JOHN FRY TRUST FELLOWSHIP
1994

The Primary Health Care Team

John C. Hasler

ROYAL SOCIETY OF MEDICINE PRESS

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THE JOHN FRY TRUST FELLOWSHIP

When he retired in 1991, after 45 years as a general practitioner, Dr John Fry established a Trust the main aim of which was to further the development of primary health care.

Through this Trust a Fellowship was established to be awarded annually to a distinguished individual from any discipline. Each holder of the Fellowship would be invited to prepare a monograph which it was hoped would contribute significantly to the progress of primary care. The monograph would be introduced by a public lecture to be delivered at a recognised teaching centre in the United Kingdom.

DR J. C. HASLER

John Hasler was educated at Lancing College and the Middlesex Hospital Medical School, London, from where he graduated in 1960. After several junior hospital posts he joined one of the early experimental vocational training schemes in Wessex sponsored by the Nuffield Provincial Hospitals Trust. In the final year, he was attached to Dr George Swift in Winchester, one of the early pioneers of vocational training.

In 1965 he entered general practice in Sonning Common, a village in south Oxfordshire where he is now senior partner. The practice has always had a strong interest in teamwork and published two of the earliest papers on the role of the nurse in primary care. At the end of the sixties the team was asked to run a pilot project by the Oxford Regional Hospital Board for a new type of community hospital, which continued for a decade. In the early seventies the practice featured in the BBC series 'The Health Team in Action'.

Teamwork continues to be a strong feature of the practice and in 1993 one doctor and two of the practice nurses were finalists in the Doctor newspaper 'Arthritis Team of the Year' award.

In 1972 John Hasler was appointed the first Regional Adviser in General Practice at Oxford. Under his leadership vocational training schemes were established throughout the Oxford region. Together with colleagues he has been involved in various initiatives including pioneering developments on training practice reviews and educational skills teaching. The region continues to play a leading role in general practice education and attracts doctors to its courses from all over the country.

In 1982 he was awarded the degree of MD by London University for his thesis on the clinical experience of trainees in general practice.

John Hasler was Chairman of the UK Conference of Regional Advisers in General Practice in the mid seventies and Chairman of the General Practice Advisory Committee for the Council of Postgraduate Medical Education in the mid eighties. For the Royal College of General Practitioners he has been examiner, honorary secretary, vice chairman and chairman of council. He has been a member of the Standing Medical Advisory Committee at the Department of Health, the Health Visiting Joint Committee of the UK Central Council and National Nursing Boards, and the Armed Services General Practice Approval Board. In 1991 he was appointed Civil Consultant in General Practice to the Royal Air Force.

He has published over 40 papers and been involved in 12 books on general practice either as editor, author or contributor: two more books are in preparation. For eight years he wrote the medical column for *Ideal Home*. He has lectured widely in the United Kingdon and overseas. In 1986 he was the Scientific Chairman for the 11th World Family Medicine Conference at the Barbican. For over 10 years he has been a member of the Editorial Board of Oxford University Press's successful GP series.

In 1984 he was awarded the OBE for services to general practice and 1991 the RCGP Foundation Council Award. He has recently been appointed Associate Director of Postgraduate Medical Education and Training at the University of Oxford Medical School in recognition of his work for general practice education as Regional Adviser.

Dedication

This monograph is dedicated to the primary health care team at Sonning Common past, present and future.

Acknowledgements

I have been helped in the preparation of this monograph by various people. In particular I wish to thank Anna Brodie, Judith Buckingham, Karen Rees, Chris Reid, Gill Roche, Pat Samuels, Kerry Sinclair, Barbara Stilwell, Sandy Tinson, John Toby, Tricia Watts and Mary Wicks. Most of my thoughts over the years have been shaped by the team at Sonning Common. I also thank my secretary Pam Phillips who has produced the manuscript on time and accepted repeated alterations with equanimity.

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1
Introduction

1
Introduction

'Team: Set of players forming one side in game; set of persons working together; set of draught animals'—*The Pocket Oxford Dictionary*

In the past few years, health care workers have faced problems, not just of their patients but of a rapidly changing environment. In primary health care doctors, nurses and other colleagues remained relatively immune to management changes until the beginning of the nineties: the new GP contract, the new trusts and other health authority alterations have now produced a world of turbulence.

The pages of the medical newspapers have carried stories of low morale amongst family doctors and the journalists have hinted at a crisis in primary health care. Some of the problems are to do with demands which are perceived as inappropriate, whether they be increased night calls or contractual requirements which scientific evidence does not support. But part of the problem is about a profession struggling to come to terms with greater accountability to the public and Government. It would be wrong to imagine that this is confined to the medical profession.

For primary care nurses, matters are little different. Many of the district nurses and health visitors have discovered that their employers are changing and with fundholding practices now purchasing their services, attached staff wonder if their future is secure. Nurses employed directly by GPs (practice nurses) saw a steady increase in their work spurred on by the introduction of clinics attracting payments under the 1990 GP contract only to find that their job security was threatened as

the clinics began to be run down when the Government changed the rules three years later.

Whilst the anxieties, fears and frustrations are genuine it is important to maintain a sense of balance. Many practices have opportunities now that they never had before. Three important features of primary health care were left intact in the 1990 upheaval: the need for patients to see specialists only after a GP referral, the registered lists of patients, and the delivery of care by a team. The addition of purchasing power, whether directly through fundholding or indirectly through health authorities, has put British general practice in an unparalleled position of power. And British general practice and primary health care at its best is unequalled: it is something of which we can be very proud.

This monograph, which argues for a strong and developing team, is about the health needs of our population and the people who strive to meet those needs in primary care.

2
History

2
History

The early NHS

There was no clear birth of the concept of a primary health team but rather a series of events which shaped its development. Nor has it reached its final shape—the development continues today.

The period following the introduction of the NHS in 1948 was difficult for general practice. It seemed as though family doctors had been left out in the cold whilst the hospitals with their technological and scientific advances forged ahead. The payment arrangements meant that any money spent on premises, staff and equipment directly reduced the doctor's income and access to diagnostic services was denied to most GPs. A few receptionists were employed but practice managers and practice nurses were virtually unknown. District nurses and health visitors worked to a geographical area and contact between doctor and nurse was often poor, if not downright abysmal.

A survey by Lisbeth Hockey of the Queens Institute of District Nursing in 1965[1] illustrates some of the difficulties. General practitioners and district nurses were interviewed in three areas of Britain. It was found, amongst other things, that:

- Much of the nurses' work did not require their professional skills and they were rarely able to use their specialist qualifications.
- Nurses had very little contact with general practitioners, hospitals or health visitors.

- 41% of the doctors, never or hardly ever, met the district nurse who looked after most of their patients.
- One in three of the nurses had the impression the doctors did not wish to discuss their patients with them.
- 40% of the doctors felt there was room for improvement or that action was urgently needed.
- Most doctors were ignorant about district nurses' qualifications and the help they could give.

The buildings did not make matters any easier. Many GPs still practised from their own homes and rooms for nurse offices or treatment rooms were rare.

Attachment schemes

Gradually a few people began to look seriously at the problems posed by the poor communication between doctors, district nurses and health visitors. With the co-operation of a few far sighted Medical Officers of Health (who employed the nurses), notably Iain McDougall of Hampshire and John Warin of the City of Oxford, the nurses and health visitors began to be attached to practices working for their registered populations rather than geographical areas. One of the earliest attachment schemes was at the St Clements' practice in Winchester[2] where I was a trainee in 1965. But not everyone was enthusiastic. Some of the Medical Officers of Health were alarmed at the dismantling of their empires. Many general practitioners were equally cautious: surveys from Wessex and Manchester showed that only a minority of doctors wanted attached health visitors[3]. Part of the problem was that some doctors did not really know what health visitors did. Nevertheless the idea caught on and by 1965 all the district nurses and health visitors in Oxford City were attached and by the early

seventies, so were three-quarters of nurses and health visitors in England and Wales[4].

The 1966 contract

Meanwhile, more fundamental changes had been taking place. General practitioners, their morale raised by the formation of the College of General Practitioners in the fifties, realised that they could not provide the kind of primary health care that the public needed and deserved within the constraints of their existing contracts. Premises needed to be modernised and enlarged to accommodate other professionals and administrative staff, new equipment had become available and needed to be used and the number of staff had to increase. These changes were impossible without a major and unacceptable erosion of the doctor's personal income.

The pressure on the Government to do something built up with increasingly angry meetings of doctors and the collection of undated resignations. The Government recognised that it had to act and after months of negotiations between Minister of Health Kenneth Robinson and the profession, the 1966 Charter was drafted. Not only did it provide a much more logical, albeit somewhat complex, framework for providing resources, it was also accompanied by a significant injection of cash in the form of £24 million. One of the main features was the arrangement whereby 70% of the salary costs of all employed staff were reimbursed up to a maximum of two whole-time equivalents per principal (a level which was eventually reached in few practices). The contract was accepted and formed the basis for payment of general practitioners for the next 24 years.

Very soon, things began to change. New health centres began to appear: these were lavish by comparison to previous

surgeries and were now a realistic option since the doctors could work in them rent free although they paid service charges. A little later, as building prices began to rise, the advantages of the new Cost Rent and Notional Rent arrangements began to be apparent. Under this scheme, doctors could offset a considerable part of the cost of erecting or purchasing new buildings from a rental paid by the NHS. Larger and better designed surgeries and medical centres appeared.

The development of nursing

With the resolution of staffing and premises behind them and with the increasing acceptance of attachment of health visitors and district nurses, doctors and nurses could now turn their attention to the shape and function of these early primary care teams.

It was during the sixties that the word team started to be used and the first paper to use the word 'Community Health Team' in the title was published by my practice in Sonning Common in the *British Medical Journal* in 1968[5]. In it we outlined the range of work that could be undertaken by a nurse in a treatment room (reproduced in Table 1) which was similar to that described by Geoffrey Marsh in the preceding year[6]. We also described an experiment whereby an attached district nurse was used to see certain patients who had requested a doctor's visit at home.

The development of nursing work on the premises quickly caught on since prior to 1966 much of it had been done by doctors, who were not best suited to it. Furthermore, whilst the attachment of district nurses had usually improved communications, there were often tight constraints over what the nurses could do and many were precluded from working

Table 1 TREATMENT ROOM WORK AT SONNING COMMON OVER FOUR MONTHS IN 1968

Injections and immunisations	593
Dressings	226
Suturing and removal of sutures	37
Advice (telephone or in person)	116
Venepuncture	227
Smallpox vaccination	84
Swab collection	12
ECG	9
BP and weight measurements	4
Reception of ill or injured patients	174

in doctors' buildings. The doctors reacted by employing more practice nurses and between 1982 and 1992 the number increased by more than six times, rising to nearly 18,000.

Many members of the nursing professions, especially those in management positions, were, and remain, concerned about this development although there was little they could do about it. Some found the concept of members of one profession employing members of another inappropriate, especially as it tended to reinforce a hierarchical structure between doctor and nurse. Equally, there were legitimate concerns about nurses being employed at rates of pay which did not always recognise their experience and qualifications, without adequate training or contracts. But it is also probably true to say that some were privately envious of a system where their colleagues were working in an environment unfettered by too many rules and where experimentation with new roles and responsibilities was comparatively easy.

Home assessment visits by nurses to replace the doctor, described by us in 1968 and previously by a Staffordshire practice in 1967[7], never really caught on, partly because the number of visits steadily fell and partly, I suspect, because

the nursing role in primary care came to be seen more in the fields of surveillance and education, rather than in diagnostic areas.

As the nursing work on practice premises increased, it was realised that training was needed since the practice nurses were outside the nursing hierarchy with its supervision and training responsibilities that had been created with the NHS. In 1972 some of us at Oxford devised a course for practice nurses which was received enthusiastically[8], as a result of which a Treatment Room Sisters' Handbook was produced in 1976 by a district nurse and general practitioner[9]. Barry Reedy, one of the original group who devised the Oxford course wrote in the foreword to the book that it was 'written as the first attempt to provide for a real, widespread and rapidly increasing need which there has been a tendency to ignore as a new area of legitimate professional activity'. Barry Reedy had by then become senior lecturer in Community Medicine at Newcastle where he was responsible for further research into primary care nursing before his premature retirement due to ill health.

Health promotion and prevention

Meanwhile, as primary care teams began to increase, people were turning their attention to the need to anticipate illness rather than simply react to it. Much of the work in this field was done by my colleagues at Oxford, notably Godfrey Fowler and Elaine Fullard who showed that most prevention in primary care could be done by nurses[10]. By providing nurse facilitators for practices, who helped practice nurses develop their skills, it was found that there was a large role for nurses in the fields of advice on smoking, alcohol, diet and exercise and in blood pressure and

other screening. Nurses also began to take cervical smears and some were trained to undertake pelvic examinations.

Chronic disease surveillance

As the eighties drew on, it was recognised that the supervision and monitoring of patients with long term problems was another ideal area in which nurses could work. In hypertension, diabetes and asthma their presence has become increasingly felt[11,12]. A special training course in asthma was established at Stratford-upon-Avon by Greta Barnes and her GP colleagues[13]. Other papers have described the benefits of nurse asthma clinics[14,15]. In my own practice nurses have now moved into arthritis care as well and there is clearly further scope for other similar activities.

Practice management and administration

In the early days of the NHS the doctor's spouse often acted as receptionist. Receptionists and secretaries gradually became commonplace and the 1966 contract gave an added impetus. Appointment systems began to appear with jokes such as 'Do I have to be ill to order?' and descriptions of 'dragons at the gate'.

As the number of people in the building increased, the job of managing them became a challenge. Up to then, all the management functions from employing and paying the staff to taking policy decisions and running the building was (and still is in some practices) the responsibility of the doctors. But it became clear to many doctors that, not only was it a significant extra burden, but the knowledge and skills needed were not those of a medical practitioner. The number of whole-time equivalent employed staff had

reached 54,000 by 1992 compared with less than half that number 10 years before.

It was not just the number of staff who were growing. Partnerships were getting larger: in 1949, 80% of general practitioners were singlehanded: now it is the reverse with 80% in partnerships. The number of general practitioners per head of population has risen and the average list size now in England and Wales is around 1,900.

But there were other reasons why administrative tasks were increasing. The 1966 contract had introduced a number of item of service fees, all of which resulted in the need to complete individual claim forms on each occasion. The reimbursement for each member of staff had to be claimed and cost rent and notional rent claims produced more paper work. Appointment systems steadily grew in number bringing with it the need (not always met) to ensure that they worked properly. Office equipment became more complex. By the early nineties legislation required a detailed understanding of the rules of employment, sickness and working conditions to name just three.

Gradually, practice managers began to appear, although their responsibility varied greatly. At one extreme, some individuals were better described as senior receptionists, simply carrying out work delegated by the doctors. At the other extreme, professional managers were appointed, some from industry and commerce. Where the doctors were prepared to let go, this new breed took over responsibility for hiring and firing staff, preparing budgets, setting up appraisal systems and dealing with complaints. It has to be said, though, that prior to 1990, professional managers were the exception rather than the rule. It was not simply that many doctors were reluctant to let managers manage. It was also felt that with a relatively undisturbed environment for 25 years the need to exercise vision,

to manage change and to set clear goals for the future was less evident than it is now.

Other professionals

Whilst doctors, nurses and administrative staff made up the core team, a number of other people began to appear. In 1968 the Seebohm report recommended the attachment of social workers to general practice[16] and one or two reports of experimental arrangements appeared [17,18]. But the development never became widespread. First, the roles of social worker and health worker only partially overlap. Second, in the early seventies, social work was emerging as a discipline in its own right and it needed to withdraw a little in order to establish itself independently of the medical profession.

Before long, however, other professionals more closely related to medicine began to appear. Midwives, dietitians, chiropodists, speech therapists, occupational therapists and community psychiatric nurses, attracted by the notion of working nearer the patient, started to do sessions in general practices attached from the local health authority. This was especially useful in situations where the primary health team was working in overlapping areas such as maternity and diabetes.

As well as attracting professions supplementary to medicine, some general practices began to employ counsellors and one of the first published accounts was reported from my own practice at the end of the seventies[19]. By the end of the eighties the development was widespread enough to provide material for a national survey[20]. A study published last August revealed that a variety of different mental health professionals were now working in general practice which included not only community psychiatric nurses and

counsellors but also psychiatrists, clinical psychologists, psychiatric social workers and psychotherapists[21].

Conclusion

It is hard not to be impressed by the development of primary health care during the first 40 years of the health service. Quite apart from the range of professional skills available to patients now from their local practice, many practices have developed into real teams, working and learning together with a real understanding of what being a team member means.

One of the chief factors (to which I shall return later) was the self-employed status of the general practitioner with the ability to move and adapt quickly as the need arose. It was that ability that was the key to survival when the new contract came into force in 1990 and that has enabled some practices to become transformed out of all recognition.

References

1 Hockey L. *Feeling the Pulse* (1966). Queens Institute of District Nursing, London.
2 Swift G, McDougall IA. The family doctors and the family nurse. *BMJ* (1964) i: 697.
3 Royal College of General Practitioners. *Present State and Future Needs* (1965), pp 40–43. Reports from General Practice II. London.
4 Otteneill R, Wall A. *The Growth and Development of Community Health Services* (1990). Business Education Publishers Ltd., London.
5 Hasler JC, Hemphill PMR, Stewart TI, Boyle N, Harris A, Palmer E. Development of the nursing section of the Community Health Team. *BMJ* (1968) 3: 734.
6 Marsh GN. Group practice Nurse: an analysis and comment on six months' work. *BMJ* (1967) i: 489–491.

7 Weston Smith J, Mottram EM. Extended use of nursing services in general practice. *BMJ* (1967) **4**: 672.
8 Hasler JC, Greenland AS, Jacka SM, Pritchard PMM, Reedy BLEC. Training for the treatment room sister in general practice. *BMJ* (1972) **i**: 232–234.
9 Jacka SM, Griffiths EG. *Treatment Room Nursing* (1976). Blackwell Scientific Publications, Oxford.
10 Fowler G, Fullard E, Gray JAM. The extended role of practice nurses in preventive health care. In: *The Nurse in Family Practice*. Bowling A, Sillwell B. Eds (1988). Scutari, London.
11 Thorn PA, Russell RG. Diabetic Clinics today and tomorrow: mini clinics in general practice. *BMJ* (1973) **2**: 534–536.
12 Mackinnon M, Wilson RM, Hardisty CA, Ward JD. Novel role for specialist nurses in managing diabetes in the community. *BMJ* (1989) **299**: 552–554.
13 Pearson R. *Asthma Care in General Practice* (1988). Asthma Society Training Centre, Stratford-upon-Avon.
14 Charlton I, Charlton G, Broomfield J, *et al.* An evaluation of a nurse-run asthma clinic in general practice using an attitudes and morbidity questionnaire. *Family Practice* (1992) **9**: 154–160.
15 Charlton IH, Charlton GPA, Broomfield A, *et al.* Audit of the effect of a nurse run asthma clinic on workload and patient morbidity in a general practice. *Br J Gen Pract* (1991) **41**: 227–231.
16 Department of Health and Social Security. *Report of the Committee on Local Authority and Allied Personal Social Services*. CMD 3703. (1968). HMSO, London.
17 Ratoff L, *et al.* Social workers and general practitioners. Some problems of working together. *J R Coll Gen Pract* (1974) **24**: 750.
18 Brook P, Cooper B. Community mental health. Primary Team and specialist services. *J R Coll Gen Pract* (1975) **25**: 93.
19 Anderson SA, Hasler JC. The effects of counselling in general practice. *J R Coll Gen Pract* (1979) **29**: 352–356.
20 McLeod J. *The Work of Counsellors in General Practice* (1989). Occasional Paper 37. Royal College of General Practitioners, London.
21 Kendrick T, Sibbald B, Addinton-Hall J, *et al.* Distribution of mental health professionals working on site in English and Welsh general practices. *BMJ* (1993) **307**: 544–546.

3
Health Needs of the Population and the Environment in Which They are Met

3
Health Needs of the Population and the Environment in Which They are Met

Before we can examine the work and the future of the primary health care team in Britain we need to be clear what needs the team has to meet. And we must try, as far as we are able, to see how those needs may change in the forseeable future.

Current and future themes

Running through the delivery of health care there are certain themes which should be self-evident. First, there is an increase in consumerism fostered both by the government in activities such as the Patients' Charter[1] and also by the patients' groups, especially those related to specific diseases. Other bodies such as the Consumers Association also encourage people to look critically at the kind of health care they receive. A number of practices are keen to demonstrate how they are achieving standards through such external assessment as that awarded by the British Standards Institute through its quality control BS5750[2].

Related to consumerism is the development of audit activities both in primary and secondary health care, where health professionals and managers identify clinical and operational areas, endeavour to measure what is actually happening and set criteria and standards for the future.

The changes brought in by the Conservative government at the beginning of the nineties introduced market place philosophy into what had previously been a relatively straightforward system with little competition. The developments have been at their most dramatic in the hospital service with departments competing with neighbouring ones or with the private sector.

In his report *On the State of the Public Health for England for 1992*, the Chief Medical Officer set out six issues which he saw as crucial to the nation's health[3]. These were

- To promote efforts to ensure health for all
- To achieve the targets in the strategy for health
- To involve patients and the public in choices and decision making
- To establish an effective intelligence and information system for public health and clinical practice
- To ensure a health service based on an assessment of health needs, quality of care and effectiveness of outcome
- To provide a highly professional team of staff.

All these themes mean that providers of health care can no longer take anything for granted and increasingly have to demonstrate that they are providing a high quality service.

Personal accessible care

Of all the aims of the National Health Service, this is perhaps the one most prized by patients (and one that has been achieved most successfully). A survey in *Which?* magazine two years ago found that the top two concerns of patients (but not GPs) were how long they had to sit in the waiting room and how long it took to get an appointment[5]. Related to accessibility is the need for initial problems to be

assessed by a generalist, unfettered by any specialist bias, and where possible to have continuity of care. These features of general practice were stressed by the Prince of Wales in his presidential editorial in the *British Journal of General Practice* two years ago[6]. Personal continuous care has been shown to be linked with patient satisfaction[7] and most patients like to see the same doctor[8].

Health promotion

The first decades of the NHS were dominated by demand-led activity. Gradually it became clear that more interest had to be taken in prevention. The enthusiasm for mass screening (still perpetuated by some private clinics) has gradually given way to activities which can largely be supported by evidence, with the exception of one or two contractual requirements introduced by the Government in the 1990 contract. At the beginning of the eighties the Royal College of General Practitioners produced its blue print[9] and matters were given a further impetus by the new contract. A survey from Sheffield found that patients' perceptions of invitations for health screening were very positive and their satisfaction ratings high[10]. Geoffrey Marsh estimated that 69% of practice nurse consultations in his medical centre in 1989 were spent on preventive activities[11].

The Government published its strategy for *The Health of the Nation* in 1992[12]. It set out its priority areas of

- Coronary heart disease and stroke
- Cancers
- Mental health
- HIV/AIDS and sexual health
- Accidents

Risk factors for the first are well known and the Government has identified those that need particular attention as smoking, diet, raised blood pressure, alcohol misuse and physical activity. Four cancers are singled out—breast, cervix, skin and lung. The other three areas have received less attention and money is now available to help develop appropriate activities.

Whilst some preventive activities are to do with immunisation or screening, such as mammography or cervical cytology, others are concerned with individual behaviour where matters are more difficult. In the first place helping people to change their smoking, drinking and sexual habits is time consuming. One of our health visitors estimated last year that it took her around eight hours to stop one smoker a year later. Second, there are questions about lifestyle interventions by health professionals and how far we have adopted models of behaviour change from social science. Kelly and Charlton reviewing the situation in 1992 argued that 'the present wave of idealistic health promotion . . . must be exposed to thorough scientific, moral and philosophical scepticism'[13]. Two further studies published in 1994 indicated that the effect of nurses performing cardiovascular health checks was smaller than had been previously suggested[14,15]. Nevertheless, most people would agree that primary health care teams have to continue to exercise what influence they can in this field.

Chronic disease and long-term problems

The number of patients with some kind of continuing health problem is very large. Fry has documented data for many years and Table 1 shows the consulting rates for some conditions for an average GP list of 2000. Table 2 shows the number of patients with problems past and present from my own practice in South Oxfordshire.

Table 1 CONSULTING RATES FOR CHRONIC CONDITIONS

Condition	*Persons consulting per year*	
	per 2,000	*per 10,000*
Cardiovascular		
High blood pressure	100	500
Chronic IHD	40	200
Heart failure	24	120
Anaemia	14	70
(Pernicious anaemia)	(3)	(15)
Central Nervous System		
Stroke (after effects)	20	100
Epilepsy	7	35
Parkinsonism	3	15
Multiple sclerosis	2	10
Cancers (under care)	15	75
Respiratory		
Asthma	36	180
Chronic bronchitis	22	110
Gastrointestinal		
Peptic ulcers	12	60
Irritable bowel syndrome	24	120
Diverticular disease	4	20
Endocrine		
Diabetes	20	100
Thyroid disorders	11	55
Chronic renal failure	15	

From Fry J. *General Practice: The Facts.* (1992), p. 26. Reproduced by permission of the Radcliffe Medical Press

We also know that chronic diseases are not distributed evenly through the population and in a study from the Netherlands, it was found that three-quarters of the problems were in under a third of the households[16]. The researchers also found that although nearly a third of the population had a long-term problem, a further quarter were involved in some way as partners, parents or children. Moreover, some of the diseases have considerable social impact. Nor are these limited to the obvious disabling disorders such as arthritis:

Table 2 LONG-TERM PROBLEMS

Number of patients at Sonning Common, January 1994	
Angina	193
Congestive cardiac failure	75
Hypertension	457
Blood pressure high: observation only	231
Diabetes	126
Epilepsy	59
Gout	106
Osteoarthritis	434
Rheumatoid arthritis	40
Eczema	1127
Psoriasis	176
Hypothyroidism	75
Hormone replacement therapy	360
Mental handicap	28

a study from Sheffield into patients admitted into hospital with asthma demonstrated that a third had had to give up their job and nearly half the children had had some difficulty with sport[17].

It has gradually become accepted that hospital outpatient departments are not appropriate places to follow up most of these patients. Furthermore the importance of effective monitoring of a number of diseases is now becoming clear. Good long-term control of glucose levels in diabetics has been shown to reduce the risk of long-term complications. A recent study from the north of England suggested that some deaths from stroke or hypertensive disease could have been avoided and that one of the factors was the failure to follow up patients with raised blood pressure[18]. It is also clear that many of the deficits of long-term care are to do with organisation rather than knowledge.

Sharing health beliefs and management

Whilst a great deal of health care involves the application of medical science there is increasing recognition that patients need to be involved in decisions about their care. I have already referred to the potential contribution from social science. There is evidence that patients are often dissatisfied with the communication they have with health professionals[19] and that the ideas they have before and after their consultations affect the outcome[20].

Relationships with secondary care

Britain is one of the few countries in the world where patients can generally only access the secondary care through primary care. In the early days of the NHS, a large proportion of serious illness was referred to hospital specialists. Many patients were admitted to hospital, often for much longer periods than today.

Gradually, as general practitioners became more confident and better trained and as access to pathology and X-ray procedures became more widespread, they took over the care of more diseases. Equally the introduction of practice nurses and the attachment of other nurses enabled more to be done in the practice and patient's home.

Three major factors are now changing the relationship and transfer of patients between the two services. The first is the purchaser–provider split and in particular fund-holding practices. Purchasers now state what they want from secondary care in terms of such things as waiting times and reducing follow-up outpatient appointments. Primary care, acting as the patient's advocate, is now an equal partner with secondary care at looking at exactly where needs can be met

most effectively. We still do not understand, however, the large differences in referral rates from different doctors[21].

The second factor is technology. An increasing number of operations and procedures are now being undertaken by non-invasive or minimally invasive techniques. The number and length of hospital admissions is falling. There have been suggestions that by the year 2010, 80% of surgery will be done by new techniques which could mean that over 50% of surgical patients will be treated as day cases. This in turn will drive down the number of hospital beds and may mean the closure of some smaller hospitals which in turn will increase the work for community nurses. More sophisticated diagnostic procedures may be done or accessed by general practitioners.

The third factor is the closure of beds for the mentally handicapped, mentally ill and elderly and the transfer of responsibility for a larger number of patients in their own homes to Social Services. It is the primary care services that will have to meet the health needs of these people at a time when the number of elderly will steadily be rising.

The dividing line between primary and secondary care, then, will become more fluid and many of those patients who do not need to leave their own beds for specialist procedures may be housed in hotel or hostel type accommodation rather than wards.

Conclusion

Primary health care teams now have a more dominant role in the NHS with more emphasis on prevention and monitoring of long-term problems. They will see the pattern of some of their work changing and they will need to develop effective communication with other colleagues. They will need to continue to provide personal accessible care to

their population. They will have to demonstrate that their care is of high quality and to accept that they will become more accountable to the NHS for both care and resources.

References

1 Department of Health. *The Patients' Charter* (1991). Department of Health, London.

2 British Standards Institution. *The Way to Capture New Markets. A Guide to BSI Quality Assurance.* BSI, PO Box 375, Milton Keynes.

3 Chief Medical Officer. *On the State of the Public Health for the Year 1992.* Introduction. (1993). Department of Health, HMSO, London.

4 Klein R. *The Politics of the National Health Service* (1983). Longmans, Harlow.

5 Consumers Association. GPs—your verdict. *Which*? (1992) 202–205.

6 HRH The Prince of Wales. The importance of the generalist. *Br J Gen Pract* (1992) **42**: 222

7 Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. *BMJ* (1992) **304**: 1287–1290.

8 Freeman GK, Richards SC. Is personal continuity of care compatible with free choice of doctor? Patients' views on seeing the same doctor. *Br J Gen Pract* (1993) **43**: 493–497.

9 Royal College of General Practitioners. *Health and Prevention in Primary Care. Reports from General Practice* (1981) **18.**

10 Norman P, Fitter M. Patients' Views on Health Screening in General Practice. *Fam Pract* (1991) 129–132.

11 Marsh G. Caring for larger lists. *BMJ* (1991) **303**: 1312–1316.

12 Department of Health. *The Health of the Nation*: *A Strategy for Health in England.* (1992). HMSO, London.

13 Kelly MP, Charlton BG. Health Promotion: time for a new philosophy? *Br J Gen Pract* (1992) **42**: 223–224.

14 Family Heart Study Group, Randomised controlled trial evaluating cardiovascular screening and intervention in general practice: principal results of British family heart study. *BMJ* (1994) **308**: 313–320.

15 Imperial Cancer Research Fund OXCHECK Study Group. Effectiveness of health checks conducted by nurses in primary care: results of the OXCHECK study after one year. *BMJ* (1994). **308**: 308–312.
16 Knottnervs JA, Metsemakers J, Hoppener P, *et al.* Chronic illness in the community and the concept of social prevalence. *Fam Pract* (1992) **9**: 15–21.
17 Nocon A, Booth T. The social impact of asthma. *Fam Pract* (1991) **8**: 37–41.
18 Payne JN, Milner PC, Saul C, *et al.* Local Confidential Enquiry into avoidable factors in deaths from stroke and hypertensive disease. *BMJ* (1993) **307**: 1027–1030.
19 Ley P. Patients' understanding and recall. In: *Doctor Patient Communication.* Eds. Pendleton D, Hasler J (1983). Academic Press.
20 Pendleton DA, Schofield TPC, Tate PHC, *et al. The Consultation: An Approach to Teaching and Learning.* (1984), pp 30–35. Oxford University Press. GP series 6.
21 Roland M, Coulter A (Eds). *Hospital Referrals.* (1992). Oxford University Press. GP series 22.

4
A Team for the Nineties

4
A Team for the Nineties

I now turn to the work and potential for the primary health care team in the nineties—in other words, what is and what can be done within the existing framework? I shall look first at the roles and requirements for the key players and then at what makes these players effective when they work together.

First, we need to be clear about who makes up the team. Different people may have different views: I identify a core team and a support team. The members of the former are those people whose main place of work is in the surgery or health centre: these are mainly doctors and nurses (both directly employed and attached) and the practice manager and administrative staff.

The members of the support team are those who provide a part time service within primary care in the building to complement the core team activities but whose main base is elsewhere. I have already referred to these in Chapter 2: they include dietitians, midwives, occupational therapists, physiotherapists, psychologists, speech therapists, chiropodists and community psychiatric nurses. There are a few practices who may have professionals such as physiotherapists in the core team but in the main most of them provide services to a number of practices. Whilst it is very important to integrate them appropriately with the core team, the extent of this will be rather less than between the core team members.

Hospital specialists also support the primary care team by being involved in the monitoring of long-term problems. But by definition they are part of the secondary care team and as such their role cannot really be regarded as primary.

There are some people who include the patient as a member of the team. I find this conceptually difficult in the same way as I would find the suggestion that spectators at a football match are members of the team. That is not to say that patients should not be involved in decisions about their own care—indeed it is essential that they are. But the team is there to serve the patient and to that extent the two are separate.

The core team

In this section I examine the roles of the three main professionals involved—general practitioners, nurses and practice managers.

The general practitioner

We have already noted that what patients want most is easy access to medical care. In most instances, this is still to a doctor, partly because of tradition and partly because a doctor's chief role is to diagnose and initiate management and treatment.

The characteristic that distinguishes primary care doctors from other doctors is the ability to make assessments and diagnoses as a generalist without a bias to one particular specialty. He or she often does this at a much earlier stage of disease than a specialist and is frequently supported by information about the patient as an individual and member of a family. Most of the conditions that the general practitioner sees are not life-threatening and have been well documented by Fry[1]. In making assessments, the doctor will be guided by knowledge and experience which were identified nearly 30 years ago by Ian McWhinney[2] as the key features of general practice. These are

- the evaluation of symptoms, signs and diagnostic tests
- the prevalence, incidence, distribution and natural history of disease
- the physical and mental development of human beings from intrauterine to adult life
- human behaviour and psychodynamics
- social influences in the presentation of disease

Since then, a great deal of work has been published and the need stressed for doctors to understand how to be effective when interacting with patients[3,4]. There is much evidence that understanding patients' beliefs and concerns is as crucial as is involving patients in their own management[3,5,6]. It is essential, then, for today's general practitioners to know how to access these beliefs and concerns quickly and to realise that, if they do not, they run the risk of their consultations being dysfunctional and not meeting the patients' needs. Equally, today's doctors must involve patients in decisions about investigation and treatment, if they do not want pills left in the cupboard or advice neglected.

The importance of effective consulting is not a substitute for a high standard of clinical medicine. There have been enough stories in the media for us to realise that patients and managers no longer take clinical competence for granted. Furthermore with the reduction in hospital beds and with more diseases looked after in the community, general practitioners must be up to meeting this challenge. The introduction of fund-holding practices has encouraged internal referral between partners, to save specialist referral costs, and it is likely that we will see an increase in the number of doctors with special interests. Provided that all doctors also remain generalists, there may be some advantages to this trend.

There are, however, serious questions about whether family doctors need to be doing much prevention work (apart from opportunistically), following up long-term problems or dealing with social or emotional problems to the extent that some do. Geoffrey Marsh has argued on more than one occasion that if doctors delegated work that could be better done by someone else, they could cope with lists of as many as 4,000 patients[7]. Few doctors would accept that they could cope adequately with this number and many complain of lack of time. General practice consultations are regarded as short by international standards. If the doctors are to practise the kind of patient-centred consultations referred to earlier, there is evidence that they need longer booking intervals than eight patients an hour (which is still usual for some practices) if they are not to feel stressed[8]. On the other hand list sizes have been falling steadily and there are many more practice nurses than before: presumably doctors continue to feel busy because they have taken on new roles. Marsh's vision is of a doctor who assesses and hands over rather than one who accepts most of the responsibility most of the time.

Whether doctors wish to move to this new role is another matter. Many believe that the relationships with their patients are such that a more team-centred approach would jeopardise it. Nevertheless, we have to ask ourselves how far we can continue to complain of lack of time, or to have patients waiting several days for an appointment and at the same time insist we need to do most things ourselves. And if cost effectiveness is also important, can we justify expensive doctor time to the extent it is currently used? More fundamentally, do we need our patients more than they need us? Personal doctoring, which most patients say they like, is not incompatible with personal relationships with others who perform different functions.

In conclusion, today's practitioner needs to be accessible, clinically competent and skilled in communication. He or she (for she will be increasingly female) also needs to recognise that in many instances someone else may be able to do the job just as well. And that person will, as often as not, be a nurse.

The practice nurse

In Chapter 2 I described the rise in numbers of practice nurses. What do they do and what is their potential?

Their first activities were largely conventional nursing procedures on the premises. Today the list of activities has not changed dramatically from when Geoffrey Marsh and I published the experience of our two practices in the sixties[9,10]. The volume of some procedures such as venepuncture may have escalated but in the main the work consists of dressings, injections, ear syringing, venepuncture, suturing and removal of sutures, assisting at minor operations and dealing with minor injuries. In 1992/93 our treatment room attendances constituted over a quarter of all attendances at Sonning Common excluding special clinics for prevention and chronic disease.

It is in these two areas of prevention and chronic disease that the work of practice nurses has expanded in the last decade. It is now known that premature deaths from coronary artery disease and stroke—two of our major killers—are linked with particular risk factors, of which smoking, hypertension and high cholesterol levels are the most important.

In 1981 the Royal College of General Practitioners published its report on this subject[11]. Interestingly there was not a single nurse on its working party although the report

did conclude that the proposals could not be implemented without a major expansion of non-medical staff in general practice. The main priorities identified were control of known hypertension, case finding of new hypertensives, control of known diabetics and reduction in smoking.

In Chapter 2 I mentioned the developments in the eighties and the use of nurse facilitators[12]. It has been shown that much of this work can be undertaken by nurses supported by administrative staff. Practice nurses who fulfil this role must have clear protocols, support from the doctors and access to a computerised record system. The two main attributes that they need are an ability to help people to change their behaviour and understanding of risk factors and when intervention is necessary. Although some doubt has been cast over how effective some of this intervention is[13], there seems little argument that provided practices adopt protocols which stand up to scientific scrutiny and look carefully at cost effectiveness, the work is important and will continue in some form or other.

Practice nurses are now increasingly involved in other areas of prevention, notably cervical cytology, teaching breast self-examination and family planning. There has been less interest, however, in two other areas in the Government strategy for health—mental health and accidents.

Marsh now estimates that two-thirds of his practice nurse time is spent on preventive activities[7]. In 1992–93 at Sonning Common there were approximately 1,500 nurse consultations for prevention which included general health promotion, well man and well woman clinics, anti-smoking, family planning and cot death prevention. Not included in these figures are a large number of immunisations. In the month of January this year half the cervical smears were carried out by nurses who have also been trained in pelvic examination and a preliminary analysis of the

laboratory comments shows that the nurses achieved a somewhat higher percentage of good quality smears than the doctors.

The enormous advantage that British general practice has over most other countries is the registered population, which enables subsections to be rapidly searched by computer and information on each person's preventive status to be gleaned. The ability to generate call and recall letters equally fast enables nurses and computer staff to send for appropriate people with the minimum of fuss. In the hand over of prevention work to their nursing colleagues, however, general practitioners must realise that some of the work still has to be done opportunistically, since this is often time effective for practice and patient and there are some patients who are only happy to be at the surgery when they believe they have a problem to be sorted out.

With prevention established within their field of activity, practice nurses are now logically turning their attention to the field of chronic disease monitoring. It has already become clear that there are deficits in the follow up and supervision of long-term problems. A recent study has shown that the rule of halves still applies to raised blood pressure detection, treatment and control (half undiagnosed, half those diagnosed untreated and half those treated inadequately controlled)[14]. A recent study of the records of children with asthma has shown a significant discrepancy between symptoms of asthma and a formal diagnosis being made with the institution of appropriate treatment[15]. I have already referred to the finding in the north of England that some deaths from stroke or hypertensive disease could have been avoided by more effective blood pressure follow up[16] and that asthma patients may still be experiencing significant interference with lifestyle[17].

A study of patients with asthma from Norfolk has shown significant reductions in wheeze, nocturnal attacks, overall trouble and interference with physical activity following the introduction of a nurse asthma clinic[18].

Another study has shown a reduction in doctor consultation and the use of oral steroids and nebulisations following the introduction of a nurse clinic[19]. In my own practice we have seen the number of emergency consultations for asthma fall since one of our practice nurses took over all routine asthma care. In the last six months of 1993 we nebulised only 20 patients, of whom only six had been to the nurse asthma clinic ever or within two years. Conversely, of the first 20 patients who attended the nurse clinic last July, only 3 have subsequently needed nebulising.

In diabetic care, too, things are changing. A recent study has shown that general practice diabetic clinics can be as effective as hospital clinics[20]. At Sonning Common all but a handful of our 126 diabetic patients are supervised by a team of one practice nurse and one district nurse with two of the partners who provide help when needed and carry out annual checks. New patients receive education and support from the nurses and those who need it can be transferred to insulin easily—largely by one of the nurses.

Hypertension at Sonning Common is now followed up entirely by the same pair of nurses (one district, one practice) apart from a few patients who still attend their doctors. Once the decision to treat someone's blood pressure has been taken after careful assessment of other risk factors and any end organ damage, and once the treatment has been determined to the patient's and doctor's satisfaction, the patient is referred to the nurse clinic. Guidelines for blood tests, ECGs and other matters have been agreed, as they have for diabetic care. In 1992/93 there were over 1,200 nurse consultations for

asthma, diabetes and hypertension in the practice. Patients with thyroid disease are also followed up by one practice nurse.

These diseases are now established in many practices as appropriate for nurse supervision to a greater or lesser extent. We now need to look at other areas and at Sonning Common we have established a nurse arthritis clinic. Another practice nurse and district nurse pair, supported by one of the partners, see patients with moderate or severe arthritis where detailed assessment of their function and disability is undertaken, their drugs reviewed and education and instruction for exercises are undertaken. In most instances, patients are seen once or twice and then discharged, but patients needing regular review, such as those with rheumatoid arthritis on suppressive therapy, continue to attend for appropriate monitoring. Acupuncture is also used. The effectiveness of the clinic is currently being investigated.

The practice nurse of the nineties has a tremendous future. Apart from technical nursing procedures, the skills of listening, educating, monitoring and supporting are the key attributes needed for many of today's patients. Most nurses have these in abundance.

The district nurse

Although the work and number of practice nurses have expanded rapidly their sphere of activity has been confined virtually entirely to practice premises. The nursing work in patients' homes continues to be done by district nurses and their assistants. With the increase in day surgery and early discharge they, too, are seeing a major change in the care they provide. Increasing numbers of elderly and elderly confused patients, although in theory often the responsibility of social services, influence the day's work.

The modern district nurse is increasingly a manager of care, rather than simply a provider.

But district nurses are uncertain about their future. The inclusion of community nursing services in fund-holding practice budgets is raising questions about the employment costs and control of work by health authorities and others. On the one hand, district nurses enjoy professional management with appropriate training and other safeguards. On the other hand, many are restricted in what they can do at a time of rapid change in primary care: moreover the money for updating is often scarce. The inappropriate division of nursing employment, to which I shall return in the final chapter, creates tensions in many practices.

Some fund-holding practices have been negotiating with authorities other than their local one for the provision of community nursing. At least one has reported a significant shift in philosophy as a result, with the attached staff feeling that they relate more closely to the practice team than they did before.

One of the ways by which we have attempted to break down barriers and to include district nurses in new developments at Sonning Common has been to give each of them a role with a special interest within the health centre. With the co-operation of their managers, one district nurse specialises in diabetes and hypertension and the other in arthritis. I have already described their method of working, paired with two practice nurses. Diabetes and arthritis are two diseases in which it is invaluable to have a nurse with experience of home care.

Another developing area of district nursing work has been terminal care and many nurses now are knowledgeable about symptom control and pain relief. With hopefully more

auxiliary help, today's district nurse should be able to use her skills imaginatively and effectively.

The health visitor

Health visitors are perhaps the members of the team who seem to feel least confident about their future. They face the same potential problems as district nurses with questions over whether fund-holding practices will move the contracts and how far practice nurses might take over their role.

Most health visitors spend a considerable amount of time dealing with children under five: a survey of over 600 health visitors in the north of England demonstrated that many were running developmental clinics on their own and over a third wanted to do it all[21].

In many practices, health visitors are limited in what they can contribute to the care of adults, either by their workload or by restrictions by their managers. Yet their skills need to be used more widely since health visitors are highly qualified nurses with the ability to deal with all age groups promoting health and giving advice on a wide range of topics. Our solution at Sonning Common (as with the district nurses) is to use them in the health centre and to enable them to integrate fully into the team. Most of the family planning is done by them and nearly all the well man and well woman checks. The nurses I referred to earlier in this chapter who were taking most of the routine cervical smears are, in fact, our health visitors. They also work with the elderly. In 1992–93 they ran five sessions on reducing the risks of cot death, three sessions on cardiopulmonary resuscitation with the practice nurse who is trained in resuscitation, and five courses of smoking cessation groups.

The nurse practitioner

Nurse practitioners first appeared in North America and the history of their development has been documented by Barbara Stilwell[22]. 1975 guidelines for them stated that nurse practitioners were registered nurses who were able to:

- assess the health status of individuals and families
- institute and provide continuity of health care
- provide instruction and counselling in the area of health promotion and maintenance
- work in collaboration with other health care providers[23].

The need for them arose because of the lack of doctors in primary care, especially in the remoter areas and in the inner cities of North America. Also developing, at around the same time, were other health professionals known as physicians' assistants who were neither doctors or nurses but seemed to pose less of a threat to the doctors. Two PAs from Duke University in North Carolina were attached to us at Sonning Common in the seventies and their knowledge and skills were impressive.

Stilwell documents some of the evidence that nurse practitioners provide care equivalent to, and sometimes more effectively than, doctors. They have started to appear in the United Kingdom although there seems to be some difference of opinion as to exactly what their role is. Barbara Stilwell herself was involved in a pilot project in Birmingham in the early eighties. During a six-month period, 858 patients consulted her[24]. Half of these consultations were for preventive medicine and a quarter for advice and health education.

In another practice in the Thames Valley, the nurse practitioner seemed to be involved largely in the follow-up

of patients with asthma, diabetes and hypertension—work which is often done by practice nurses. Perhaps what distinguishes nurse practitioners from practice nurses is the ability to make initial assessments and formulate diagnoses: exactly where they will fit in the future is not yet clear. In the meantime, demand for places on the RCN nurse practitioner course has been rising steadily over the past four years.

Patient views

One of the factors in delegating more work to nurses are patients' views on whom they would like to see. A small survey was carried out in 1993 by a medical student attached to our practice. In the ante-natal clinic patients generally preferred to see the midwife although they found asking questions of either doctor or midwife just as easy. For asthma it was fairly evenly balanced both for whom they preferred to see and whom they thought more competent. In diabetes the preference was tilted in favour of the doctors. In all three clinics both doctors and nurses scored well on explanations, approachability, understanding and the patients feeling relaxed. In one of the asthma studies referred to earlier, the nurse scored more highly than the doctors on approachability although patients said their confidence in their doctor was unaffected by the nurse assuming responsibility for their asthma[18]. In another small survey at Sonning Common towards the end of 1992, nearly all the patients attending the hypertension clinic were happy for their check up to be done by the nurse.

The practice manager

Three factors are now assisting the emergence of the new manager in primary care. First, the increasing

number of health workers and the activities they undertake mean that effective management is needed if co-ordination is to be effective. Second, the new 1990 contract produced more paperwork and accountability to the family health service authorities and health boards, and doctors who attempted to deal with much of it found they were inundated with adminstration. Third, the introduction of fund-holding practices has required a range of new skills including budgeting and negotiating.

A successful manager's skills include team leadership, motivating powers and organisation[25]. It has been pointed out that practice managers are unique: whereas the majority of managers handle a specific function within a large organisation such as finance, personnel and so on, a practice manager works in a relatively small but nevertheless complex organisation where she or he has a very wide range of responsibilities[26]. The author identifies seven elements to the manager's role:

- establishing objectives
- defining roles, tasks and procedures
- establishing priorities
- securing and allocating resources
- securing compliance
- monitoring performance
- watching the outside world

There are still practices where the doctors make all the decisions and the manager carries them out. In these circumstances, he or she would be better described as an administrator. At the other extreme, managers hire and fire staff, oversee budgets and control expenditure, deal with complaints and carry out staff appraisals. In my own practice the manager does all these things and much more.

The skills that practice managers most need are not necessarily acquired in the NHS and certainly not from being a secretary or receptionist. They are often better acquired elsewhere and many managers now have come from commercial organisations. As with the nurses, it is up to the doctors to decide how far they wish to delegate responsibility. It is also up to the doctors to give consistent messages and decisions if they want their managers to manage.

Adminstrative staff

There are now a number of skills required by the people who run the adminstrative side of the practice under the practice manager. Secretaries use word processors, computer staff deal with various software packages and finance managers are using accounts spreadsheets and payroll packages. Receptionists and telephonists need communication and computer skills and basic knowledge of various claim forms and registration procedures. Desk top publishing is used in my own practice for our quarterly newsletter.

The support team

The situation regarding support team members is easier to discuss. Their roles are generally well-defined and they deploy their expertise alongside the core team. In some instance, they simply need a consulting room and appropriate support, as in the case of speech therapists and chiropodists. In other instances we interact, as with the dietitian and midwife in diabetic and ante-natal clinics. We have new expertise in, for instance, counselling services from community psychiatric nurses. Physiotherapy is moving into larger fund-holding practices where the local waiting list is too long.

Teamwork and quality

Unfortunately the fact that a number of dedicated professionals work in one building does not mean that they will all work effectively and well together. Teamworking does not happen by magic: it needs to be nurtured. Whilst some individuals naturally relate to each other more easily than others, everyone in a team must invest time in getting results. What is the nature of this investment?

Roles and relationships

The role and potential contribution of each team member must be understood by everyone else. Health visitors and district nurses must ensure that the doctors know what they have to offer and, equally important, know how to refer work to them appropriately. The same may need to be done between members of the same profession—between practice nurses and health visitors and between female and male doctors for example.

Not only do people need to understand each other's roles—they need to respect them too. One survey has shown that many women doctors believe that their share of partnership profits is too low for the work that they do and that this feeling is associated with the belief that their opinions do not carry equal weight with those of the men[27]. In a study of health visitors referred to earlier, many health visitors said they felt undervalued by many of the general practitioners with whom they worked[21]. Health visitors' perceptions of relationships with doctors were significantly worse than those of the doctors.

There are many similar anecdotal stories. It should also be said that many general practitioners are unaware that there is a problem. If these issues are to be tackled, people must

make time to talk and listen to each other informally and regularly and also at intervals for longer sessions. One useful way we have found to learn from others (and to demonstrate that learning, taking place) is to hold tutorials with our trainee conducted by a doctor and nurse where, in the course of the session, the latter is able to demonstrate her knowledge and skill to the former.

Objectives and policy

A team needs to know where it is going. A number of practices now hold 'away days' when members go off to a hotel or similar venue to produce mission statements and develop policy for the next few years. Without these, management of the practice tends to be decided from day to day. Doctors often find strategic planning difficult since so much of their work is driven by day to day patient demand.

The reasons for having aims and objectives have been summarised in the *Handbook of Practice Management*[28]. They are:

- members of the team need to be clear about what they are trying to achieve
- differences of opinion, especially amongst the doctors, must be identified and discussed, so that there is no conflict of direction
- the work of the practice can be assessed and quality measured
- team members understand each other's roles better
- the construction of aims and objectives is itself a team building exercise
- they provide the practice with a mechanism for handling change.

Objectives need to be detailed. For example, a statement such as 'we aim to provide high class preventive services' tells us about intent but not what is proposed. On the other hand, the statement 'we aim to check the blood pressure of every adult aged between 20 and 70 every five years' is detailed enough for everyone to know what is intended. Furthermore it enables someone to audit how far it is being achieved.

A practice without any aims and objectives is like a ship without any steering: it tends to drift according to the winds and tides. At times of rapid change, such as those that prevail today, having a clear direction helps everyone to cope much more easily. Practices that were clear about where they were going, that were well organised, and where everyone worked well together, survived the introduction of the 1990 contract more easily than those practices that had none of these attributes.

The construction of aims and objectives is itself a powerful team-building exercise. Because issues have to be discussed at length, individuals learn about each other. In my own practice we have had two full away days to review overall strategy and one half day to review health promotion for the doctors, nurses and practice manager. Different people chaired different sessions: for example, one of our health visitors chaired the health promotion session. Each day resulted in a list of proposals which were subsequently worked on by small groups in which every member of the core team was involved.

Day to day decisions and policy

Apart from these occasional activities, decisions have to be taken regularly about policy and other matters. Most practices have partnership meetings for this purpose. Whilst this is fine for the partners it excludes others from

decision-making. Nurses in many practices say that whilst they get on well with their doctors, they cannot influence policy easily and decisions affecting them are made without their involvement. We have tackled this by abolishing partners' meetings except for occasional ones to deal with accounts: they have been replaced by executive meetings which are attended not only by the practice manager and her deputy but also by one of the attached nurses and one of the practice nurses. The agenda and the subsequent minutes are displayed in the office: anyone who wishes something discussed can raise it through their representative.

Education and delegation

Doctors need to be clear that, when they delegate work to nurses or others, they are certain that the persons concerned are competent to carry that work out: the General Medical Council's view is that the doctor must retain ultimate responsibility for the patient[29]. Education is obviously important. Learning together is another powerful team-building exercise. Nurses and doctors often attend meetings together. For example, the four nurses and doctors involved in diabetes at Sonning Common attend study days together. The partners sometimes pay the educational costs for the attached nurses (if they cannot get funding) and regard this as recognition that the attached staff help to generate income for the practice.

Team roles

A number of practices have used the management team model developed by Meredith Belbin[30]. Whilst working at Henley Management College he discovered that people tend to assume certain roles in groups regardless

of their individual professional expertise. He identified eight such roles: many people have more than one role in which they feel comfortable. They include 'shapers' (who tend to drive projects along), 'company workers' (practical commensense people who get on with the job), 'teamworkers' (who are interested in people getting on well with each other) and 'chairmen' (who are keen to hear all the relevant contributions). Belbin discovered that successful teams have a balanced group of different role players. Each role player has a negative as well as a positive side and it is helpful for everyone to recognise this.

The conclusions are not totally applicable to practices because the decision-makers all follow roughly the same professional jobs, whereas in industry everyone has different jobs—finance, marketing, personnel and so on. Nevertheless, many practices have found it useful to identify the team roles of the partners and practice managers. This enables people to understand the effect they have on others and also to appreciate the roles that others adopt in meetings. Some practices, including ours, have used Belbin when recruiting new partners and practice managers. Whilst the final decision is based on many considerations, it is helpful to see what kind of contribution the applicants would be likely to make to decision making. There are other personality tests available but Belbin seems to be the most widely used in general practice and the self-administered questionnaire is published in Belbin's book.

Auditing care

One of the themes I identified at the beginning of the previous chapter was the need for primary health care (in common with other branches of the health service) to demonstrate that it is attempting to measure quality.

Although there are various definitions of audit it is generally accepted that it involves setting standards, looking to see how far these standards are being achieved, adjusting them and then looking again. There has been a tendency, partly because of the way it was introduced, for audit to be confined to the activities of general practitioners. It goes without saying that, because of the major contribution of all team members, audit must embrace everybody. It also must be clear by now that all the appropriate people must be involved not merely in measuring what happens, but also in the construction of the standards. There is also a tendency for audit to be a sporadic activity, responding to various pressures of the day such as requests from Medical Audit Advisory Groups or contractual requirements. But for the future, teams must establish regular and repeated measurements of quality which are an integral part of day to day functioning.

Total quality management

More recently an approach to quality development in industry has been introduced to health care in the United Kingdom. Based on the premise, amongst others, that most workers are trying to deliver a good service most of the time, total quality management (TQM) is now being developed in general practice. In the Oxford region, 19 practices including mine are currently engaged in exploring the aims and methods of TQM.

TQM relies on four general theses[31]. First, that success depends on meeting the needs of customers (patients); second, that quality is an effect caused by the process of production (running the practice); third, that most humans

(team members) want to do well and fourth, that simple data collection and analysis systems enable the process of production (running the practice) to be improved.

So TQM concentrates less on the people doing the work and more on what they are doing and how they do it. This enables the work processes to be improved. Everyone is familiar with the fact that because we know something *should* be done (examining a diabetic's feet regularly or checking blood levels of a patient on lithium regularly) does not mean it *will* be done. Imparting information does not ensure behaviour change. TQM attempts to bridge this gap.

Leadership

If the team is to function well and develop, who leads it? Debates in the past have focused on whether it should be a doctor or nurse or someone else. That seems to me to be more of an issue of status and recognition than about direction.

Paradoxically, there is a danger that, in the drive to help team members move to equality and mutual respect, no one assumes a leadership or chairman's role. Yet every practice needs good leadership if it is to survive and be successful. That role has a tendency to fall to the longest serving partner, who may or not be capable of filling it. The qualities of a leader are not ones of domination or imposition but of listening and respect for colleagues combined with vision and a drive for excellence. Most health workers want to provide an excellent service; the leader's job is to help them achieve it together and to have the vision to grasp the opportunities. Primary health care teams need leaders.

References

1 Fry J. *General Practice. The Facts* (1992), Ch. 4. Radcliffe Medical Press, Oxford.
2 McWhinney IR. General practice as an academic discipline. *Lancet* (1966) i: 419–423.
3 Pendleton DA, Schofield TPC, Tate PHL, Havelock PB. *The Consultation: An Approach to Learning and Teaching* (1984). Oxford University Press, GP series, Oxford.
4 Neighbour R. *The Inner Consultation* (1987). MTP Press, Lancaster.
5 Pendleton DA, Hasler JC, Eds. *Doctor–Patient Communication* (1983). Academic Press, London.
6 Martin E, Russell D, Goodwin S, *et al.* Why patients consult and what happens when they do. *BMJ* (1991) **303**: 289–292.
7 Marsh GN. Caring for larger lists. *BMJ* (1991) **303**: 1312–1316.
8 Howie JGR, Hopton JC, Heaney DL, Porter AMD, Attitudes to medical care, the organisation of work, and stress among general practitioners. *Br J Gen Pract* (1992) **42**: 181–195.
9 Hasler JC, Hemphill PMR, Stewart TI, Boyle N, Harris A, Palmer E. Development of the nursing section of the Community Health Team. *BMJ* (1968) **3**: 374.
10 Marsh GN. Group Practice Nurse: an analysis and comment on six months work. *BMJ* (1967) **1**: 489–491.
11 Royal College of General Practitioners. *Prevention of Arterial Disease in General Practice. Report from General Practice 19.* (1981). Royal College of General Practitioners, London.
12 Fullard EM, Fowler GH, Gray JAM. Facilitating prevention in primary care. *BMJ* (1984) **289**: 1585–1587.
13 Oliver MF. Doubts about preventing coronary disease. *BMJ* (1992) **304**: 393–394.
14 Smith WCS, Lee AJ, Crombie IK, *et al.* Control of bloodpressure in Scotland: the rule of halves. *BMJ* (1990) **300**: 981–983.
15 Neville RG, Bryce FP, Robertson RM, *et al.* Diagnosis and treatment of asthma in children: usefulness of a review of medical records. *Br J Gen Pract* (1992) **42**: 501–503.
16 Payne JN, Milner PC, Saul C, *et al.* Local confidential enquiry into avoidable factors in deaths from stroke and hypertensive disease. *BMJ* (1993) **307**: 1027–1030.

17 Nocon A, Booth T. The social impact of asthma. *Fam Pract* (1991) **8**:37–41
18 Charlton I, Charlton G, Broomfield J, *et al.* An evaluation of a nurse-run asthma clinic in general practice using an attitudes and morbidity questionnaire. *Fam Pract* (1992) **9**: 154–160.
19 Charlton I, Charlton G, Broomfield J, *et al.* Audit of the effect of a nurse-run asthma clinic on workload and patient morbidity in a general practice. *Br J Gen Pract* (1991) **41**: 227–231.
20 Parnell SJ, Zalin AM, Clarke CWF. Care of diabetic patients in hospital clinics and general practice clinics: a study in Dudley. *Br J Gen Pract* (1993) **43**: 65–69.
21 Marsh GN, Russell D, Russell IT. What do health visitors contribute to the care of children? A study in the north of England. *J R Coll Gen Pract* (1989) **39**: 201–205.
22 Stilwell B, The origins and development of the nurse practitioner role—a worldwide perspective. In: *The Nurse in Family Practice.* (Bowling A, Stilwell B, Eds). (1988), Ch.1. Scutari.
23 Bliss AA, Cohen ED, Eds. *The New Health Professionals.* Aspen Systems Corporation, Maryland.
24 Stilwell B, Restall D, Burke-Masters B. Nurse practitioners in British general practice. In: *The Nurse in Family Practice.* (Bowling A, Stilwell B, Eds). (1988), Ch.7. Scutari.
25 Macmillan L, Pringle M. Practice managers and practice management. *BMJ* (1992) **304**: 1672–1674.
26 Drury M, Ed. *The New Practice Manager* (1990), Ch. 4. Radcliffe Medical Press, Oxford.
27 Hooper J, Millar J, Schofield P, Ward G. Part-time women general practitioners—workload and remuneration. *J R Coll Gen Pract* (1989) **39**: 400–403.
28 Hasler J, Bryceland C, Hobden-Clarke L, Rose P. *Handbook of Practice Management* (1991), Ch. 1. Churchill Livingstone, Edinburgh.
29 General Medical Council. *Professional Conduct and Discipline: Fitness to Practice* (1991). London.
30 Belbin RM. *Management Teams: Why They Succeed or Fail* (1981). Butterworth-Heinemann, Oxford.
31 Berwick DM, Enthoven A, Bunker JP. Quality management in the NHS: the doctor's role—I. *BMJ* (1992) **304**: 235–9.

5
A Team for the Twenty-first Century

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A Team for the Twenty-first Century

As we approach the close of the twentieth century, the forces within and without the health service are creating changes to which primary health care has to adapt if it is to continue to provide a high quality service. Not only must patients receive exemplary care, but health workers have to feel valued and morale must be high.

Charles Handy, a business consultant, believes that the changes now facing society are no longer a pattern but are what he describes as discontinuous, which tend to be confusing and disturbing[1]. Changes in the way our work is organised will make the biggest differences to the way we all will live.

In this chapter the arrangements for contracts and employment, now out of date, will be reviewed. Some issues relating to education and professional development and the shape of a new team will also be discussed. The views are mine, although I have talked at length with various colleagues who have helped me in the formation of those views.

Contracts and employment

The three main groups of professionals whose contractual arrangements need reviewing are doctors, nurses and practice managers. It will be easiest to look at each one in turn.

The general practitioners

In recent years, people have questioned whether general practitioners should remain self-employed. One argument against this comes from those who believe that, by being self-employed, the doctors remain to some extent outside the health service, both contractually and emotionally. The other pressure to make GPs employed comes from inside general practice: there are some who agree with the view expressed above and others who do not want the responsibility of owning buildings and the work involved in running a business.

I believe firmly that the vast majority of general practitioners in charge of practices should remain self-employed. The reason that primary care has adapted as well as it has to major change in the last few years is because practices have been able to make decisions and carry them out rapidly. The ability to hire and fire one's own staff, to extend buildings and purchase equipment without interference is a prize not to be discarded lightly. The suggestion that by being employed all these things, together with locum cover for illness, would be more easily accomplished by a health authority does not, in my view, hold water. Moreover, in current arrangements where authorities purchase rather than provide care, a self employed group of people in partnership providing primary care makes obvious sense.

There is another reason why general practitioners should remain self-employed. There have been instances in recent years when professionals in hospital have been reprimanded by managers for speaking out about deficiencies in health care at their establishments. General practitioners remain the one group of health workers who can highlight shortcomings

without fear of interference and in a democracy that freedom needs to be safeguarded jealously.

But if the doctors running the practice are self employed partners, it does not mean that all the doctors working there need to have the same status. First, there are those who have just completed vocational training. It is generally agreed that one year of such training based in practice is too short and both the Royal College of General Practitioners and the Royal Commission on Medical Education 26 years ago have argued for two more years[2,3]. For this period the young doctors could achieve associate principal status, being employed by the partnership and with protected educational time for day release and other educational activities for what has come to be known as higher professional training.

This would address two current problems apart from the educational ones: many young doctors I have spoken to would welcome arrangements of this kind. First, there is the question of instant partnerships. No other profession has instant partnerships and we know that one of the reasons that they became the fashion in the late sixties was because they were financially attractive. But no matter how sophisticated the selection procedure for a new partner (and some are pretty primitive) it is impossible to know exactly how it will work out without a spell of working together. I have visited a number of practices where superficially the partners get on but underneath there are some significant differences which only gradually emerged after the doctors started working together and which hold them back from progressing.

The other difficulty that an associate principal grade immediately after vocational training would address is that of young doctors who do not wish to commit themselves to a partnership at this stage in their careers. Many of these doctors are married to spouses who are likely to move whilst

others simply do not wish to settle down. At the moment they have only two alternatives—either to become a partner with all that that entails, or become an assistant or locum with no clear status; Although many of these doctors are women, they are not exclusively so.

There is another group of doctors who might like the option of principal status without the responsibility of running the practice or owning the buildings. These include some of those who would like to opt for a salaried service. They too could have the status of a principal but remain employed by the partnership or alternatively have a contract with the partners for clinical services. Obviously there are potential problems, mainly to do with exploitation, but nevertheless the practicalities need exploring.

The nurses

The present arrangements with three different kinds of nurses, some employed by the partnership and others by an external authority, is out of date. Various options have been suggested: they boil down to having all nurses employed by an external agency or integrating them in some way with the doctors.

It will be clear from what I have said previously that the responsibilities and range of work of nurses is broadening rapidly. Further, arbitrary distinctions of where the service is rendered and which nurses perform which procedures now seems inappropriate. The fact that some of us have got round the rules with the co-operation of all concerned does not alter the fact that change is due.

If nurses are to assume a greater role in primary care and if—as I have argued—practices should remain based on partnerships of self-employed people, then should not all the nurses be treated on the same basis as the doctors? Nurses,

like doctors, should have the opportunity to become partners with all that that involves—profit sharing, joining in the responsibility of running the practice, sharing in building costs and so on. Of course, not every nurse would wish to take up such an option and many, like a few doctors I described earlier, could be employees of, or be in contract with, the partnership. There could be mixed partnerships of doctors and nurses employing or contracting with other nurses and, in some cases, other doctors.

The division of nursing work needs exploring: looking at the boundaries between the existing roles of health visitors and district nurses will need some courage. The Bachelor of Arts degree in Community Health Studies at the University of Reading now covers core modules for all primary care nurses which include interpersonal relationships, law, ethics, social aspects of health and social policy[4]. (Some of the subject matter and background reading would be a revelation to many GPs.) The education for each branch of community nursing (including practice nursing) is provided through specialist options. In future all nurses in the primary care core teams should reflect the fact that much of their training is similar and have a common title. Some could continue to pursue individual interests, such as prevention or home nursing whilst others might work in several fields. Has the time come to lose the titles of health visitor, district nurse and practice nurse and devise a new generic title of community or primary care nurse?

Possibly the health visitors are the most at risk. As several have pointed out to me, much of their work is not easily quantifiable and the boundaries are not always clear cut. Traynor has emphasised the need for health visitors (and other health workers) to produce credible and well documented accounts of their effectiveness. He says 'It is not enough to be busy on honourable business'[5]. We should be

on our guard against allowing health visitors' work to be sidelined, since their activities with families and in the wider community are important. Equally, there are anxieties about skill mix, that is the division of work between different grades of nurse. Whilst it could be one way for the NHS to reduce its staff costs by using lower grades than at present for some work, nurses like doctors, have to be careful about clinging to work practices that could be equally well or better done by someone else.

I sense that many nurses are in a dilemma. Do they continue to preserve their individual spheres of work or do they form a real nursing team? More importantly are they now—as many would claim—independent practitioners or do they need to be managed? Nurse managers have argued, with some justification, that many doctors are poor employers when it comes to pay, delegation and training. There is also the question of who provides nursing in places where some people are not registered with a local GP. The doctors (and some nurses) have responded by suggesting that some managers seem to inhibit rather than facilitate work and insist on endless work activity figures being collected for purposes which are not immediately apparent.

If nurses are professionals in their own right—and clearly they are—I am driven to asking whether they need to be managed any more than doctors, architects and accountants? The responsibility for ensuring proper training and conditions of work in my model would rest with the individual nurse and with the partnership (as it does now for practice nurses) which would include nurses as well as doctors. In those areas where such practices did not exist—in some urban areas for example—there would be nothing to stop health authorities employing nurses directly as they do now.

What then of nurse practitioners and where do they fit in the nursing team? In spite of much discussion I remain a

little unclear after 20 years exactly where their future lies. The main differences from other nurses in primary care appears to be that they have more knowledge and confidence and that they admit and discharge patients from the system more readily. Another difference suggested is that they can deviate from protocols when the individual patient's problem does not quite seem to fit. But we still have to explore how they relate to and differ from doctors and whether the dividing line will partly depend on the particular team rather than fixed definitions. Nevertheless, the philosophy behind the development fits with the expanding role and responsibilities of nurses in general and more research into nurse practitioner work is needed. What we have to remember is the key role of the general practitioner in formulating diagnoses as described so eloquently by David Morrell in the first John Fry Fellowship Lecture and it is because of this that we have to view the dividing line between doctor and nurse practitioner with care.

Practice managers

As the demands on primary care grow, as multidisciplinary partnerships develop, and as the need for demonstration and delivery of high standards becomes paramount, so the need for high quality managers will increase. Their role will be to ensure that the doctors and nurses work in an appropriate environment and to take responsibility for any activity which does not need a medical or nursing professional. A number of models for their employment are possible. First, they could remain as they are now with or without bonus related pay, possibly reflecting partnership profits. Or they could become partners, like the nurses. It would be up to the individuals concerned—the

important thing is to have a framework that allows for all possibilities.

One or two practice managers have said to me that they would not wish to accept the offer of partnership because then they can be seen to be independent of the final decision-making. I also sense that some feel they can influence things more easily from outside. But I suspect as their confidence and responsibilities grow practice managers will be more interested in a partnership option.

Some kind of generally recognised management diploma or degree seems to be needed for the future. Not only would that demonstrate their skills and abilities, but would enable those practice managers who are so inclined to move more easily into other management posts.

Organisation and accountability

As the make up of partnerships change, as the nurses' status in relation to that of the doctors rises and as the contractual relationships inside the practice alter, the decision-making will become more complex. Already some larger partnerships devolve day-to-day decisions to subgroups of doctors, nurses and others. The partners will need to ensure that the other professionals who are employed by, or contracted with them are involved in relevant decisions about the future of the organisation.

Accountability

The change to having all professionals either self-employed or partnership employees does not mean that the practice will be able to go its own way without reference to the rest of the health service. It is important to distinguish between employment and accountability. Health authorities as

purchasers would contract with partnerships rather than with individual doctors to provide primary health care comprising a list of agreed services. Standards would be laid down and there would be obligations in terms of education and personal development. Patients would continue to be registered but with the partnership. Reaccreditation for all professionals will be the norm: since the delivery of care will be increasingly multiprofessional, reaccreditation will involve a review of the quality of teamwork.

Out of hours work

It has been shown that there are long term trends towards decreasing GP personal commitment and rising demand from patients for out of hours care[6]. There are wide variations and little data on evaluating different patterns of provision. It is also well known that it is one of the activities that doctors enjoy least. There are a number of reasons—inappropriate demand, danger from attack and excessive hours. But I suggest that there is another reason, which is that the doctors are left on their own. Teamwork is necessary for good care, yet nearly all the team members except for the doctor on duty go home at the end of the working day.

One suggestion is that there should be central treatment rooms staffed by practice nurses. With the increasing role of the nurse, it would be appropriate for mini teams rather than doctors only, to provide out of hours care. This would, amongst other things, give support to the doctors.

Professional development

The model I have proposed would of itself tend to help all the professionals in the team to develop and

remain up to date. But other facilities are needed for people to progress and to survive future changes.

Traditional education

There are serious questions being asked about the quality and results of postgraduate medical education. Educationalists tell us that for learning to be effective, education has to be clearly relevant to what the learner needs and wants rather than to be chosen, sometimes at random, by a third party. Furthermore, updating is only part of the story. Professionals also need to learn and develop relevant skills such as communication, team-working, auditing care and counselling as well as manual procedures.

Professional development

It has been pointed out that lack of stimulation over 40 years may lead to demoralisation and that many GPs (and nurses) need to consider how to develop their careers[7].

A number of us have been running courses for GP Tutors, audit facilitators and others proposing a model of development based on practice strategic planning shown in Figure 1[8]. Briefly, our argument is that before relevant education (CME) and audit (tracking systems) can occur, the practice needs to have a strategic plan from which individuals derive their own development needs. At the moment most education activities are provided separately for doctors and nurses at various venues with the content decided by the organisers. Audit activities are directed at the doctors with some practices going through the motions to satisfy external requirements.

In the future, we will need to provide facilitators to help teams identify their aims and objectives. One useful technique

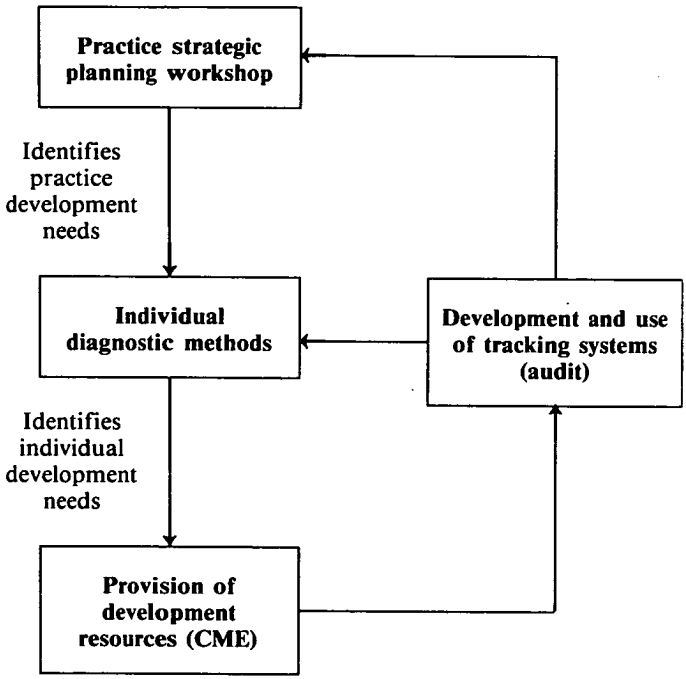

Figure 1 Putting CME in its place
(*Reproduced from* Primary Care Workshop Notes; (King J, Pendleton D) *by permission of the BMS College*)

is that of force field analysis in which the participants are asked to describe where they want to be in a few years time and then list the helping and hindering forces that influence the move to get there. From that, individuals can look at their individual educational needs. Increasingly these needs will be met in the practice and will involve different team members learning together. For example, doctors and nurses may wish to update their management of asthma in joint sessions. Together with practice managers, they may want to explore new management structures or the improvement of preventive services.

The team members will want to find out how well they are doing for their own satisfaction and esteem and for

explaining to others how they are providing good care. Audit will become an automatic part of management activity—every operation will have a method of measuring its success and these measurements will be made at regular intervals.

The criteria and standards for care against which the team will audit its performance will not be devised by the doctors on their own. The whole team will be involved. Further, the criteria will have to take note of nationally agreed good practice: doctors, in particular, will have to find ways round the difficulties of accepting and owning criteria devised by third parties on the basis of scientific research. But even that is not the whole story. Patients too will be asked to contribute to deciding what some of the criteria should be. Diabetics, for example, will want to influence the provision of practice diabetic care so that the arrangements are not solely determined by the professionals.

Handysides has also listed a number of activities that enable GPs to enrich their professional lives[7]. These include teaching (students and trainees) and hospital work. He also underlines the need for personal support and sabbatical periods. Good team-work can provide much of the former.

Practice nurses

Whilst health authority and trust employed nurses are required to undergo recognised training before appointment, no such requirement exists for practice nurses. Some courses are now available but uptake is often poor, partly because the nurses concerned are usually in post and the courses are expensive in time and money.

The issue has been highlighted in a recent survey in South West Thames[9]. Practice nurses were undertaking a wide range of activities and procedures but their formal qualifications were limited to a minority. Whilst just over 60% had a

family planning certificate, only 12% and 1% held an appropriate qualification for asthma and diabetic care respectively. Areas identified by the nurses as being of interest for future development included counselling and interviewing skills, theory and practice of health promotion and practice management. The authors concluded there was a mismatch between training and practice. Some were undertaking tasks which could be done by someone else without a nursing qualification, whilst others were engaged in work for which they had no formal training. Over 30 institutions are now approved to offer an English Nursing Board Practice Nurse post-registration course: there is also a variety of specialist courses.

Whilst there may be a danger of going too far and demanding certificates for everything, we must provide appropriate training for all practice nurses in the future similar to that required for health visitors and district nurses. Only then can we have freedom of movement and reassure the nurses and the public that standards are being met: only then can we fully integrate the nursing team.

Paradoxically, the funds available for updating community nurses are limited—in my own area in 1993/94 they averaged £1 per nurse per year whereas the partnership spends considerably more on the practice nurses (and often pays for the community nurses as well).

The management of change

Doctors and nurses in primary care have had to learn uncomfortably fast about change and how to cope. They have joined their hospital and public health colleagues in realising that a stable environment is no longer possible.

The challenge

Much of the reported low morale in general practice is not necessarily to do with the new contract but seems more to do with change and uncertainty[10]. There is a need to understand how to handle change well, both for ourselves and those whom we employ. The development of a first class team and clear vision for the future will do so much to help us.

Handling change

Rogers has examined in detail the way innovations diffuse and what characteristics make them more likely to succeed[11]. In other words, paying attention to these will enable us both to make things easier for our own staff when we introduce new ideas and also to see what is happening to ourselves.

The characteristics are:

- Relative advantage: is the change going to be better for us and our team?
- Compatibility: is the change consistent with our existing values and past experiences?
- Complexity: can people understand how the innovation will work?
- Trialability: can we carry out pilot projects to see how it will work?
- Observability: can we see it at work elsewhere before we take it up ourselves?

New ideas that can meet these criteria are far more likely to be taken up easily.

The role of Government

There was an agreement by many that general practice had to be nudged on at the end of the eighties. Whilst there had been many innovations and examples of high quality care there was evidence that poor care also existed. Many practices, including mine, have been excited and stimulated by the changes of the past few years.

But others have not. Whilst one has some sympathy with the Government for wanting to produce change in the face of some professional opposition, Ministers were clearly unfamiliar with change theory or chose to ignore it. The result has contributed to low morale and the feeling by some GPs that they are undervalued. In the end, standards of care cannot be regulated from the centre: they have to derive from individual professionals who are content in their work. As Richards has pointed out there are considerable risks in continuing to enforce changes without considering the effects of those changes on the doctors (and nurses) themselves[12].

A team for the future

If we are to design a team for the future, it is important to look at trends in health care and elsewhere. Handy has emphasised that people are moving to shorter working lives and an increasing number see the advantages of working part-time[1]. (With more general practitioners becoming female, this point is particularly relevant, although some men are also interested in this development.) Jobs for life will be less common. Both Handy and Garratt stress that organisations need to be what they call 'learning organisations'—that is organisations that both continuously develop (as well as provide a service) and which encourage learning in its people[1,13]. Quality will be paramount.

Garratt has listed five conditions for a successful climate of organisational learning. Four of them are:

- A perception of learning as a cyclical process,
- An acceptance of the different roles of policy, strategy and operations,
- A free flow of authentic information,
- An ability to value people as the key asset for organisational learning.

Handy's vision of future organisations is that many will come to resemble shamrocks or clover leaves. A core team, generally made up of professionals, is the essential element which drives the activities forward. But not all the work is done by care workers: some of it is contracted out to others. The third component is a part time labour force that can expand or contract as demands change. Whilst the parallels with primary health care are not exact there may be some messages for us here.

A list of 8,000 patients in the next century might be cared for by a team of around four to five doctors and 10 to 11 nurses. Some doctors and nurses will be part time: some will be partners, some self-employed under contract and some employees. The average list size per doctor will be higher than in the mid-nineties but because of the large percentage of work done by nurses (many of whom will be graduates), consultations will be longer than now. A higher percentage of patients than now will consult the nurses directly, and nurses will do most of the prevention and long-term disease monitoring. Rigid divisions between the various nursing activities will have gone. Nurses will work with doctors to provide out of hours work, which will be largely based on central treatment areas.

The practice will have a clear strategy and each individual will have a personal development plan. Regular meetings where everyone can contribute will be held and audits demonstrating quality of care will be published regularly. Morale will be high.

The choice to be made

If the primary care team in the United Kingdom is to be reorganised there are two ways it could go. One is for it to be fully integrated into the NHS with the doctors directly employed at a time when hospitals are reducing their ties by becoming Trusts. Or it could go the way I have argued for, with loosening controls for the nurses but retaining the move to greater accountability. David Taylor writing in a recent publication from the King's Fund Institute and the Nuffield Provincial Hospitals Trust has said:

'The wave of far reaching changes now affecting the British health and social system clearly provides opportunities for improvements in such contexts. But it equally clearly brings threats to the established pattern of, in many respects successful, primary care services. For example, were general medical practices eventually be forced to group together . . with large—but low status—supporting staffs, rule (rather than personal responsibility) dominated by operational procedures, and an ethos of top-down management imposed by people with direct day-to day care responsibilities, much that is good about the existing family doctor service would certainly be lost. The achievement of better primary care depends critically upon extending high levels of self-esteem and independent responsibility to all those involved in its use and provision, rather than merely the imposition of control from above.'[14]

With the loosening of controls, there is the opportunity to respond to tighter accountability and a more consumer dominated service in the way that seems best for the team concerned. With the right education and support, the team will be able to adapt and move on as demands change.

References

1 Handy C. *The Age of Unreason* (1990). Arrow Books, London.
2 Royal College of General Practitioners. *The Front Line of the Health Service. Report From General Practice, 25.* (1987). Royal College of General Practitioners, London.
3 *Royal Commission on Medical Education 1965–68. Report 1968.* HMSO, London. Cmnd 3569
4 University of Reading, Faculty of Education and Community Studies. BA (Hons) in Community Health Studies. Course Handbook 1993/4.
5 Traynor M. Some current issues for health visiting. *Health Visitor* (1993) **66**: 216–217.
6 Hallam L. Primary medical care outside normal working hours: review of published work. *BMJ* (1994) **308**: 249–253.
7 Handysides S. Building morale through personal development. *BMJ* (1994) **308**: 114–116.
8 Pendleton DA, Hasler JC, Eds. *Professional Development in General Practice* (in preparation).
9 Ross FM, Bower PJ, Sibbald BS. practice nurses: Characteristics, workload and training needs. *Br J Gen Pract* (1994) **44**: 15–18.
10 Handysides S. Morale in general practice: is change the problem or the solution? *BMJ* (1994) **308**: 32–34.
11 Rogers EM. *Diffusion of Innovations.* 3rd Ed. (1983). The Free Press. Collier Macmillan, London.
12 Richards C. General practice as a career. *BMJ* (1991) **303**: 827–828.
13 Garratt B. *Learning to Lead* (1991). Fontana, London.
14 Taylor D. *Developing Primary Care. Opportunities for the 1990s* (1991). King's Fund Institute and the Nuffield Provincial Hospitals Trust, London.

6
Conclusion

6
Conclusion

The British primary health care team has led the way in demonstrating how to provide relevant high quality care in a very civilised health system. It came about through men and women of vision adapting regulation and circumstances as they saw fit. It stands poised on the threshold of changes resulting from advances in technology and alterations in society.

Doctors, nurses and managers need to recognise each other's talents, integrate their work and forge new relationships. The opportunity and prize is great if we have the vision to see it and the courage to grasp it.

Appendix

Appendix

Sonning Common Health Centre
Statistics 1994

List size 7,300
4 Partners (2 P/T)
1 Assistant (2 days pw)
1 Trainee Assistant
2 Health Visitors (1 P/T)
2 District Nurses (1 P/T)
4 Practice Nurses (P/T)
1 Midwife (2 sessions)
1 Speech Therapist (1 session)
2 Community Psychiatric Nurses (P/T)
1 Dietitian (2 sessions per month)
2 Nursing Assistants
1 Dispenser/Nursing Assistant (P/T)
1 Practice Manager
1 Finance and Fundholding Manager
1 Deputy Practice Manager
2 Secretaries (P/T)
7 Receptionists/Telephonists (P/T)
1 Audit Clerk (P/T)
1 Filing Clerk (P/T)