger of taking these methods of working at their face value. It appeared that in the town where a complete attachment scheme was formally in operation, this was not rigidly adhered to; nor was it the case that in the town where nurses were organised on a geographical basis that this entirely determined their method of working. 'In both towns there was evidence of work sharing to reduce pressure in certain areas and to reduce travelling time and costs.' Hence it was thought that the above analysis could not be expected to identify differences between true attachment and true geographical patch schemes. In fact in the conclusions based on an actual study of the nurses working according to the two approaches very little difference was found. The authors endeavoured, therefore, to compare the cost of district nurses working on attached and geographical bases by means of the analysis of theoretical models incorporating the central characteristics respectively of the two approaches. They concluded that if one accepts the assumptions built into these models, geographical allocation would be considerably less expensive than attachment.

Keywood (1978) in discussing the pros and cons of attachment versus the geographical patch approach, suggests that a better service might be given in the community and that better use might be made of resources if:

'1. There was closer co-operation and more flexibility in the allocation of duties and responsibilities of health visitors and district nurses and midwives. (The usual management structure - whereby a

district nurse is accountable to a nursing officer (district nursing), a midwife to a nursing officer (midwifery), and a health visitor to a nursing officer (health visiting) - tends to separate rather than co-ordinate their work.).

2. A compromise were sought to enable the advantages of group attachment to be combined with the advantages of geographical schemes .... .'

She suggests that 'a scheme based on the concept of the triple duty nurse who undertakes health visiting, district nursing and midwifery, might be well worth the trial .....

Small teams consisting of health visitors, district nurses and midwives, (possibly assisted by some less qualified staff) could be formed and each team be led by a nurse with all three qualifications. This leader, in addition to participating in practical work would have overall responsibility for the co-ordination of work within her team and would ensure that continuity of care was achieved and an overlap of duties eliminated.

In health districts where large group practices cover wide areas, the conflicting claims of group attachment and geographical working might be satisfied by dividing the districts into zones. Each zone would then have allotted to it a number of these small nursing teams, each team being also attached to a general practice.'

Dingwall (1977) suggests that a single worker might take on health visiting and social work in remote rural areas, who would then be geographically based. More radically he advocates primary medical care as a whole being geographically based also, with so many G.Ps., and other health workers per unit of 20,000 population. However, writing later Dingwall & Watson (1980) argue that, at least in the present system of primary health care, which has changed in recent years, attachment should not be abandoned hastily. They recommend a series of trials to evaluate attached versus district systems.

The 'attachment' versus 'geographical patch' debate would be largely resolved where general practitioners agreed to zone their practice areas in a locality. Where several general practitioners work in partnership or at least as a group preferably from the same base premises, it is possible for them to collectively cover a 'zone' and yet to offer from within the group some freedom of choice to the population served as to their family doctor. Basically the issue comes down to the fact that in moving towards attachment

arrangements, community nursing tailored its organisation to fit into the existing scheme of general practice which was based essentially on the right of patients and doctors to have some freedom of choice as to whether they accepted one another. Ultimately it is the duty of the community nursing services of a district to provide community nursing care for the population within the boundaries of that health district and it is administratively tidy as well as facilitating the case finding and surveillance roles of particularly health visitors, to organise the deployment of community nurses on the basis of a geographical sub-division of the district's area. Thus for attachment to work most conveniently if not effectively from the point of view of community nurses, there is a corresponding need for general practice to adapt also as far as the zoning of practice areas is concerned.

Two questions arise which might be settled by a suitable investigation.

1. How imperfect can zoning be, in the sense of the proportion of the population resident within the zone being registered with practices serving adjacent areas, without raising the level of inconvenience and inefficiency in surveillance and case finding in the zone to a point where these disadvantages outway the benefits of attachment.

2. What is the situation as regards zoning of practice areas in England as a whole? Over the last fifteen years there has been a steady growth in the number of doctors practising from health centres or other similar premises purpose built for primary health care teams and a tendency for doctors generally to organize themselves into groups. Has this trend led to a substantial part of the country being zoned in a sufficiently complete sense as defined by (1) above, by practice areas? The answer to this question might effect decisions on policy about whether and in what way to encourage the remaining practices to proceed towards zoning by practice area.

Implicit in the above arrangement, if the freedom of the patient to have some choice over his or her family doctor is to be preserved, is a group of several doctors serving a geographical patch in collaboration with an attached group of community nurses, also between them providing district nursing and health visiting services for that same patch. This is essentially the primary health care team envisaged in 'Primary health care teams' (British Medical Association 1974).

A further organisational issue tied up with attachment is that of the nursing officer's relationship with subordinate community nurses, and the general practitioners to whom they are attached. It is clear that problems have arisen when the nursing officer acting for the health authority, exercises a line-management role in the way her staff are deployed and controlled without due regard to the interests of the general practitioner and possibly of her subordinates as primary health care team members. (See pages 7,32,35,37,41 and 44). It may indeed be that the nursing officer's role in relation to attached community nurses is not appropriately that of a line manager. Arguably the act of attachment to general practice implies that of detachment of the nurses in question from the health authority, and the nursing officer for the duration of the attachment exercises only the residual role of adviser and arbitrator on request, and constitutes a channel of information on D.H.S.S. and health authority policy and developments. Thus it may be that one would be thinking of an 'attachment agreement' as between the health authority on the one hand and practice(s) making up a group of family doctors on the other for a defined period of years in which each party, as it were nursing and general medical, agrees to operate within broad guidelines essentially set down by the respective professions rather than the health authority. This approach might be a means of assimilating suitably qualified practice nurses into the team - as a nursing 'partner' in the group practice of nurses.

Also particularly if we are thinking of teams of the larger kind described above - 'group practices' of nurses attached to group practices of doctors - there may be a need for a nurse equivalent to the senior partner for the team of nurses. Such a senior nursing partner would be more suitably 'first-among-equals'[1] than a line manager if her role was to parallel that of the senior general practitioner partner, given the variety of specialized disciplines to be found within the group of nurses in question[2]. At all events the role of the nursing officer in relation to primary health care team nurses seems worth exploring.

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[1] A nurse with a role with some affinities to this was the nurse co-ordinator referred to in Gilmore,Bruce and Hunt (1974).

[2] See also Keywood (1978) where it is suggested that a triply qualified nurse would be the leader of a community nursing team in the field.

So far we have been discussing a particular form of attachment - in effect full attachment. However, 'Collaboration in Community Care' (C.H.S.C. & P.S.S.C. 1978) (see page 29 of our report) suggests a definition of attachment as follows - 'an arrangement whereby a member of one profession has a formalized means of working with another professional group within the latter's own territory'. This definition allows various degrees of attachment, where the attached member of staff may be working within the other professional's territory for any time between half day a week and a whole week with freedom in the former case to deal with other clients on another basis for the rest of his/her time. Health visitors who appear to have particular doubts about attachment in the full sense may find some form of attachment along the spectrum mentioned above, more acceptable. For example a health visitor might work on a geographical patch basis but would have a duty to attend at stated practices for say half a day a week to act as a go-between for that practice between health visitors and the general practitioners involved. Note that sometimes attached nurses do also have formally or informally, geographical responsibilities (see page 84 and 85 of this report, and Dunnell and Dobbs (1982)). Certainly investigation into the costs and benefits of such more limited forms of attachment may be worthwhile.

2. Community evening and night nursing services

What is the optimum way of organising these services, e.g. night sitters, with qualified nurses on call or visiting.night nurses, 'tucking down' service from nurses?

What sort of service would patients and relatives prefer?

'Out-of-hours' district nursing services, covering evenings, nights and weekends, have been increasingly adopted in the period under survey for this report, that is, since 1974. Some out-of-hours district nursing services were in existence before 1974, and several professional and government documents have advocated that all health authorities should provide these services. (British Medical Association 1974, Royal College of Nursing and Royal College of General Practitioners 1974, D.H.S.S. 1977, S.M.A.C. & S.N.M.A.C. 1981.)

Some provision of out-of-hours nursing for patients dying of cancer is charitably funded in part, for instance the Marie Curie nursing staff.

Where these nursing staff are not available, and for other conditions needing night or evening care at home, health authorities need to provide nurses or other help.

The studies and schemes reported on demonstrated a variety of types of out-of-hours nursing services. These included (see pages 60-61) a nurse staying all night with the patient; a night sitter (that is an unqualified person given some training and employed by health or social services) staying all night, with a nurse on call or making routine visits during the night; and a 'tucking down' service where the nurse comes in to settle the patients at night. Obviously these variations have different cost implications, depending on the type of staff used (qualified or not) and how much they are with one patient or with several during any given evening or night. One study (Martin 1981) concluded that providing evening and night nursing services was less costly than institutional care, except for Part III accommodation. However the patients referred to in these out-of-hours services in the study were too ill or handicapped to be accepted for Part III.

Moreover different patients and their families may have different needs, and different health authorities different resources available. This suggests that it would be useful to know what type of arrangements for out-of-hours nursing would be helpful to the patients and their relatives and generally feasible to operate. Another factor to be taken into account is whether or not providing out-of-hours services keeps at home patients who would otherwise have to go into institutional care. A number of the schemes described in the literature asserted that patients were able to stay at home by using these services, but there was no real proof of this. If keeping patients at home and out of hospital is an objective of providing out-of-hours community nursing services, then this needs to be demonstrated.

3. Provision of primary care aides

Who should direct primary care aides- problem of health and social services both being concerned?

How far can their role be extended?

How should they be trained?

Many of the schemes reported on depended on the services of a group of people who provided both help in the home and some personal care. These people had various names given to them, such as care assistants, home aides, home care workers, care attendants and primary care workers.

The London H.P.C. (1981) suggested 'care assistants' for the provision of nursing and domestic care and in Care in Action (D.H.S.S. 1981) the overlap between home help and nursing ancillary care was seen as an issue worth studying. The Royal Commission (1979) recommended research into the use of aides in community nursing (see pages 42,16, 31 of this report).

Mostly the primary care aides in the schemes we came across were paid workers, but volunteer workers were also used. Their role appears to combine elements of nursing auxiliary and home help roles, but varies between different schemes, for instance in the scheme in Avon (Dexter 1981) the 'home aides' aim to re-educate, stimulate and motivate 'clients' towards rehabilitation. A number of schemes using these workers mentioned that they were available for seven day, twenty-four hour cover, and their help was given to various groups, notably the frail elderly, those discharged from hospital, the disabled, and the dying.

The emergence of these 'primary aides' raises a number of issues. First of all what should their role be - and how far could it be extended? These workers appear to be undertaking relatively unskilled but nonetheless important tasks which enable patients to continue living at home. How much can be delegated to them? Secondly the availability of 'primary care aides' who are relatively unskilled, may enable more professional staff to extend the range of care they offer to patients in the community. Thirdly how should primary care aides be trained, and who should be recruited? Muir Gray (1977) suggests that a 'primary care worker' should be developed 'with common training for those staff who are at present labelled home helps, care assistants, nursing auxiliaries, wardens of sheltered housing, and occupational therapy and physiotherapy aides'. Currently any training and recruitment appears to depend on the individual employing authority and varies accordingly.

Fourthly, the employer also varies between health authorities and social service departments, which in turn begs the question of who should be responsible for these aides, and how can their work be monitored and

co-ordinated between the demands of different professional workers on behalf of their patients or clients? From the primary health care point of view, there is the problem of how these aides fit into the primary care team structure, especially if they are volunteers or social service employees.

Fifthly, schemes making extensive use of this type of staff claim that they delay or prevent entry into residential care, an assertion which appears to need testing, as does the claim that patients or clients are satisfied with the schemes.

Finally information on the comparative cost implications of using these aides does not appear to have been reported on.

4. The roles of health visitors and district nurses

Should the roles of health visitors and district nurses be modified, particularly in relation to one another, e.g. could a nurse particularly concerned with the elderly take on some other functions such as 'health visitor' type work (educative and preventive) and physiotherapy?

Should the roles of the health visitor and district nurse be combined?

Health visitors' clientele largely consists of young children and their mothers whilst district nurses' major patient group is the elderly. The Court Report (1976) proposed that Child Health Visitors should take on nursing as well as health visiting (as it is currently understood) roles for children under sixteen years of age. We have noted two studies where district nurses did routine assessments of the elderly population in a practice (Wallace, 1975 and Shaw, 1975 - see page 64 of this report). Whilst not suggesting any formal changes in role, 'Primary health care nursing - a team approach' (Royal College of Nursing, 1980 - see page 33 of this report) noting that there were already some areas of overlap in the job descriptions of health visitors and district nurses (as well as other primary health care workers) suggested that who did what depended in part on context and the best interests of the client/patient by ensuring continuity of care, and partly on the special interests and talents of individual members of the team.

The Health Visitors' Association in 'Health Visiting in the 80s' felt that it was best to let the health visiting profession get on with the job as currently defined, which was more than enough to attempt with the existing complement of health visitors. (Although they do indicate how the role can be expanded given suitable increments in the numbers of health visitors - see page 37 of this report.) Indeed from evidence to the Expenditure Committee (House of Commons,1977) it appears to the Committee that health visitors still regarded their work with babies and young children as their first priority and had some reservations about the pressures on them to spend time visiting elderly people - perhaps the least contentious and the longest established development in their role.

Clark (1982) comes down strongly for health visitors specializing in child health, on the grounds that this is an area where health visitors have real knowledge, that 'no other professional worker can offer a service to this group which is as appropriate and comprehensive as the service the health visitor can offer', and that 'our child health services are a disgrace to a civilised country'.

The principles of health visiting set down in 'An Investigation into the Principles of Health Visiting' (C.E.T.H.V., 1977) have been influential (see page 28 of our report). These, and the definition of health visiting produced in the same report (also reproduced on page 28 of our report) clearly envisage as an ideal at least that the health visitors should move to a key role in the surveillance of the health of individuals and communities particularly in relation to families, and educators on health matters on the same basis. The conference 'Primary Health Care in Europe: the Role of the Health Visitor' (North East London Polytechnic, 1981) endorsed these principles and suggested that the curative and preventive roles of the 'Public Health Nurse' should be kept separate as they are in the United Kingdom but participants were in no doubt that health visitors should otherwise be generalists. They also discussed the idea that given the shortage of resources for health visiting activities they should set out to achieve the objectives implied in the principles of health visiting by community involvement of health visitors rather than continuing to provide one to one services to which health visitors in the U.K. were accustomed.

De'Ath (1982) also observed that no health visitor can be all things to all women or to all families and suggested that health visitors can best help families by creating a local network of support and gives

examples of many such schemes which were already being successfully run in different parts of the country. (See also page 81).

Watson (1982) who, as part of a research study of child health clinic use in one London health district, has been interviewing mothers, questions whether health visitors have the power to solve the social problems which in turn affect health in inner city areas. She suggests for the minority of families who have such social and environmental problems that these would best be attacked by a 'task force' comprising a health visitor, social worker, environmental health officer and possibly a general practitioner.

The discussion document 'Thinking About Health Visiting' (R.C.N., 1983) concluded that health visiting is nursing and sets out a number of problems and questions for the profession to address itself to in connection with the role of health visiting in the future (see pages 43-45 of our report).

Dingwall (1977) states 'health visitors should be seen as the principal case finding agency of the welfare state'. She is qualified for this by her 'combination of health and social work skills, and her knowledge of the individuals and services in her area', which means she can refer clients appropriately. However Dingwall feels that health visitors probably need more training in social science to fulfil this role and that it may be desirable for some non-nursing trained persons to be trained for the role. He also refers to the health visitor as having an 'enabling' role, bringing together 'people with common interests or problems in mutual assistance groups'.

Another call for change comes from Spray (1982) who says that where ill health is caused by bad social and environmental conditions 'then the health visitor's role is not to teach people to adapt or adjust, it is to organize and protest, and where necessary to act as an advocate', and this view is also taken by Clark (1982). Rigler (1982), a general practitioner, also supports the view that the health visitor should actively work for change in her local community and that a health visitor should be set up experimentally to do this.

One suggestion was that nurses in the community should be a specially trained group from the outset, most of the training being done in the community and not in the hospital (Russell, 1975). This person would be a 'general nursing practitioner' who would combine in one the roles now undertaken by the three types of community nurses - midwives, district

nurses and health visitors. She could follow up visits, it was argued, for the general practitioner, assess needs, immunize, carry out routine maternity care and regularly visit the elderly and the chronic sick.

Saint-Yves (1978, 1979) advocated 'three grades of para medical staff involved in community care'. The nursing aid, the community nurse and the clinical associate - the last of which was seen as replacing the health visitor. The clinical associate in his view, would be trained to

'a) provide an initial emergency service
b) carry out initial diagnosis
c) treat commonly encountered illnesses
d) prescribe from a restricted list of drugs

and would thus be responsible for all routine initial screening procedures, general surgeries, house calls and ante and post natal clinics'.

Another family doctor who supports the development of nurse practitioners who can undertake much of the work now done by general practitioners is Lefever (1982). He considers that 'suitable protocols can be established for trained nurses to investigate and manage episodes of minor illness' and that 'nurses should recognise that general practitioners in Britain's health service have usurped a position that should rightfully have been theirs'.

Keywood, 1978 (see page 86 of this report) suggested that a triple duty nurse qualified to undertake health visiting, district nursing and midwifery might well serve as the team leader of a team in combining all three groups of primary care worker. It is envisaged that this leader would have a definite clinical role and not just be a nurse manager.

Hicks (1976) also argued that there was a case for combining the role of health visitor and district nurse and took the health service professions to task for their unwillingness to even contemplate let alone experiment with such changes. Here perhaps is the heart of the issue - professional bodies naturally have a duty and right to safeguard the interest of their members but arguably in professions such as nursing and medicine which see themselves as increasingly research based, plausible ideas should be carefully tried out on an experimental basis and accepted or rejected on the evidence thus provided. The role of a professional body would then be to ensure that policy took due and balanced account of this research evidence.

Many health visitors do in fact have district nursing qualifications as well and even though such persons would often be in the nursing officer grades, there are presumably health visitors well equipped to take on a combined role should experimentation with such a role be put in hand. Moreover a very high proportion of health visitors have a midwifery or obstetric qualification - 70% had S.C.M. or C.M.B. Part I (Dunnell and Dobbs in the O.P.C.S. Survey, 1982). Indeed the nurse practitioner in the experimental scheme described by Stilwell (1981) (see page 79 of our report) was a health visitor.

The overlap in the responsibilities of health visitor and social worker was also noted by Hicks (1976) but because of the organisational difficulties, no doubt, there have been a few suggestions that there should be a professional combining of the roles of health visitor and social worker, though this was thought to be in principle possible by Hicks. Dingwall (1977) however, has suggested that a single worker might take on health visiting and social work in remote rural areas. An example (see page 42 of our report) of agreement as to the respective roles appropriate to social workers and health visitors in dealing with a specific problem - child abuse - is that reached by the British Association of Social Workers and the Health Visitors' Association in 1982.

Thus there have been a number of articles on the role of the health visitor which suggests that there is an ongoing debate about the whole future of health visiting. The function, and roles, indeed the continuation of the health visitor in her present form are all being questioned.

Goodwin (1982) felt that there should be an enquiry into health visiting which should 'examine and make recommendations about the proper role, and functions of the health visitor and to establish up to date health visitor-to-population ratios in the light of changes in the health visitor's work necessitated by altered patterns of health, and social conditions'. Among the questions she felt that any enquiry should try to answer were

What is the evidence that the health visitor's work has any effect?

What do consumers think of the service?

Is a nursing background, and existing training, the most appropriate training for health visiting?

Are health visitors necessary or have some other kind of worker more potential for prevention?

The Health Visitors' Association has called for a national enquiry into the proper role and functions of, and the relationship between, health visitors and school nurses (H.V.A., 1982). The Association pointed out in support of this call that there had been many changes in the characteristics of the population served by health visitors and school nurses since the last enquiry into health visiting, with some reference to school nursing, was carried out in 1956/57 by the Jameson Committee. Yet the calculations and recommendations of the Jameson Committee are still used, the Association stated, as a basis for assessing the acceptable ratio of health visitors to populations served.

The development of primary health care teams with the basing of health visitors' case loads on patient lists instead of on geographical areas has also had a profound effect on health visiting and school nursing. To a considerable extent this has meant that health visiting has become more and more divorced from school nursing, and training specifically designed for school nurses has emerged.

Prior to 1974 'whilst working as local government officers health visitors claimed and were given the status of practitioners in their own right. Within the nursing hierarchy of the integrated NHS this status is proving incompatible with the type of managerial and financial control required by health authorities, and increasingly professional judgements are becoming the subject of challenge and even of disciplinary action.

Another real anxiety is the growing number of small surveys or simply expressions of opinion about health visiting and school nursing which are influencing health authorities and others often quite unjustifiably ...

In addition to the many other reasons for a full scale enquiry it is naturally of great concern to the Association that the future development of health visiting and school nursing should be based on fully informed opinion resulting from a nation-wide enquiry, and not on one or more of a variety of limited surveys which may not be scientifically designed and which cover only a restricted geographical area'.

By contrast, developments in the role of the district nurse appeared to be less contentious, partly perhaps because details of organisation and role assignment apart, the need for suitably trained persons to render nursing care in the community is not in dispute. The question is 'in what

ways should her role be developed if at all'. We have seen that one possibility would be for a district nurse to take on the screening and educational functions associated with health visitors in the case of elderly persons. The adoption of the nursing process approach in district nursing, with its implication of greater autonomy in devising and managing the conventional nursing activities for district nursing sisters and the direct conveyance of nursing plans so developed to hospital nurses where patients are admitted (and vice-versa on discharge) is another area of development. There has also been a suggestion that the district nursing team (taking this to include the district nursing sister, other trained nurses - S.R.N. and S.E.N., - and nursing auxiliaries) should be responsible for care of patients in greater depth taking account of all their social and other circumstances in their management in the nursing sense of the case. A district nurse is one person who might extend her role to become a nursing practitioner, that is to say that she would take on some functions traditionally associated with doctors.

As far back as 1974 the report of a Panel of the Board of Science and Education of the British Medical Association (B.M.A., 1974, see page 17 of our report) concluded that 'in certain defined areas, with appropriate training, registered nurses could undertake patient assessment and counselling and in certain circumstances the initiation of therapy'. (Although they did not think there was a need at that time for the introduction of a grade of personnel with a label such as medical assistant or nurse practitioner.) They recommended in particular a controlled trial to compare primary health care teams where the nurse makes independent decisions in certain areas with those teams where she does not.

Early in the same year the report of the classic Burlington Randomized Trial of the Nurse Practitioner (Spitzer et al.,1974) provided evidence of the substantial contribution that Nurse Practitioners might make at least in the context of primary health care in Canada. The 'trial was conducted to assess the effects of substituting nurse practitioners for physicians in primary-care practice as the person of first contact. Before and after the trial, the health status of patients who received conventional care from family physicians was compared with the status of those who received care mainly from nurse practitioners. Both groups of patients had a similar mortality experience, and no differences were found in physical functional capacity, social function or emotional function. The quality of care rendered to the two groups seemed similar, as assessed by a quantitative 'indicator-condition' approach. Satisfaction was high among both patients and

professional personnel'. The authors report that the nurse practitioners were able to successfully 'function alone in 67% of all patient visits' (in which the nurse practitioner was the person of first contact).

Both the British Medical Journal (1977) and the Lancet (1975) in leading articles have given cautious approval to the introduction of nurse practitioners in Britain. Indeed Maguire (1980) argued that 'in any event in the United Kingdom, nurses were quietly extending their roles to meet new demands.' (Examples of these developments, which involve district nurses, have been described on pages 77 to 80 of this report).

Kratz (1982) argued that for nurses to expand their sphere of expertize they should devise record systems which showed their clients' needs, what was provided, and what could have been provided given sufficient resources; and also identify new approaches to nursing tasks and 'new tasks or target populations for themselves'.

5. District nurses, practice nurses and the treatment room

How best should the work of the district nurse be allocated between work on surgery premises and work in the patient's home?

How best should the work of district nurses and practice nurses be arranged in relation to each other?

Does open access to a nurse at the surgery utimately provide a better outcome for the patient?

The Royal Commission on the N.H.S. and the Harding Report (see pages 31 and 41 respectively of this report) raised questions of this kind. A considerable number of the district nurses' first treatments take place in the health centre or other general practitioner premises. (The proportion was 55% in 1976, see Reedy et al., 1980). At the same time the trend towards early discharge of patients and keeping patients in the community where possible can lead to the district nurse having to provide nursing care for a number of people who might in the past have been the responsibility of hospital nurses for a greater part of their spell of illness - see for example the study (Russell et al., 1977) outlined on page 66 of this report, where the district nurses caring for patients discharged early from hospital after surgery, paid on average four visits more per patient compared with those who had not been discharged early. (See also Ruckley et al. 1978, page 66). Moreover it is likely that the extra load resulting from 'care in the community' policies will be of cases needing nursing care in their homes for a greater part of their spells of illness. It

may be that the extra load will change the pattern of district nurse's working, that she will tend to give more first treatments in the home and then follow up recovering patients in her surgery sessions. In these circumstances it may be that where district nurses are in short supply, certain of the kinds of cases previously seen in the surgery would have to be excluded in order to cover the increased demand for home nursing.

Clearly if the treatment can be given in a surgery session, it takes less time than if it had to be undertaken in the course of a visiting round. A practice transport service could be used to bring in patients for treatments by the nurse in the surgery in much the same way as they have occasionally been used to carry general practitioners' patients to the surgery. (See for example Floyd, 1968).

The question of how in the context of increasing care in the community, district nurses should divide their time between work in the surgery and work in the patients' homes, seems not to have received attention.

The practice employed nurse is clearly a crucial element here, where in post. It is likely that a minority, albeit a large minority of general practitioners, have access to a practice nurse. (See page 74.) However one cannot legislate on the basis of a minority and for the majority, it would appear that the district nurse is the only general nursing support available to general practitioners in their practices. Studies of the work of practice nurses and district nurses (Reedy, 1980) suggest that practice nurses are more likely to undertake technical activities of the sort normally associated with general practitioners than district nurses who 'score' more highly on the caring aspects of the job. This is partly because practice nurses are mainly accountable to the general practitioner, who will refer any patient to the practice nurse that he thinks fit. The district nurse has to work within the confines of the policy laid down by the health authority and there is in particular the possible difficulty of the district nurse feeling that some referrals from the general practitioner to herself are inappropriate for some one employed by another authority, particularly where the general practitioner obtains a fee for the item of service although actually performed by a district nurse. What does not appear to have arisen in the literature we searched, is a hybrid district nurse/practice nurse, that is where the health authority and the general practitioner share the cost according to some agreed division of the nurse's time between the two kinds of function. (There is a parallel

for this in the case of health centre administrators where in some authorities the costs of this officer's salary is shared between the health authority and the general practitioner on the basis of an agreed apportionment of his time between health authority and general practitioner matters respectively. See Baker and Bevan, 1981). Such an arrangement would presumably lead to the district nurse/practice nurse being accountable only to the general practitioner for procedures undertaken in 'his time'. Certainly there seems a need for experiments about approaches to co-ordinating the work of practice nurses and district nurses, and towards the evolving of a policy generally applicable to family doctors as to how services associated with the two kinds of nurse can be appropriately provided.

Finally there is the question of whether open access to the nurse in surgery premises ultimately provides benefits to the patient in terms of outcome and the patient's satisfaction. Does it affect the magnitude of the demand on the general practitioner, or other parts of the health services, in any way which has implications for cost?

6. Schemes to keep patients in the community as much as possible

Do these schemes cost less than institutional care when all costs - not necessarily just those to the N.H.S. - are taken account of?

Do they in the longer term reduce patient time in institutional care?

Are sufficiently high standards of care maintained?

How do community nursing staff regard the extra work and responsibilities these schemes entail?

Are patients happy with these schemes?

Are relatives able to cope with the patients at home in these schemes?

Increasingly there has been an emphasis on keeping patients in the community and out of institutional care as far as possible. This has been advocated on the grounds of cost and for the benefit of patients who prefer to be at home and who may become 'institutionalised' in long stay hospitals. (D.H.S.S., 1976).

Many of the schemes reported in the literature were concerned with keeping patients in the community who might formerly have had more institutional care. These included day surgery, care of the dying at home, intensive community nursing of acute or chronically sick patients (the elderly in particular) and the 'Hospital at home' scheme.

It was generally reported that, where costs had been looked at, the cost of having the patient at home was cheaper than the cost of keeping them in hospital or in residential care. One writer who disputed this common assertion was Opit (1977), who argued that when full costs of all services provided for the elderly sick at home were taken into account, they were comparable to the costs of residential care. He concluded that intensive care at home could only be more economic if it became inadequate. This of course raised the whole question of standards of care in these schemes, which need to be assessed in making comparisons between care at home and in institutions.

Reports on these schemes also usually implied or stated that patients recovered quicker, and were generally happy with the arrangements made, but this appeared to be mainly impressionistic evidence, which needs further testing. There was also little hard evidence about what the staff involved in these schemes felt. In some schemes, extra staff were made available, in others it appeared that the extra work and responsibility was undertaken by the existing community nursing staff. It would be of interest to know what all these staff felt about the intensive care-at-home schemes they are involved in.

7. Regular screening of the elderly by community nursing staff

Does screening detect ill-health and other problems which would not otherwise be known?

What age group should be screened and how regularly?

Who should undertake screening, e.g. health visitors, district nurses or trained lay people?

What list of the population is sufficiently comprehensive and up-to-date for providing a basis for screening the elderly, e.g. G.P. age-sex register, electoral registers?

A number of the schemes and studies we found were concerned with screening the elderly, a concern which is not new. (See for instance the Acheson Committee, page 42 of this report.) The schemes varied in their approach to screening, and in their results, which raises a number of issues.

A fundamental question is whether screening of the elderly is worthwhile - does it detect problems (health or social) which would otherwise be missed, and which can be helped if detected. Most studies reported that screening had detected needs, which could be helped, although they varied in the amount detected. Barber and Wallis (1982) in Glasgow reported that as many as 78% of patients 65 and over had 'unrecognised or unreported problems or symptoms'. In contrast Freedman et al. (1978) found very little'treatable but previously undiagnosed illness' in patients over 65, and Currie et al. (1974) in Glasgow, had similar findings in an age group of 70-72.

Although the age groups in the studies varied, they were concerned with persons at least in their sixties. Figgins (1982) suggests that surveillance, albeit at less frequent intervals than for the elderly, should begin at 45 years and be undertaken by health visitors, or district nurses with suitable updating in knowledge.

Obviously how many problems are unknown will depend partly on how 'problems' are defined - they can be defined narrowly on a serious health problem basis or extend into lesser health problems and social problems generally. Another factor is the way the practice is run - for instance if all members of the primary care team take the opportunity, whenever they have professional contact with an elderly patient, of finding out about any problems then they may detect these early on, and be in touch with most of the elderly practice population. A problem which arose in one study (Curnow et al. 1975) was that not all the needs which were uncovered could be met, a pitfall which has to be considered before embarking on a programme of screening.

Shaw (1975) who described a study using a nurse to screen patients over 70 for health and social problems, has discussed the issues involved in screening and where further research is needed. These areas include frequency of screening, what resources should be allocated to screening

(obviously this is linked to frequency), and the need to reconsider the training of community nursing staff if regular screening of the population is widely adopted. Shaw demonstrated that district nurses could be used for this work, as did Wallace (1975), but generally health visitors were the staff used in elderly-screening studies. In some cases staff were especially recruited for screening, in others staff undertook this as part of their normal workload. Curnow et al. (1975) found that the health visitors in the screening programme did not find it a satisfying full-time occupation. If screening is widely adopted, it would probably mean employing extra staff.

Luker (1982) was concerned that screening of the elderly by health visitors was often based on a medical model, looking for disease rather than assessing how people were coping with daily living. She contends that 'health visitors may serve the elderly more effectively if they abandoned the traditional medical model and develop screening programmes based on an activities of daily living framework'.

Finally, Shaw raised the problem of finding a satisfactory population register for screening, since the general practitioners' lists were inaccurate, and of course they exclude any patients not registered with a practice.

8. The consumer viewpoint

Are schemes thought successful by professional workers viewed in the same way by consumers?

Where there is a difference of view between professional workers and consumers, what are the reasons and what should be done about it?

Consumer views of developments in community nursing have not been much reported, although some of the policy documents referred to in the early part of this report have called for more involvement by the consumer in planning and evaluating primary care services (see for example Primary Health Care Nursing - a team approach on page 35 and Thinking about Health Visiting, page 44).

A few of the studies and schemes referred to in this literature review mention patient reaction. Patients were said to have liked health

visitors being on call out-of-hours (p.48), specialized health visitors giving a service to Down's Syndrome infants (p.56), specialized nursing for children at home to avoid or reduce the length of hospital admission (p.65), and a 'hospital at home scheme' (p.69). One study specifically sought relative's views on an advisory domiciliary service for terminal care (p.73), compared to relatives who had not had this service. Another study of an innovation in the nurse's role in a general practice, included extensive postal surveys and interviews with patients. (See page 76). Patients were more likely to accept a change in the role of the nurse once they had experience of the innovation. One practice which undertook a general patient satisfaction survey also found that patients experiencing an innovation in the role of the nurse were more prepared to accept it. (See page 80). In addition studies have been made specifically of consumer attitudes, particularly as regards satisfaction with health visiting services. From these studies some suggestions and reactions have emerged.

Interviews of 78 first-time mothers in Cambridgeshire produced definite views on a number of topics (Field et al., 1982). Many mothers wanted health visitors to be mothers themselves, were unhappy with the child health clinics and felt the need for a 24 hour service to turn to. The authors suggest that married women with children might be given preference in recruitment to health visiting, and that part-time work could encourage qualified health visitors with children to return to health visiting. (Of course although the state of 'motherhood' may be appropriate for child health visiting, in other aspects of health visiting work it would not apply, e.g. the elderly, disabled, or adult age groups). It is suggested in the same study that instead of traditional child health clinics, informal daily 'drop-in' centres might be organised, supplemented by a night time telephone service to provide 24 hour cover.

Interviewing 68 mothers in a study in Northern Ireland, Orr (1980) found that mothers particularly valued seeing the health visitor at home, rather than at the clinic (and preferably if notified in advance), where they had time and privacy to talk. Child health clinics were attended primarily for weighing of the baby, and to meet other mothers, not so much for talking with the health visitor about the baby. As in the study discussed above, clinics did not seem to be very popular. If social contact is important to mothers, then it might be better provided for in

the kind of groups initiated by Hiskins (1981, 1982) described on page 53 of this report. Interestingly the mothers in Orr's study did not seem to be particularly bothered about whether the health visitor was a mother herself.

Robinson (1982) suggests that the mothers in Orr's study were selected in a way to exclude those most likely to be dissatisfied with the health visiting service, and in her own study tried to find out the reasons for families not taking up child health services. The non-attending families proved elusive when approached for interviews, but from a study of the records and the few families interviewed no clear differences emerged between attenders and non-attenders. There was some suggestion that non-attending families included some who did not like outside intervention or authority, and Robinson's study illustrates the difficulty of evaluating health visiting services from a consumer viewpoint.

In a study of 200 elderly infirm patients living at home, Poulton (1981) found that the elderly patients and the district nurses caring for them had different perceptions of the patients' needs. The nurses 'give nursing care on the basis of the medical model. The patients perceive their state of health mainly in terms of discomfort and disability and their effects'. The author writes 'consideration needs to be given to a comprehensive nursing care planning system which should be the result of maximum participation of patient, relative and nurse, and should be based on social and health issues'.

These studies indicate that the consumer view of services provided may well diverge from the professional view. Where clinical innovations are being introduced, for instance a nurse doing some home visits instead of the doctor, there is evidence that those with experience of the innovation are more likely to be favourably disposed to it than those without this experience. Acceptance by patients of changes of this kind might be helped by advance information and discussion.

Much of the innovation in primary health care is concerned with changes in organisation, or extension of existing services (e.g. night nursing, home care aides, early discharge after surgery). These changes have considerable implications for the convenience and comfort of patients and their relatives, making it all the more important to be aware of the impact on the consumer. In order to find out what consumers feel about

existing services, and to take into account their views on future developments, there is accordingly scope for surveys of consumer opinion, and patient participation groups in general practice, such as those described in Pritchard (1981).

Concluding remarks

It will be apparent from the preceding sections that we have encountered descriptions in the literature of a wide variety of schemes but very few of these have been the subject of formal evaluations. Most commonly schemes were described and impressions about their effects reported, anything approaching a controlled trial was extremely rare, partly because of course they are correspondingly time consuming and expensive to undertake. (See for example The Burlington Randomized Trial of the Nurse Practitioner, Spitzer et al. (1974) briefly described on page 98 of this report.) The literature moreover revealed little evidence of attempts to appraise standards of care for schemes implemented.

Finally it appeared that schemes were being devised, implemented and appraised largely in isolation from one another with little evidence of the sustained and concerted attack directed at particular issues that Hicks (1976) and Hockey (1979) have urged. This is not in any way to belittle the efforts of those who have innovated imaginatively in the midst of all their other commitments but it does explain why there are so many unanswered or partly answered questions about the effects of developments that have taken place.

REFERENCES

THE CONTEXT IN WHICH PRIMARY HEALTH CARE TEAM DEVELOPMENT TOOK PLACE IN THE PERIOD 1974-1982

(1965) Charter for the Family Doctor Service. British Medical Journal 1, Supplement 89-91.

(1980) Report of the L.M.C. Conference. British Medical Journal, 281, 166.

(1981) G.M.S. Committee discusses Harding Report. Primary Health Care Team. British Medical Journal, 283, 1557.

(1982) Health and Social Service Journal, 92, 842.

(1982) British Medical Journal, 284, 1584.

Baly, M.E. (1980) Nursing and Social Change. London: Wm. Heinemann Medical Books Ltd.

Central Statistical Office (1982) Social Trends No.12. London: H.M.S.O.

D.H.S.S. (1974, 75, 76, 77, 78 and 79) Primary Health Care Services, Health visiting, nursing and midwifery staff statistics. England and Wales. London: D.H.S.S.

D.H.S.S. (1976) Priorities for Health and Personal Social Services in England. A Consultative Document. London: H.M.S.O.

D.H.S.S. (1977) Priorities in the Health and Social Services. The Way Forward. London: H.M.S.O.

D.H.S.S. (1977) Circular CNO(77)8, Nursing in Primary Health Care. Appendix.

D.H.S.S. (1980) Circular HC(80)8, Health Service Development: Structure and Management.

D.H.S.S. (1981) Nursing 1977-80. Report of the Chief Nursing Officer of the Department of Health and Social Security. London: D.H.S.S.

D.H.S.S. (1981) Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England. London: H.M.S.O.

D.H.S.S. (1982) Nurse Manpower: maintaining the balance. London: D.H.S.S.

D.H.S.S., Scottish Home and Health Department and Welsh Office (1969) Report of the Working Party on Management Structure in the Local Authority Nursing Service. (The Mayston Report) London: H.M.S.O.

E.E.C. Council of Ministers (1977) Nursing Directive 77/452. Concerning the Mutual Recognition of Diplomas, Certificates and Other Evidence of the Formal Qualifications of Nurses Responsible for General Care, including Measures to Facilitate the Effective Exercise of the Right of Establishment and Freedom to Provide Services

Ford, G.R. and Pincherle, G. (1978) Arrangements for Terminal Care in the N.H.S. Health Trends, 10, 73-76

Hicks, D. (1976) Primary Health Care: a review. London: H.M.S.O.

Hughes, J. and Roberts, J.A. (1981) Nurse managers views of community nursing services. Report to study group B of the N.E. Thames Regional Health Authority Primary Health Care Working Party. London School of Hygiene and Tropical Medicine, Department of Community Health.

Illich, I. (1976) Limits to Medicine. London: Marion Boyars.

London Health Planning Consortium (1981) Report of a Study Group on Primary Health Care in Inner London. (The Acheson Report) London: D.H.S.S.

Lunt, B. (1982) Where people die. Nursing, 34, 1479-80.

Ministry of Health and Scottish Home and Health Department (1969). Report of the Committee on Senior Nursing Staff Structure. (The Salmon Committee). London: H.M.S.O.

Royal College of Nursing (1976) New Horizons in Clinical Nursing. London: R.C.N.

Royal College of Nursing (1980) Nurse prescribers of oral contraceptives for the well woman. London: R.C.N.

Royal Commission on the National Health Service (1979) Report. Cmnd.7615. London: H.M.S.O.

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, R.S., Gent, M., Kergin, D.J., Hackett, B.C., Olynich, A. (1974) The Burlington Randomized trial of the Nurse Practitioner. The New England Journal of Medicine, 290, 251-256.

The Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (1981) Report of a Joint Working Group on The Primary Health Care Team. (The Harding Report). London: D.H.S.S.

Standing Sub-Committee on Cancer (1980) Terminal Care. Report of a Working Group. (Wilkes Report). London: D.H.S.S.

D.H.S.S. AND PROFESSIONAL POLICY STATEMENTS, AND REPORTS CONCERNED WITH THE DEVELOPMENT OF COMMUNITY NURSING

(1981) Primary health care in Europe: The Role of the Health Visitor. Report of a Conference. North East London Polytechnic.

Board of Science and Education of the British Medical Association (1974) Primary health care teams. Report of a Panel. London: British Medical Association.

British Association of Social Workers/Health Visitors' Association (1982) Joint Statement: The role of the health visitor in child abuse.

Central Health Services Council and the Personal Social Services Council (1978) Collaboration in Community Care - A discussion document. Report of a working party. London: H.M.S.O.

Council for the Education and Training of Health Visitors (1977) An Investigation into the Principles of Health Visiting. London: C.E.T.H.V.

Council for the Education and Training of Health Visitors (1980) The Investigation Debate. London: C.E.T.H.V.

Council for the Education and Training of Health Visitors (1982) Principles in Practice. London: C.E.T.H.V.

Department of Education and Science, Scottish Office and Welsh Office (1978) Report of the Committee of Enquiry into the Education of Handicapped Children and Young People. Special Educational Needs. Cmnd. 7212 (The Warnock Report). London: H.M.S.O.

D.H.S.S. (1975) Staff Training Memorandum STM(75)13. Nurses employed privately by general medical practitioners (practice nurses).

D.H.S.S. (1976) Priorities for Health and Personal Social Services in England. A Consultative Document. London: H.M.S.O.

D.H.S.S. (1976) Circular HC(76)26. Health Services Management: Vaccination and immunisation: Involvement of Nursing Staff.

D.H.S.S., Department of Education and Science, and Welsh Office (1976) Fit for the future: The Report of the Committee on Child Health Services. Cmnd.6684 (The Court Report) London: H.M.S.O.

D.H.S.S. (1977) Circular HC(77)22. Health Services Management: The Extending Role of the Clinical Nurse: Legal Implications and Training Requirements.

D.H.S.S. (1977) Circular HC(77)9. The Extending Role of the Clinical Nurse: Legal Implications and Training Requirements.

D.H.S.S. (1977) Priorities in the Health and Social Services. The Way Forward. London: H.M.S.O.

D.H.S.S., Department of Education and Science, Scottish Office, Welsh Office (1977) Prevention and Health. Cmnd. 7047. London: H.M.S.O.

D.H.S.S. and Welsh Office (1977) Residential homes for the elderly. Arrangements for health care. A memorandum of guidance. D.H.S.S. and Welsh Office.

D.H.S.S.(1977) Circular CNO(77)8. Nursing in Primary Health Care. Appendix.

D.H.S.S., Scottish Office, and Welsh Office (1972) Report of the Committee on Nursing Cmnd. 5115 (The Briggs Report). London: H.M.S.O.

D.H.S.S. Welsh Office (1978) A Happier Old Age. A discussion document on elderly people in our society. London: H.M.S.O.

D.H.S.S. (1981) Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England. London: H.M.S.O.

First Report from the Expenditure Committee (1977) Preventive Medicine Vol.1, Report. Session 1976-77. HC.169-i. London: H.M.S.O.

Health Visitors' Association (1981) Health Visiting in the 80s. London: Visitors' Association.

London Health Planning Consortium (1981) Report of a Study Group of Primary Health Care in Inner London. (The Acheson Report). London: D.H.S.S.

Moore, M.S., Barber, J.H., Robinson, E.T. and Taylor, T.R. (1973) First contact decisions in general practice. The Lancet, 1, 817-819.

Royal College of Nursing (1979) The Extended Clinical Role of the Nurse. London: Royal College of Nursing.

Royal College of Nursing, Society of Primary Health Care Nursing (1980) Report of a working party on Primary Health Care Nursing - a team approach. London: R.C.N.

Royal College of Nursing, Society of Primary Health Care Nursing (1983) Thinking about Health Visiting. London: R.C.N.

Royal College of Nursing and the Royal College of General Practitioners (1974) Report of a Joint Working Party on Nursing in general practice in the reorganised National Health Service. London: R.C.N.

Royal Commission on the National Health Service (1979) Report, Cmnd.7615. London: H.M.S.O.

Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (1981) Report of a joint working group on The Primary Health Care Team. (The Harding Report). London: D.H.S.S.

SCHEMES IMPLEMENTED AND STUDIES UNDERTAKEN

Health Visiting

Organisational aspects of health visiting

Bolton, P. (1981) Contingency plan to meet an acute health visitor shortage in Thanet, Kent. Health Visitor, 54, 368-369

Clode, D. (1978) Of primary concern .... Health and Social Service Journal, 88, 538-540.

Walsworth-Bell, J.P. (1979) Patch work. A comparative study of the organisation of the work of health visitors. Health Visitor, 54, 307-310

Health visitors providing services out of normal hours

(1979) Telephone talk. Nursing Times, 75, Community Outlook, July, 199.

Anon. (1982) Outside office hours (24-hour visiting service in Enfield) Health and Social Service Journal, 92, 1053-1055

Beech, C.P. (1981) A new service for parents with crying babies. Nursing Times, 77, 245-246

Bogie, A. (1981) A crying baby advisory service. Health Visitor, 54, 535-537

Haylock, M. (1981) A 24-hours health visiting service. Health Visitor, 54, 16-18

Metcalf, B., Morris, M., Thompson, A., Unsworth, D. and Hoyle, E. (1981) A 24-hour HV service. Nursing Times, 77, Community Outlook, 115-118

Health visitors and the elderly

Barber, J.H. and Wallis, J.B. (1976) Assessments of the elderly in general practice. Journal of the Royal College of General Practitioners, 26, 106-114

Barber, J.H. and Wallis, J.B. (1982) The effects of a system of geriatric screening and assessment on general practice workload. Health Bulletin, 40, 125-132

Barber, J.H., Wallis, J. and McKeating, E. (1980) A postal screening questionnaire in preventive geriatric care. Journal of the Royal College of General Practitioners, 30, 49-51

Curnow, R.N., MacFarlane, S.B.J., Gatherer, A. and Lindars, M.E. (1975) Visiting the elderly. Health and Social Service Journal, 85, 79-80

Currie, G., MacNeill, R.M., Walker, J.G., Barnie, E. and Mudie, E.W. (1974) Medical and social screening of patients aged 70 to 72 by an urban general practice health team. British Medical Journal, 2, 108-111

Day, L. and Mogridge, J. (1981) Health visitor who stayed. Health and Social Service Journal, 91, 1114-1115

Health visitors and the elderly (cont.)

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

Figgins, P. (1979) Screen now - benefit later. Nursing Mirror, 149, 9, 24-25

Freedman, G.R., Charlewood, J.E. and Dodds, P.A. (1978) Screening the aged in general practice. The Royal College of General Practitioners, 28, 421-425

Gardiner, R. (1975) The identification of the medical and social needs of the elderly in the community. Age and Ageing, 4, 181-187

Griffiths, A., and Eastwood, H. (1974) Psychogeriatric liaison health visitor. Nursing Times, 70, 152-153

Halladay, H. (1981) A geriatric team within the health visiting service. Nursing Times, 77, 1039-1040

Heath, P.J. and Fitton, J.M. (1975) Survey of over-80 age group in a GP population based on an urban health centre. Nursing Times, 71, Occasional Papers, 109-112

Luker, K.A. (1981) Health visiting and the elderly. Nursing Times, 77, Occasional Papers, 137-140

Luker, K.A. (1982) Evaluating health visiting practice. Royal College of Nursing of the United Kingdom.

Neil, M. (1982) It's nice to know that someone cares. Nursing Times, 78, Community Outlook, 243-246.

Powell, C. and Crombie, A. (1974) The Kilsyth questionnaire: a method of screening elderly people at home. Age and Ageing, 3, 23-28

Thursfield, P.J. (1979) The hospital that doesn't say goodbye. Nursing Mirror, 150, 6, 50-52

Health visitors and psycho-social problems

Briscoe, M.E. and Lindley, P. (1982) Identification and management of psychosocial problems by health visitors. Health Visitor, 55, 165-169

Clark, J. (1976) The role of the health visitor: a study conducted in Berkshire, England. Journal of Advanced Nursing, 1, 25-36

Clarke, M.G. (1980) Psychiatric liaison with health visitors. Health Trends, 12, 98-100

Hiskins, G. (1981) How mothers help themselves. Health Visitor, 54, 108-111

Hiskins, G. (1982) Personal view. British Medical Journal, 285, 204

Mottram, E.M. (1980) The sister's role in group therapy in a general practice. Nursing Times, 76, 253-254

Reavley, W. (1981) A joint clinic between health visitors and clinical psychologists. Midwife, Health Visitor and Community Nurse, 17, 337-339

Health visitors liaising between hospital and community services

Ahamed, M. (1978) Follow up of children age 0-5 years seen in accident and emergency unit (preliminary surveys). Health Visitor, 51, 84-86

Ahamed, M. (1982) A research project, Nursing Times, 78, Community Outlook, 223

Firth, D., Chamberlain, M.A., Fligg, H., Wright, J. and Wright, V. (1978) Health visitors in a rehabilitation unit. Nursing Times, 74, 249-250

Griffiths, A., and Eastwood, H. (1974) Psychogeriatric liaison health visitor. Nursing Times, 70, 152-153

Halladay, H. (1981) A geriatric team within the health visiting service. Nursing Times, 77, 1039-1040

Jackson, M.M. (1979) Diabetics at home. Nursing Times, 75, Community Outlook, 123-126

Matheson, W.J. and Tillson, H. (1978) The child health visitor. Public Health, 92, 234-236

Paxton, C.M. (1974) Co-operation and care 1 and 2. Nursing Times, 70, Occasional papers 113-119

Thursfield, P.J. (1979) The hospital that doesn't say goodbye. Nursing Mirror, 150 6, 50-52

Trotter, J.M., Scott, R., Macbeth, F.R., McVie, J.G. and Calman, K.C. (1981) Problems of the oncology outpatient: role of the liaison health visitor. British Medical Journal, 282, 122-124

Wallis, M. (1982) An extended talking service. Nursing Mirror, 155, 10, 24-28

Specialization in health visiting

Cunningham, C.C., Aumonier, M.E. and Sloper, P. (1982) Health visitor support for families with Down's syndrome infants. Child Care Health and Development, 8, 1-19

Dawson, J. (1979) The severely disabled. Health Visitor, 52, 262-264

Holland, J. (1981) The Lancaster Portage Project: a home based service for developmentally delayed young children and their families. Health Visitor, 54, 486-488

Murray, J.T. and Baillie, J. (1974) A study of the contribution of the health visitor to the support and care of terminally ill patients and their relatives. Health Bulletin, 32, 250-51

Wilshaw, B. and Aplin, M. (1981) A terminal care and bereavement counselling service. Health Visitor, 54, 333 and 336

Health visitors and 'screening'

Connolly, P. (1982) An enquiry into child health surveillance procedures undertaken by health visitors in England. In Health visiting: principles in practice, Chapter 7, London: C.E.T.H.V.

Lawrence, W.C.M. and Sklaroff, S.A. (1978) Who should carry out developmental screening examinations. Health Bulletin, 36, 25-33.

Morris, J.B. and Hird, M.D. (1981) A neurodevelopmental infant screening programme undertaken by health visitors - preliminary report. Health Bulletin, 39, 236-250

Rankin, H.W.S., Horn, D.B., Mackay, A.W. and Forgan, C.M. (1976) The control of coronary heart disease risk factors in general practice: a feasibility study. Health Bulletin, 34, 66-72.

District Nursing

Community night nursing services

(1981)..... and at home. Health and Social Service Journal, 91, 861

Gillespie, J.V. (1980) Night nursing service in West Fife. Health Bulletin, 38, 187-193

Hornby, A. (1976) 24-hour community nursing - a pilot scheme in the Lancaster area. Nursing Times, 72, 428-429

Jack, M.A. (1976) A home night nursing service, Nursing Times, 72, Occasional papers, 140.

Martin, M.H. and Ishino, M. (1981) Domiciliary night nursing service: luxury or necessity? British Medical Journal, 282, 883-885

Sims, R. (1981) A community night nursing service in Essex. Nursing Times, 77, Occasional Papers, 133-135

Sims, R. (1982) An 'out-of-hours' nursing service (Pilot scheme in community nursing in Southend) Geriatric Medicine, 12, 7, 50-53

District nurses and the elderly

(1981) The Polegate Project in East Sussex. On the spot for the elderly Health and Social Service Journal, 91, 1021-1023

Allibone, A. (1979) Community caring scheme in rural Norfolk. Update, 19 781-786

Allibone, A. and Coles, R. (1982) A study of the cost effectiveness of a community caring scheme providing medical services for the patients of a primary health care team in a rural area - England, U.K. Department of Economic and Social Studies, University of East Anglia

Currie, C.T., Burley, L., Doull, C., Ravetz, C., Smith, R.G. and Williamson, J. (1980) A scheme of augmented home care for the acutely and sub-acutely ill elderly patient: Report on a pilot scheme. Age and Ageing, 9, 173-80

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

Gibbins, F.J., Lee, M., Davison, P.R., O'Sullivan, P., Hutchinson, M., Murphy, D.R. and Ugwu, C.N. (1982) Augmented home nursing as an alternative to hospital care for chronic elderly invalids. British Medical Journal, 284, 330-333.

Gooding, H., Williamson, G.H., Honneyman, F.D. (1982) Developing a preventive care service for the elderly. Health Visitor, 55, 593-600

Opit, L.J. (1977) Domiciliary care for the elderly sick - economy or neglect? British Medical Journal, 1, 30-33

Shaw, S. (1975) The role of the nurse in assessing the health of elderly people. In: Probes for Health. Edited by Gordon McLachlan, Nuffield Provincial Hospital Trust. London: Oxford University Press.

Central Statistical Office, (1982) Social Trends No. 12. London: H.M.S.O.

Wallace, C.M. (1975) Assesment of the elderly. Nursing Mirror, 140, 9, 54-60.

Paediatric home nursing

Atwell, J.D. (1975) Paediatric day-case surgery in Southampton. Nursing Times, 71, 841-843

Gow, M. and Atwell, J. (1980) The role of the children's nurse in the community. Journal of Paediatric Surgery, 15, 26-30

Hally, M., Holohan, A., Hugh Jackson, R., Reedy, B.L.E.C. and Walker, J.H. (1977) Paediatric home nursing scheme in Gateshead. British Medical Journal, 1, 762-764

Day surgery and early discharge

Hart, C. (1982) Back home to nurse. Nursing Mirror, 154, 10, Supplement, ii, iv, vi, vii.

Ruckley, C.V., Garraway, W.M., Cuthbertson, C., Fenwick, N. and Prescott, R.J. (1980) The community nurse and day surgery. Nursing Times, 76, 255-56

Ruckley, C.V., Cuthbertson, C., Fenwick, N., Prescott, R.J. and Garraway, W.M. (1978) Day care after operations for hernia or varicose veins: a controlled trial. British Journal of Surgery, 65, 456-9

Russell, I.T., Brendan Devlin, H., Fell, M. and Glass, N.J. (1977) Day-case surgery for hernias and haemorrhoids. The Lancet, 1, 844-847

Shepherd, P. (1976) Early discharge from hospital after surgery. Midwife, Health Visitor and Community Nurse, 12, 289-290

District nurses in the treatment room

Bowling, A. (1981) Delegation to nurses in general practice. Journal of the Royal College of General Practitioners, 31, 485-490

Cartwright, A. and Anderson, R. (1981) General Practice Revisited. London: Tavistock Publications

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

McIntosh, J.B. (1979) Making the best use of time. Nursing Mirror, 149, 6, 32-33

Reedy, B.L.E.C., Metcalfe, A.V., de Roumanie, M. and Newell, D.J. (1980) A comparison of the activities and opinions of attached and employed nurses in general practice. Journal of the Royal College of General Practitioners, 30, 483-489

The 'Hospital at home' scheme

Mowat, I.G. and Morgan, R.T.T. (1982) Peterborough Hospital at home scheme. British Medical Journal, 284, 641-643

Nursing and related care - joint schemes with social services

(1981) Nursing care in local authority residential units... Health and Social Service Journal, 91, 859, 860.

(1981) Helping hands at home. Health and Social Service Journal, 91, 766-769

Bowling, A. and Bleathman, C. (1982) The need for nursing and other skilled care in local authority residential homes for the elderly: overall findings and recommendations. Research report No. 5. London: Social Services Department, Hounslow.

Dexter, M. (1981) Intensive care at home. Health and Social Service Journal, 91, 170-172

Lovelock, R. (1981) Caring at home. Health and Social Service Journal, 91, 925-927

Quelch, K.(1981) A choice to stay at home. Health and Social Service Journal, 91, 1336-1338

Support services for community nurses in the care of the dying

Bates, T., Hoy, A.M., Clarke, D.G. and Laird, P.P. (1981) The St. Thomas' Hospital Terminal Care Support Team. The Lancet, 1, 1201-3

Doyle, D. (1980) Domiciliary terminal care. The Practitioner, 224, 575-582

Doyle, D. (1982) Domiciliary terminal care: demands on statutory services. Journal of the Royal College of General Practitioners, 32, 285-291

Lunt, B. and Hillier, R. (1981) Terminal care: present services and future priorities. British Medical Journal, 283, 595-598

Parkes, C.M. (1980) Terminal care: evaluation of an advisory domiciliary service at St. Christopher's Hospice. Postgraduate Medical Journal, 56, 685-689.

Wells, K. (1980) Social care for the terminally ill at home and the bereaved. Report to Kent County Council Social Services Committee. Sponsored by Kent Voluntary Service Council

Practice Nurses

Numbers of practice nurses

Cartwright, A., and Anderson, R. (1979) Patients and their Doctors. Journal of the Royal College of General Practitioners, Occasional Paper No. 8

Department of Health and Social Security, Operational Research Service. (1982) Nurse Manpower. Maintaining the balance. London: D.H.S.S.

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

Reedy, B.L.E.C., Philips, P.R. and Newell, D.J. (1976) Nurses and nursing in primary medical care in England. British Medical Journal, 2, 1304-1306

Training courses and associations for practice nurses

Department of Health and Social Security. (1977) Circular CNO(77)8. Nursing in Primary Health Care, Appendix.

Leiper, N.K. (1975) A course for practice nurses. Royal College of General Practitioners, 25, 537-542

Mourin, K. (1980) A practice nurses' course - content and evaluation. Journal of the Royal College of General Practitioners, 30, 78-84

Rankin, I.F.M. Practice Nurses, Scotland. (Correspondence) Journal of the Royal College of General Practitioners, 31, 506 (1981)

Reedy, B.L.E.C., Metcalfe, A.V., de Roumanie, M. and Newell, D.J. (1980) The social and occupational characteristics of attached and employed nurses in general practice. Journal of the Royal College of General Practitioners, 30, 477-482

Wrightson, M. (1975) Practice nurses get together. Nursing Mirror, 140, 1, 41-2

The practice nurses work at the surgery

Bain, D.J.G. and Haines, A.J. (1974) A treatment room survey in a health centre in a new town. Health Bulletin, 32, 111-119

Bevan, J., Cunningham, D. and Floyd, C. (1979) Doctors on the Move. Journal of the Royal College of General Practitioners, Occasional Paper No. 7.

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

Marriott, R.G. (1981) Open access to the practice nurse. Journal of the Royal College of General Practitioners, 31, 235-238

Waters, W.H.R., Sandeman, J.M. and Lunn, J.E. (1980) A four-year prospective study of the work of the practice nurse in the treatment room of a South Yorkshire practice. British Medical Journal, 280, 87-89

Waters, W.H.R. and Lunn, J.E. (1981) 102 886 treatment-room procedures: implications for nurse training and item-of-service payments. British Medical Journal, 282, 1368-1370

Extending the role of the nurse

First Report from the Expenditure Committee (1977) Preventive Medicine Vol. 1, Report. Session 1976-77. HC.169-i. London: H.M.S.O.

Barber, J.H., Moore, M.F., Robinson, E.T. and Taylor T.R. (1976) Urgency and risk in first-contact decisions in general practice. Health Bulletin, 18, 21-29

Bowling, A. (1981) Delegation in general practice. A study of doctors and nurses. London and New York: Tavistock Publications.

Bowling, A. (1981) Delegation to nurses in general practice. Journal of the Royal College of General Practitioners, 31, 485-490

Bryan, J. (1982) An MRC study of use of nurses to take blood pressure in general practice. Nursing Mirror, 155, 23, 18-19

MacGuire, J.M. (1980) The expanded role of the nurse. Kings Fund Project Paper RC3. London: King Edward's Hospital Fund

Marsh, G. and Kaim-Caudle, P. (1976) Team care in general practice. London: Croom-Helm.

Marsh, G.N. (1976) Further nursing care in general practice. British Medical Journal, 2, 626-627

Marsh, G.N. (1977) 'Curing' minor illness in general practice. British Medical Journal, 2, 1267-1269

Martys, C.R. (1982) Drug treatment in elderly patients: GP audit. British Medical Journal, 285, 1623-1624

Miller, D.S. and Backett, E.M. (1980) A new member of the team? Extending the role of the nurse in British primary care. The Lancet, 2, 358-361

Reedy, B.L.E.C., Stewart, T.I. and Quick, J.B. (1980) Attachment of a physician's assistant to an English general practice. British Medical Journal, 281, 664-666

Stilwell, B. (1981) Role expansion for the nurse. Journal of Community Nursing, 5, 3, 17-18

Stilwell, B. (1981) Role expansion for the nurse.....2 Journal of Community Nursing, 5, 4, 8 & 11

Stilwell, B. (1982) The nurse practitioner at work. 1. Primary care. Nursing Times, 78, 1799-1803

Wilson, D. (1977) Horses for courses at Staines. Journal of Community Nursing, 1, 2, 18-19

Whitehead, G. (1982) Hypertension: detection and management by the district nurse. Journal of District Nursing, 1, 5, 9-12

General Reviews of Schemes and Studies

Baker, G. and Bevan, J.M. (1983) Developments in Community Nursing within Primary Health Care Teams. Part III - Report of the survey addressed to Chief Nursing Officers. Health Services Research Unit Report No. 46, University of Kent at Canterbury.

Clark, J. (1981) What Do Health Visitors Do? A Review of the Research 1960-1980. London: The Royal College of Nursing of the United Kingdom.

De'Ath, E. (1982) A preventive approach to family life - the role of the health visitor. Health Visitor, 55, 282-284.

Ferlie, E. (1982) Sourcebook of Initiatives in the Community Care of the Elderly. Personal Social Services Research Unit. University of Kent at Canterbury.

Hockey, L. (Ed) (1983) Primary Care Nursing. London: Churchill Livingstone

DISCUSSION

1. Organisation of Community Nursing

Acheson Report - See London Health Planning Consortium

Ambler, M., Anderson, J.A.D., Black, M., Draper, P., Lewis, J., Moss, W. and Murrell, T.G.C. (1968). The attachment of local health authority staff to general practices: a study in three county boroughs with special reference to health visiting. Medical Officer, 119, 295-299.

Board of Science and Education of the British Medical Association (1974) Primary health care teams. Report of a Panel. London: British Medical Association.

Central Health Services Council and the Personal Social Services Council (1978). Collaboration in Community Care - A discussion document. Report of a working party. London: H.M.S.O.

Clark, J. (1981) What do health visitors do? A review of the research 1960-1980. London: Royal College of Nursing

Dingwall, R. (1977) What future for health visiting. Evidence to the Royal Commission on the N.H.S. Nursing Times, 73, 77-79

Dingwall, R. and Watson, P. (1980) Pausing before a rush to change. Health and Social Service Journal, 90, 749-750.

Dunnell, K. and Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division. London: H.M.S.O.

Gilmore, G., Bruce, N. and Hunt, M. (1974) The work of the nursing team in general practice. London: C.E.T.H.V.

Hart, C. (1977) The Independent Contractor and the Primary Care Team - Correspondence. Journal of the Royal College of General Practitioners, 27, 377-8

Hicks, D. (1976) Primary Health Care: a review. London: H.M.S.O.

Keywood, O. (1978) Attachment scheme or geographical patch? Nursing Mirror, 147, 6, 35

London Health Planning Consortium (1981) Report of a Study Group on Primary Health Care in Inner London. (The Acheson Report) London: D.H.S.S.

Poulton, K.R. (1977) Evaluation on community nursing service of Wandsworth and East Merton Teaching District: Research Report. Wandsworth and East Merton Teaching District.

Walsworth-Bell, J.P. (1979) Patch work. A comparative study of the organisation of the work of health visitors. Health Visitor, 52, 307-310.

West Midlands Regional Health Authority, Management Services Division (1977) Community Nursing Organisation. Attachment v. allocation. Birmingham: West Midlands Regional Health Authority.

2. Community Evening and Night Nursing Services

Board of Science and Education of the British Medical Association (1974) Primary health care teams. Report of a panel. London: B.M.A.

D.H.S.S. (1977) Priorities in the Health and Social Services. The Way Forward. London: H.M.S.O.

Harding Report - see Standing Medical Advisory Committee

Martin, M.H. and Ishino, M. (1981) Domiciliary night nursing service: luxury or necessity? British Medical Journal, 282, 883-885.

Royal College of Nursing and the Royal College of General Practitioners (1974). Report of a Joint Working Party on Nursing in general practice in the reorganised National Health Service. London: Royal College of Nursing.

Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee (1981) Report of a joint working group on The Primary Health Care Team. (The Harding Committee) London: D.H.S.S.

3. Provision of Primary Care Aides

Acheson Report - see London Health Planning Consortium.

Care in Action - see D.H.S.S.

Dexter, M. (1981) Intensive care at home. Health and Social Service Journal, 91, 170-172.

D.H.S.S. (1981) Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England. London: H.M.S.O.

London Health Planning Consortium (1981) Report of a Study Group of Primary Health Care in Inner London (The Acheson Report) London: D.H.S.S.

Muir Gray, J.A. (1977) A difficult decade. Nursing Mirror, 145, 6, 36-37.

Royal Commission on the National Health Service (1979) Report, Cmnd. 7615, London: H.M.S.O.

4. The Roles of Health Visitors and District Nurses

(1975) An Assistant in the House? Editorial. The Lancet, 1, 842-843

(1977) Leading article. Making better use of our nurses. British Medical Journal, 1, 1306.

(1981) Primary Health Care in Europe: The Role of the Health Visitor. Report of a Conference. North East London Polytechnic.

Board of Science and Education of the British Medical Assocation (1974). Primary Health Care Teams. Report of a panel. London: British Medical Association.

Clark, J. (1982) That uncertain knock on the door. Nursing Mirror, 154, 26, 33-35.

Council for the Education and Training of Health Visitors (1977). An investigation into the principles of health visiting. London: C.E.T.H.V.

Court Report - see D.H.S.S., D.E.S. and W.O.

De'Ath, E. (1982) A preventive approach to family life - the role of the health visitor. Health Visitor, 55, 282-284.

D.H.S.S., Department of Education and Science and Welsh Office (1976). Fit for the future: The Report of the Committee on Child Health Services. Cmnd. 6684 (The Court Report). London: H.M.S.O.

Dingwall, R. (1977) What future for health visiting? Evidence to the Royal Commission on the N.H.S. Nursing Times, 73, 77-79

Dunnell, K., Dobbs, J. (1982) Nurses working in the community. Office of Population Censuses and Surveys, Social Survey Division, London: H.M.S.O.

First Report from the Expenditure Committee (1977) Preventive Medicine Vol. 1, Report. Session 1976-77. HC.169-i. London: H.M.S.O.

Goodwin, S. (1982) A cure for all ills? Nursing Mirror, 154, 22, 20-22

Health Visitors' Association (1981) Health Visiting in the 80s. Health Visitors' Association.

Health Visitors' Association (1982) The need for a national inquiry into the proper role and functions of health visitors and school nurses. London: Health Visitors' Association.

Hicks, D. (1976) Primary Health Care: a review. London: H.M.S.O.

Jameson Committee - see Ministry of Health.

Keywood, O. (1978) Attachment scheme or geographical patch? Nursing Mirror, 147, 6, 35.

Kratz, C.R. (1982) Community Nursing - a prescription for excellence? Nursing Times, 78, 676-682

Lefever, R. (1982) Starting from scratch. Nursing Mirror, 155, 6, 15-16.

MacGuire, J.M. (1980) The expanded role of the nurse. Kings Fund Project Paper RC3, London: King Edward's Hospital Fund.

Ministry of health (1956). An inquiry into health visiting: report of a working party (Jameson Report) London: Ministry of Health.

Rigler, M. (1982) Tomorrow's health visitor: can she change our attitudes to health? Health Visitor, 55, 107-108.

Royal College of Nursing, Society of Primary Health Care Nursing (1980) Report of a working party on Primary Health Care Nursing - a team approach. London: Royal College of Nursing.

Royal College of Nursing, Society of Primary Health Care Nursing (1983). Thinking about Health Visiting. London: Royal College of Nursing.

Russell, H. (1975) General nursing practitioner. Nursing Times, 71, 1855-57.

Saint-Yves, I.F.M. (1978) Patient care in time and space. Royal Society of Health Journal, 98, 238-239.

Saint-Yves, I.F.M. (1979) Nurses hold the key. Journal of Community Nursing, 2, 10, 7 & 14.

Shaw, S. (1975) The role of the nurse in assessing the health of elderly people. In: Probes for Health. Edited by Gordon McLachlan, Nuffield Provincial Hospital Trust. London: Oxford University Press.

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, R.S., Gent, M. Kergin, D.J., Hackett, B.C., Olynich, A. (1974) The Burlington Randomized trial of the Nurse Practitioner. The New England Journal of Medicine, 290 251-256.

Spray, J. (1982) Time to visit change. The Health Services, May 28, No. 24, 16.

Stilwell, B. (1981) Role expansion for the nurse. Journal of Community Nursing, 5, 3, 17-18.

Stilwell, B. (1981) Role expansion for the nurse .....2. Journal of Community Nursing, 5, 4, 8 & 11.

Wallace, C.M. (1975) Assessment of the Elderly. Nursing Mirror, 140, 9, 54-60.

Watson, E. (1982) Problems of the health visitor in the inner city. Health Visitor, 55, 574-576.

5. District Nurses, Practice Nurses, and the Treatment Room

Baker, G.E. and Bevan, J.M. (1981) Administering health centres: a survey of the policy and practice of health districts and single district areas in England. Health Services Research Unit Report No. 44, University of Kent at Canterbury.

Floyd, C.B. (1968) Car service in general practice: a two-year survey. British Medical Journal, 2, 614-617.

Reedy, B.L.E.C., Metcalfe, A.V., de Roumanie, M. and Newell, D.J. (1980) A Comparison of the Activities and Opinions of Attached and Employed Nurses in General Practice. Journal of the Royal College of General Practitioners, 30, 483-489.

Ruckley, C.V., Garraway, W.M., Cuthbertson, C., Fenwick, N. and Prescott, R.J. (1980) The community nursee and day surgery. Nursing Times, 76, 255-256.

Russell, I.T., Brendan Devlin, H., Fell, M., Glass, N.J. (1977) Day-case surgery for hernias and haemorrhoids. The Lancet, 1, 844-847.

6. Schemes to keep patients in the community as much as possible

D.H.S.S. (1976) Priorities for Health and Personal Social Services in England. A Consultative Document. London: H.M.S.O.

Opit, L.J. (1977) Domiciliary care for the elderly sick - economy or neglect? British Medical Journal, 1, 30-33.

7. Regular screening of the elderly by community nursing staff

Barber, J.H., Wallis, J.B. (1982) The effects of a system of geriatric screening and assessment on general practice workload. Health Bulletin, 40, 125-132.

Curnow, R.N., Macfarlane, S.B.J., Gatherer, A., and Lindars, M.E. (1975) Visiting the elderly. Health and Social Service Journal, 85, 79-80.

Currie, G., MacNeill, R.M., Walker, J.G., Barnie, E. and Mudie, E.W. (1974) Medical and social screening of patients aged 70 to 72 by an Urban General Practice Health Team. British Medical Journal, 2, 108-111

Figgins, P. (1982) Surveilling the elderly and others. British Journal of Geriatric Nursing, 2, 2,18-19.

Freedman, G.R., Charlewood, J.E. and Dodds, P.A. (1978) Screening the aged in general practice. The Royal College of General Practitioners, 28, 421-425.

Luker, K.A. (1982) Screening of the well elderly in general practice. Midwife, Health Visitor and Community Nurse, 18, 222-224, 228, 229.

Shaw, S. (1975) The role of the nurse in assessing the health of elderly people. In; Probes for Health. Edited by Gordon McLachlan, Nuffield Provincial Hospital Trust. London: Oxford University Press.

Wallace, C.M. (1975) Assessment of the elderly. Nursing Mirror, 140, 9, 54-60.

8. The Consumer Viewpoint

Field, S., Draper, J., Kerr, M., Hare, M. (1982) A consumer view of the health visiting service. Health Visitor, 55, 299-301.

Hiskins, G. (1981) How mothers help themselves. Health Visitor, 54, 108-111.

Hiskins, G. (1982) Personal view. British Medical Journal, 285, 20.

Orr, J. (1980) Health visiting in focus. London: Royal College of Nursing.

Poulton, K.R. (1981) Perceptions of wants and needs by nurses and their patients. Research report. Wandsworth and East Merton Teaching District.

Pritchard, P.M.M. (compiler) (1981) Patient participation in general practice. Occasional Paper 17. London: Journal of the Royal College of General Practitioners.

Robinson, J. (1982) An evaluation of health visiting. London: Council for the Education and Training of Health Visitors.

Concluding Remarks

Hicks, D. (1976) Primary health care: a review. London: H.M.S.O.

Hockey, L. (1979) A study of district nursing. Ph.D. Thesis, City University.

Spitzer, W.O., Sackett, D.L., Sibley, J.C., Roberts, R.S., Gent, M., Kergin, D.J., Hackett, B.C., Olynich, A. (1974) The Burlington Randomized Trial of the Nurse Practitioner. New England Journal of Medicine, 290, 251-256.