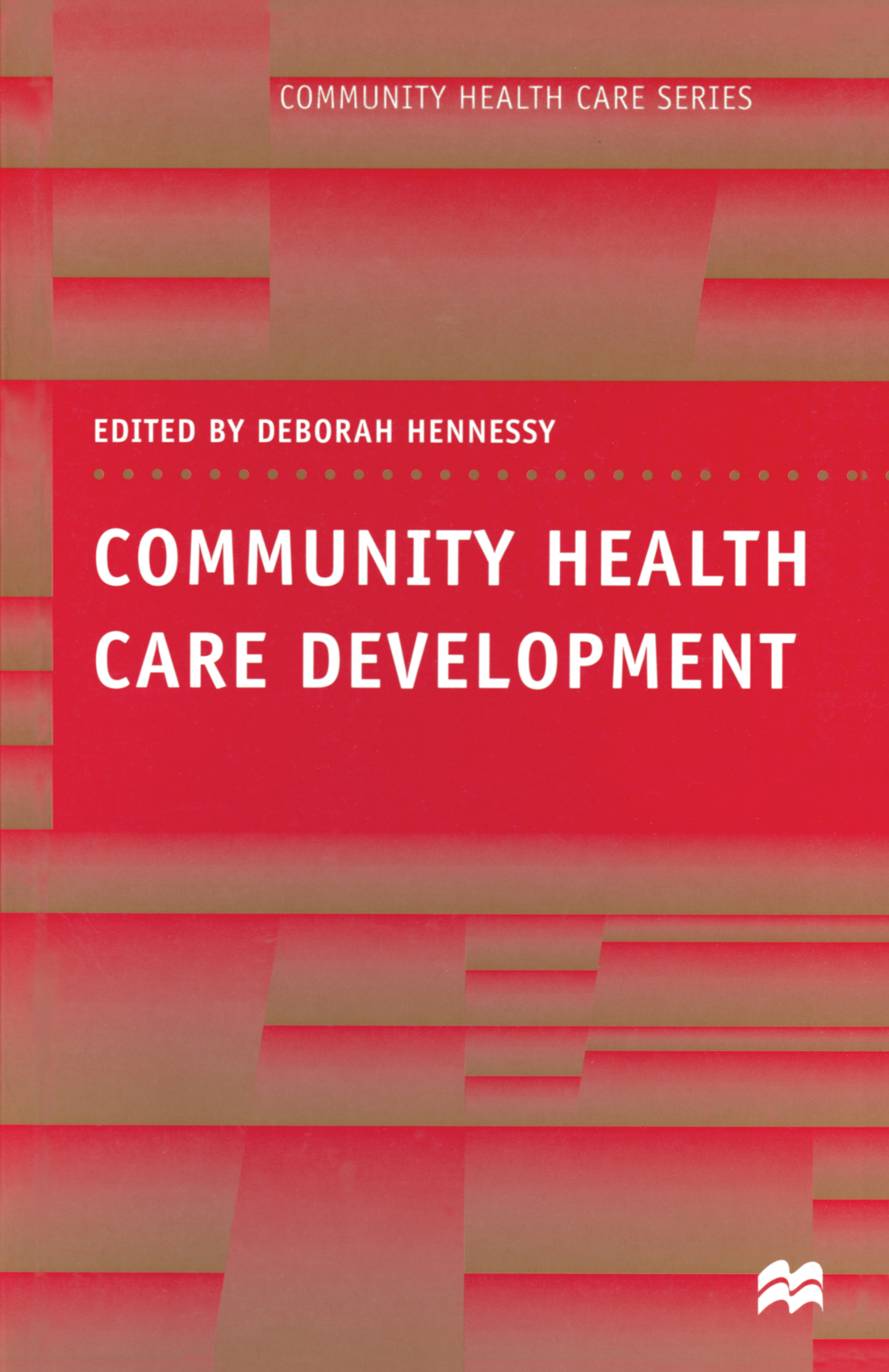

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Community Health Care Development

Edited by
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Foreword by Andrew Wall

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FOREWORD

Care started in the community. In the most primitive societies there were no alternatives to caring at home. But with the developing sophistication of civilisations health care went beyond the home and people other than the immediate family became involved. And with this came problems which we are now beginning to recognise and are attempting to alleviate.

As care became more institutionalised so the family became more distanced. The normal responses based on day-to-day knowledge of the sick person could no longer be relied upon and nurses and others had to learn to become proxies for the family and learn to understand their patient. In an institution this is difficult because there is no prompting from the patient's own context. We now are attempting to redress the situation both by treating the patient at home for as long as possible and when they have to be admitted encouraging the care staff to acknowledge the patient as a complete individual, not just a set of symptoms.

This regard for the wholeness of the patient is one of the differences between primary care and community care. Primary care is about the time and place of treatment but community care comprehends the person in their own setting. The simplistic divide between primary (good) and secondary (bad) therefore fails to recognise the uniqueness of each individual and how that uniqueness needs to be understood at every point along the continuum of care.

Given the intimate knowledge that all care workers need to have of those they are looking after, values and standards arising from those values need to be articulated. These values have sometimes been politically motivated: community care was thought to be a cheaper option. Or they can lead to dogmatism: community care is always best. But both these views are flawed. Community care can be very expensive – think about twenty-four-hour home care – and treating people at home is beneficial only if their full clinical needs can be met. So the values need to be centred much more on appropriateness.

Community care can create other problems. One of the reasons for preferring institutional settings for care has been to standardise practice. This has of course been the keystone of professionalism. But how can this work in the community? Will the patient be put to unnecessary risk when care workers are relatively unsupervised?

Community care is diffuse and therefore more difficult to manage. This is a challenge to managers who, by their very nature, are concerned with control. They may react unfavourably to what they may see as a sentimental approach to patients which in fact camouflages poor practice and inefficient use of resources.

Community care is at the heart of today's health care rhetoric. What this book does so valuably is to explore the reality of community care and re-establish that, fundamentally, community care is about recognising the supremacy of the patient and the obligations health care workers have to recognise the patient's individuality in the most appropriate manner possible. It is not easy, it is not cheap, but adherence to the highest standards never is!

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PREFACE

Successive governments have indicated their commitment to enhancing the health of the nation and, in recent years, the focus of care delivery has shifted with escalating speed into the community. In so doing, it has become evident that community nurses and health visitors provide the focus for the promotion of health gain, and for the maintenance of positive health status for individuals, groups and local communities. Community nurses and health visitors are destined, therefore, to become leaders in the design, delivery and evaluation of effective health care interventions, informed by academic discovery, and advanced practice skills and competencies.

The changes that confront the contemporary community nursing practitioner are characterised by the diverse nature of the context within which community care is transacted, with an increasing emphasis on inter-sectoral co-operation, interprofessional collaboration, community action and development, and reduced reliance on the acute sector and residential care provision for longer-stay client groups.

The impact of change, pushed by a growing demand for flexible, high-quality services provided within local communities, will inevitably shape the NHS of the future. Resources have already been shifted to the community (although at a pace that is all too often criticised as being grossly inadequate to meet client need). Commissioners and providers are now required to demonstrate that the care they purchase and deliver is effective and responsive to the needs of local practice populations. To complement this, community nurses will be required to ensure that their activities make a significant impact on health gain for their practice population and, as such, should become seriously involved in structuring the political agenda that ultimately governs their practice environment.

In order for the community workforce to respond to these challenges, it will be necessary to ensure that community workers are equipped with the necessary skills and knowledge-base to be able to function effectively in the 'new world of community health practice'. Nurses will be required to develop and change, drawing upon the very best of their past experience, and becoming increasingly reliant upon the production of research evidence to inform their future practice.

This series is aimed at practising community nurses and health visitors, their students, managers, professional colleagues and commissioners. It has been designed to provide a broad-ranging synthesis and analysis of the major areas of community activity, and to challenge models of traditional practice. The texts have been designed specifically to appeal to a range of professional and academic disciplines. Each volume will integrate contemporary research, recent literature and practice examples relating to the effective delivery of health and social care in the community. Community nurses and health visitors are encouraged towards critical exploration and, if necessary, to change their own contribution to health care delivery – at the same time as extending the scope and boundaries of their own practice.

Authors and contributors have been carefully selected. Whether they are nurses or social scientists (or both), their commitment to the further development and enrichment of health science (and nursing as an academic discipline in particular) is unquestionable. The authors all demonstrate knowledge, experience and excellence in curriculum design, and share a commitment to excellence in service delivery. The result is a distillation of a range of contemporary themes, practice examples and recommendations that aim to extend the working environment for practising community nurses and health visitors and, in so doing, improve the health status of their local consumer.

Community Health Care Development, edited by Dr Deborah Hennessy, has been written by a range of carefully chosen selected authors. Between them, they provide a breadth of creative vision informed by a range of commissioning and practice perspectives. The book challenges community practitioners to replace conventional methods of delivery with a community action/development focus. The authors provide an excellent synopsis of health-needs assessment within the context of the present-day health service and, in so doing, examine the growing importance of clinical and cost-effectiveness in health care. The text is based on a vision of an integrated primary care service and is imbued with examples from clinical practice. Readers will be challenged to adopt a proactive approach to care delivery and to act as change agents in their area of specialist practice.

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Deborah Hennessy

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Introduction

Deborah Hennessy

The transformation of the Health Service has had a huge impact on the development of community health care. The introduction of commissioning authorities has led to an emphasis on the provision of identified health needs of geographical and general practice populations. This has been accompanied by shifts of long-term patient care into the community in the recent past, a considerable proportion of acute care in the present and more in the immediate future. This shift has been accompanied by new medical and information technology and the changing epidemiological status of the population.

The health care that has been provided in the community in the United Kingdom to date has been the envy of many parts of the world. This includes the free availability of general practitioners, extensive community nursing services and the links and collaboration of other public sector services such as social services and housing. The health care that develops in the community in response to the NHS reforms must hold on to the key elements of current practice, particularly for the benefit of long-term patients. At the same time there must also be massive development of highly innovative and creative responses. Eventually both strands will merge, but until they do there will be practical problems. One of these is that many of the people who have to do the thinking and the changing have both considerable experience and were educated and trained to carry out pre-reform work in community health care.

Ways of influencing others to change traditional organisations, systems and practices will be considered. Practitioners will be encouraged to keep their eye on what is happening in Europe, internationally, the United Kingdom, the British public sector, the

National Health Service and health care. This will be so that practitioners can be very flexible and able to recognise signs that require the development of new skills, and also so that they have the power to contribute fully to the changes in health and social services.

The text of this book breaks new ground and provide a practical framework within the wider context of other issues for community health practitioners working with a range of clients, with specific attention given to community nurses.

The text is primarily aimed at an undergraduate nursing market and reflects the needs of the post-diploma level students in higher education. Consequently, attention will be given to the integration of theory with practice and to analyses and synthesis of subject matter. Issues relating to critical debate and moral deliberation form the foundation of the text.

CHAPTER ONE

Developing Community Health Care

Deborah Hennessy and Geraldine Swain

INTRODUCTION

> 'Community is not only an entity or a structure like a monastery. It is also a process that has to do with exchanging what is held in common.'
>
> Christopher Perry

The intention of this book is to provide a useful resource to assist nurses in the community in their comprehension of the societal and policy framework within which they work, and within which they will have to develop their nursing models of clinical practice.

These are challenging, and interesting, often painful times for nurses, and indeed for all clinicians working within the health sectors. At the time of writing, a general election is not so far distant and we cannot tell what changes may lie ahead. Whatever the outcome, the constant factors will remain, that is, the challenge, the interest and the pain. Constant factors too are the pleasure and the privilege of contributing to a service, working with, alongside, for and on behalf of women, men and families, groups and communities, of which we ourselves are a part.

Before we engage in an exploration of the main terms, let us remind ourselves of the fundamental values and beliefs that underpin the human services in which we participate and which we promote as necessary for the common good.

In the past decade and a half there has been a gradual eroding of the professional confidence of many of those who work in clinical practice within the NHS, certainly, and especially, amongst nurses. The values, too, which many espouse are felt to be disregarded and considered by others to be old-fashioned. In the current political climate, zeal for wealth not enthusiasm for health, would appear to many to be paramount. Social policies do not reflect a desire to meet, or even acknowledge, some of the clear and basic unmet needs within society, increasingly demonstrated in the widening gaps of inequality together with an increase in social deprivation with its concomitant low health status. It is, we believe, worth re-stating the values and why we engage in the work at all. In the existing climate of pressure it is easy to lose sight of this.

First and foremost, there is the belief in the fundamental value of the individual human person, as a being of worth and having potential for creative individual development, enabling creative constructive engagement with other persons – in partnership, in families, in groups and in the community.

> 'In a modern world which every day becomes more a mass world, with massive problems that seem to despair of any but mass solutions, the hold of the individual system of rights and value and concerns becomes every day more precious.'
> (Ekstein and Wallerstein, 1972, p. xviii)

In our work we meet individual women and men on a daily basis. We forget their 'unique system of rights and values and concerns' at their developmental peril and our own, and certainly ultimately to the peril of the 'community' in which each is a unique part.

Garner (1989) writes: 'Human service is the heart of our collective attempt to build a decent, fair and humane society.' We would endorse that, adding simply that a precursor for a human service, and humane society, is the acknowledgement of the humanity of each and everyone. Other values will include:

> '. . . an equitable, universal health care service, funded through taxation and free at the point of delivery; a service which values the individual and the community; a service which acknowledges their right to health care to meet – within realistic resource levels – their need for care; a service which respects their right to humane, respectful care and attention, and to protection from abuse and exploitation; the value of a trained body of professional nurses; the valuing of the individuals providing those services through the provision of continuing professional

> education and development, and individual support to help them cope with the demands of their work.'
> (Swain, 1995, p. 8)

Despite the vicissitudes of professional working life, let us exhort each other to hold on to these values. In so doing we value our own humanity which is fundamental to valuing others, and their valuing ours. Enshrined in this possibility is our hope for the world.

'Community health care development' quite clearly means different things to different people, whether described as patients or clients, or professionals from either the health or social services. The term itself is comprised of words which themselves are given a multiplicity of meanings. It will be helpful to give some clarification of these together with the whole term itself as used in the context of this resource book.

Community

In respect of planned resources a community is usually defined geographically. Matters of culture, ethnicity and age, however, define, sometimes tightly and sometimes not, other communities which are within the geographical community. All of these have to be taken into account in respect of a service which is delivered sensitively, responsively and responsibly. Sometimes the words community and society are used interchangeably. Margaret Thatcher, when Prime Minister, made infamous her dictum that there is no society only individuals and families. While it is true that the family is the first group of which a child discovers himself to be a member, it is also true that families need other people from other families to enable the bulk of their needs to be met, whether emotional or social or in the form of service provision of every type. A dictionary definition gives us: '[Community is] a collection of individuals composing a community or living under the same organisation or government', and 'the state or condition of living in association, company or intercourse with others of the same species; the system or mode of life adopted by a body of individuals for the purpose of harmonious co-existence or for mutual benefit' (*The Shorter Oxford English Dictionary on Historical Principles*).

'Society', therefore, we see in this context as the generic, larger term, comprising all communities with all the complexities to be found within each community – some of which may be very different indeed.

Turton and Orr write:

> 'The word community poses problems of definition . . . in nursing we utilise the word in two main ways. Firstly we use it to describe the location of activities, eg. community nursing. Secondly, we use it to place value or worth on feelings and sentiments, eg. we speak of community spirit to describe the feelings shared by people within a particular region . . . . Firstly, you identify the community, as a place and secondly, as a set of relationships which are important to you, eg. neighbours. In the first we are referring to a defined geographical area; we need to study those aspects of the environment which are its features. In the second we are referring to the social relationships and networks which exist within the area and which contribute to the lives of the residents . . . When we talk of assessing the community therefore we are focussing on these two elements, both of which are important.'
>
> (Turton and Orr, 1993, p. 5)

For the nurse working in community health care development, the understanding and knowledge of the community is important, not least because of the absence, or existence or potentiality of support networks/systems that are within it.

Health

There are many familiar descriptions of health, but here we will regard a state of health as a state of balance or harmony, of homeostasis between the emotional, mental, physical, social and spiritual aspects of a person's individual life. Even at the best of times this state of health may be somewhat precarious for each one of us, to say the least, and it is most assuredly not easy to maintain such balance for any significant length of time. Emotional life alone can cause such inner chaos that a state of balance or harmony can seem far distant.

However, there is no doubting the fact that for some individuals and families and communities, factors so mitigate against them that their health status is in considerable jeopardy. For large sections of society as a whole and within certain communities especially, and for some people in all communities, this state of affairs has become exacerbated over the past decade and a half (see for example Quick and Wilkinson, 1991; Benzeval, Judge and Whitehead, 1995). The resultant inequalities in health are a major area to be addressed, with utmost urgency.

Although this is referred to again in this chapter, it is perhaps important to say at this point that health services alone cannot enable people to achieve their optimum health status. Other national social policies need to be devised and directed which will assist people to develop their self-confidence and self-respect, and appropriate independence and autonomy. This will enable people to move from the margins of society into a life of community in which they can participate and to which they can contribute, in a state of health.

The following from Benzeval, Judge and Whitehead is considered to be so important that it is here quoted in its entirety:

> 'A crucial step in tackling inequalities in health is the need to create opportunities for prosperous and fulfilling employment for all citizens. The causal link that runs from deprivation to poor schooling, unemployment, low earnings and poor health, must be broken. We highlight four key policy initiatives that are required to help both the next generation of workers and those who currently find it more difficult to find opportunities in the world of work.
>
> 'Pre-school education should be expanded, particularly for children living in disadvantaged circumstances, to give them a better start in life and to create greater equality of educational opportunity;
> 'Particular efforts are needed to increase resources for education in disadvantaged areas and to support those working there.
> 'Long-term unemployment should be tackled by improving education and training programmes, overhauling the tax and benefit system, and stimulating new patterns of working and entrepreneurship.
> 'The quality and quantity of childcare services in Britain need to be improved. The lack of provision of childcare facilities is thought to be a major cause of poverty, since it prevents women, particularly lone mothers, from taking up paid employment.
>
> '. . . observed social inequalities in health are amenable to purposeful policy interventions. The problem is well documented and the solutions become clearer every day. What is needed is a

> determined effort to mobilise the political will to create a fairer society that embraces all sections of the community . . . there should be a genuine commitment by policy makers to promote action which will improve the health prospects of those whose lives are blighted and shortened by avoidable and unacceptable disadvantage.'
> (Benzeval, Judge and Whitehead, 1995, p. xxv)

The nurse engaged in community health care development cannot afford to underestimate this. The interrelatedness of matters which necessarily contribute to genuine health for people is quite clear.

In 1977, health visitors were exhorted to 'influence policies affecting health care' (Council for Education and Training of Health Visitors, 1977) as one of the four basic principles of health visiting. Twenty years later this has to be re-emphasised. True social justice and a true state of health as we have defined it here go hand in hand.

Care

Care is about having a concern for another/others; an appropriate regard; a preparedness to act; and, sometimes properly, not to act. Care, too, has to do with the balance which assists in promoting independence and appropriate protection of the vulnerable from exploitation and abuse. Intelligent, compassionate care recognises the stressors which lead to occasional vulnerability to which we all are prone, and recognises those who are permanently vulnerable.

Care demands 'serious mental attention' to what is needful. Care is not about false sentimentality. Care and concern for others has its rightful place in the human condition, in the development of the individual human psyche. The development of a 'capacity for concern' has its roots in infancy and will depend on a 'facilitating environment' for assisting towards its eventual maturation (Winnicott, 1990).

The ability to provide a facilitating environment in infancy, usually provided by the mother and which *is* the mother at the start, will be affected by the mother's and the family's health status. Those engaged in organised care and concern for the development and promotion of health have to understand this, and ensure the organised care which assists in the facilitation of the mother's provision of a facilitating environment for her developing young.

Organised care, from the state, voluntary, or through social networks, has its benefits for the health of the psyche. There is evidence to suggest that an altruistic approach contributes to the positive health status of all participants.

Development

Development has to do with 'a gradual unfolding; a fuller working out of the details of anything' (*The Shorter Oxford English Dictionary on Historical Principles*).

In the context of community health care 'being more fully worked out in respect of the details', a prerequisite is an ongoing understanding and knowledge of what is happening within the community; the present health status; what is it most people in the community are saying, and thinking and asking for; and their views on what is wanted or is needed.

Community health care development here, then, has to be concerned with responding imaginatively and flexibly in collaboration with others, both within the geographical community and those other specific communities within it, who together will shape the 'fuller working out'. The responding developments should be such as to contribute to the emotional, physical, social and mental well-being of all those individuals and families and groups who make up the community. To add to the interest of the nomenclature and of the term community health care development, there are further additional and familiar terms which are sometimes used interchangeably, for example community care, community health care, primary health care or primary care. (Primary nursing refers to a form of organised nursing care for the nursing process within the acute health care sector. It predates the 'named nurse' which arose from *The Patient's Charter*, DoH, 1991b.)

Primary health care – sometimes referred to as primary care – is the first point of call for health service provision. It is provided by the general practitioners and district nurses, health visitors, practice nurses and other personnel who more often than not (but not always) comprise a primary health care team. This could also include the professional services of a social worker, a counsellor and other specialist nurses who may or may not define themselves as being part of the primary health care team, but who will certainly be contributing and offering primary health care.

Turton and Orr (1993) describe the aims of primary health care as:

‘1. The promotion of health in its widest sense through education, support and the encouragement of self-care.
2. The prevention of ill-health by prophylaxis, early diagnosis, education and advice on the value of early contact with the primary health care services.
3. The care, treatment and rehabilitation of those who are acutely or chronically ill.
4. The referral of patients to specialist services where necessary and the provision of continuing care following specialist treatment.’

(Ibid., p. 18)

Community health care

Refers to all the health care provided in the community both by the primary health care team and others besides: dentists, dieticians, pharmacists, ophthalmic workers, continence advisers, stoma care advisers, Macmillan nurses, the Marie Curie services, to name but a few.

Community health care development includes all these concepts, those implied in the NHS and Community Care Act 1990, those services traditionally now supplied by community trusts, and the development of related voluntary and private sector services.

Historically, the term ‘community care’ or ‘care in the community’ has come to mean the de-institutionalisation of people who for reasons of chronic sickness or physical frailty or emotional or intellectual vulnerability, or profound physical disability or a continuation of all these factors, have found themselves in what we call ‘long-stay institutions’. For many, and some complex, reasons such environments are no longer regarded as appropriate places for people to be living and receiving care or indeed in which staff should be offering professional services (see for example Martin, 1984). Care in the community or community care also refers to service provision for people already living in the community who, by reason of increased frailty or vulnerability, require specific services or attention or help to enable them to remain in their own homes, which is something the majority of people desire. The term also embraces provision in smaller residential accommodation which is not the person’s own home, but neither is it the same as the traditional long-stay institution.

Thus, community care or care in the community is used in this way specifically to distinguish it from primary health care, community health care and social care (James, 1994). In social services, community care means all the latter and more besides. For social services it is a way of working with specific values and methods. Health and social services therefore use the same language but with different emphases and sometimes different meanings.

In Autumn 1994, the NHS Executive published an Executive Letter, *Developing NHS Purchasing and GP Fundholding: Towards a Primary Care Led NHS* (NHS Executive, 1994). This announced changes confirming a central position for primary health care in decision-making within the NHS. For many individuals, primary health care and its development has its own significance and different interpretations. There are also many different models for primary health care provision. *New World, New Opportunities* (NHSME, 1993) looks at developments in primary health care and stresses the importance of primary health care services focusing on the general-practice population, those people registered with each practice. A number of people believe that the emphasis on a primary health care-led NHS actually means a focus on a general practitioner led NHS. In the UK, however, despite the emphasis on primary health care, community health services, as already intimated, are also provided by community and acute trusts, as well as independent and voluntary agencies; this has been so for a century.

For the purpose and framework of this book, community health care is defined as all the health care that is taking place and developing at the interface of hospitals and communities, and also all health care provision outside hospitals in the United Kingdom. Consequently, community health care development is defined as all the developments that are and will take place in these places of care.

It is perhaps somewhat mischievous to introduce yet another term. Nevertheless, it is significant for our purposes here and that is 'Community Development'. Benzeval *et al.* (1995) write: 'In its purest form, community development is essentially about increasing the ability of marginalised communities to work together to identify and take action on priorities defined as important by the communities themselves.' For example, 'Community development has traditionally been concerned with strengthening the way the social dynamics work in a community' (ibid., p. 36), and 'Investment in community development . . . can reduce crime, fear of crime, stress and mental illness' (ibid., p. 67).

Reference has already been made to inequalities in health, and will be again. It has been stressed eloquently by others that health care provision cannot alone redress the imbalance that unequivocally exists in the health status within the population. It is axiomatic, therefore, and particularly in certain areas, that community health care development and community development are closely interrelated. All those involved in the work of such developments need to be working with and alongside each other.

DEMOGRAPHIC FACTORS

Four demographic factors are affecting the changes occurring in community health care thinking and provision: a declining fertility, an ageing work-force, more women in paid employment outside the home and growing numbers of elderly people. All these have a profound effect on the care and provision required to meet the need.

Nursing is being particularly affected by these demographic changes. There is a very long and world-wide respected history of nursing in the community, with a record of a very major contribution to the health and care of the population. As we move towards the next century this unquestionable fact should be recognised and provide further courage for the changes that are taking place.

Community health care services in the United Kingdom are amongst the most advanced in the world. In 1993 about 50 000 nurses were working in the community. Most of them were district nurses, practice nurses, health visitors, school nurses and community psychiatric nurses. The number of contacts that they make with patients and clients, particularly in their own homes, runs into tens of millions (NHSME, 1993). Their work includes the care and treatment of people with acute and chronic illness, health promotion and prevention of ill-health. Clearly, a comprehensive primary and community health system is believed to prevent over-use of hospital services which will both assist people to stay at home, thus avoiding the trauma of hospital admission, as well as containing the costs of the expensive acute health care sector.

A very significant and large part of the work of the community nurse is that it takes place within the patient's/client's own home. Liaschenko reminds us that:

> '. . . early in the development of nursing, people were cared for in their own homes; hospitals developed, not as meccas of knowledge, but as society's response to the poor. With the rise of technology and therapeutics, the medical professional hospital

> usurped the home as the pre-eminent place of sickness . . . Once again the geography of sickness is shifting as hospitals are losing their spatial pre-eminence and the home, and other structures of the community are becoming central to the sick.'
> (Liaschenko, 1994, p. 18)

Since 1994, the Department of Health has emphasised a shift in strategy towards a primary health care-led NHS. This is emphasised in considerable documentation. The specific definition of a primary health care led NHS is less clear. In October 1995 Stephen Dorrell, Secretary of State for Health, sketched out a further development for the primary health care led NHS (Wood, 1995). This strategy encourages more work to be moved from highly-technological hospitals to primary and community health care. This includes minor injuries from accident and emergency departments. It is important to realise that inevitably this has implications for patients and their nursing care. Not all these will necessarily be positive. Nurses who work in people's own homes at present (and the profession has been doing so for the last century) have respected and recognised the home as the domain of the patient. This is precisely why there are specific differences in the education and preparation of professional nurses for the community. A different approach is required on the part of the nurse, something perhaps only truly understood by those who know and have engaged in the work. One of the most important aspects of the common core foundation in *Project 2000* (UKCC, 1986) was, and is, that it gives student nurses an experience of working in the community and the socialised context of the patient/client. The importance of recognising the patient as a person first will also enable the development of a more holistic approach to the delivery of acute health care services.

Increasingly though, if health care is moved from the modern technological hospitals into people's homes with computer links and mobile support machines (and renal dialysis is not unknown at home), 'the home, a separate domain from medicine, where the inhabitant's agency has been primary, may find itself an extension of hospitals, those awesome citadels of science where it is the agency of dominant practitioners that is pre-eminent' (Liaschenko, 1994).

The challenge for the nursing profession and individual nurses is to maintain a perspective of respect for the patient's/person's dominance in their own home, and to act as a strong antidote to an exclusive bio-medical and evidence-based clinical effective model. The nurse's role of patient/client advocate will be vital here. This is not to say that clinical effective care is unimportant, indeed it may be unethical not to provide such care. Doubtless many ethical discussions will and must ensue. What is being underlined here is that nursing and nurses offer something which must not be lost, and which transcends the bio-medical and the shifts in the locus and status of primary and community care. Nurses stay alongside patients in their pain, emotional and mental as well as physical pain. They gather observations which are more than observed physical changes. They need exquisite interpersonal skills to accompany their theoretical knowledge. Other nursing skills are influenced by the nurse's capacity to access, trust and use their own intuition. While they can be the eyes and ears of the physician, they are also in relationship with the patient; patient and professional nurse – two people. 'The work of all nurses in the community, indeed of all nurses wherever they work, centres on human relationships and personal communication. The quality of this will determine the effectiveness of the practitioner's practice' (Swain, 1995, p. 78).

The work of the nurse engaged in community health care development both now and for the future, has to be set against the background of recent, enormous and rapid change within the NHS. The amount of change exceeds that of all previous years since the NHS, based on the Beveridge Report of 1946, came into being in 1948.

The National Health Service and Community Care Act received the Royal Assent in June 1990. The different interpretations of the reforms are worth noting and nurses are encouraged to read both Ham (1994) and Robinson and Le Grand (1994) amongst other texts.

The following may be of interest; Ham writes:

> '. . . it is often argued that the reforms involve the introduction of an internal market into the NHS. In fact it is more accurate to use the phrase "managed market". One reason for preferring this terminology is that competition is not confined to the NHS but also involves providers outside the NHS. Even more important is the fact that it has never been the government's intention to introduce a free market. Rather, the aim has been to graft some of the incentives that are often found in markets on to the structure of the NHS and to regulate or manage the operation of these incentives to avoid the problem of market failure.'
> (Ham, 1993, p. 10)

which may be compared to:

> 'The reforms embodied in the 1990 NHS and Community Care Act and introduced on 1 April 1991 represent the greatest change in the organisation and management of the NHS since it was established. In essence an internal market has been created within the NHS in which the responsibility for purchasing or commissioning services has been separated from the responsibility for providing them.'
> (Robinson and Le Grand, 1994, p. 2)

and again:

> 'In shorthand language, the internal market in the NHS was the product of a political environment that valued wealth above welfare, markets above bureaucracies and competition above patronage; and it was the steady application of these preferences to the NHS throughout the 1980s that made possible the introduction of the internal market in the 1990s.'
> (Butler in Robinson and Le Grand, p. 14)

Nurses will be familiar with encountering these somewhat different interpretations as well as the possibility of accompanying passion or otherwise within the ethos of their working environment. Inevitably, those who see and experience the effects of such reforms on services *per se* and on individual patients/clients, for good or ill, will form their own views.

The word 'reform' itself is interesting. It is thrice presented in *The Shorter Oxford English Dictionary* definition:

> *'To convert into another and better form; to free from previous faults or imperfections. To amend or improve by removal of faults or abuses. To put a stop or end to (an abuse, disorder, malpractice, etc) by enforcing or introducing a better procedure or conduct.'*
>
> 'Re-form, reform.'
> *'To form a second time, form over again.'*

As to whether what are called NHS reforms constitute 'another and better form' of NHS, or the 'introduction of better procedures' within the NHS, or the 'ending of abuse and malpractice' within the

NHS, or a newly-created form of NHS, or something intermediate between these each practitioner will decide.

The development of the NHS reforms is shown in Table 1.1. Ham cites the most significant elements of the reforms as:

- separation of purchaser and provider roles;
- the creation of self-governing NHS trusts;
- the transformation of district health authorities into purchasers of services;
- the introduction of GP fundholding;
- the use of contracts or service agreements to provide links between purchasers and providers.

and adds that, 'Taken together, the reforms involve a transition from an integrated system of health services financing and delivery to a contract system . . . They have proceeded in parallel with reforms of community care' (Ham, 1994, p. 10).

Sir Roy Griffiths, whose name is linked with the introduction of General Management into the NHS, also undertook the task of looking at service provision for those who were particularly vulnerable. His work and recommendations emphasised the responsibility of local authorities in service provision. Initially a very unpopular response for the then Governmental leadership, it was acknowledged in the White Paper *Caring for People* (DoH, 1989b) whose recommendations have subsequently been incorporated in the NHS and Community Care Act.

> 'The Act gave local authorities the lead responsibility for community care, and their role was that of enablers rather than direct service providers. Local authorities were required to prepare community care plans in association with health authorities and other agencies. They were also given additional resources to enable them to discharge their responsibilities. Most of these resources involved the transfer of funds from the social security budget. The Government made it clear that it expected these funds to be used primarily to buy services from providers in the independent sector rather than to fund direct provision by local authorities. This meant that a community care market began to grow alongside the NHS market, based on a separation of purchaser and provider roles, the use of contracts, and the emergence of a mixed economy of care.'
> (Ham, 1994, p. 29)

Table 1.1 The development of NHS reforms

1988	January	Margaret Thatcher announces Ministerial Review of the NHS.
	July	Department of Health created following the splitting up of the Department of Health and Social Security. Kenneth Clarke appointed as Secretary of State for Health.
1989	January	*Working for Patients* published.
	November	*NHS and Community Care Bill* published.
1990	June	*NHS and Community Care Bill* receives Royal Assent.
	November	William Waldegrave replaces Kenneth Clarke as Secretary of State for Health.
1991	April	NHS reforms come into operation. The first wave of 57 NHS trusts and 306 GP fundholders is established in England.
	June	The government agrees guidelines with the medical profession to avoid queue-jumping by GP fundholders. A green paper on *The Health of the Nation* is published.
1992	April	The Conservative Party is re-elected. Virginia Bottomley replaces William Waldegrave as Secretary of State for Health. The second wave of 99 NHS trusts and 288 GP fundholders is established in England.
	July	A white paper on *The Health of the Nation* is published.
	October	The report of the *Tomlinson Inquiry* into health services in London is published.
1993	February	The government publishes its response to the *Tomlinson Inquiry, 'Making London Better'.* A review of functions and manpower in the NHS is announced.
	April	The third wave of 136 NHS trusts and over 600 GP fundholders is established in England.
	July	The functions and manpower review reports to ministers.
	October	The government publishes its response to the functions and manpower review, *Managing the New NHS*. This includes the proposed abolition of regional health authorities, the merger of district health authorities and family health services authorities, and a streamlining of the NHS management executive.
1994	April	The fourth wave of 140 NHS trusts and 800 GP fundholders is established in England. The Government set up pilot scheme of Total Purchasing GP Fundholding.
1995	August	The Health Authorities Act was passed. Virginia Bottomley replaced by Stephen Dorrell as Secretary of State for Health.
1996	April	The Health Authorities Act came into effect and RHAs were abolished, District Health Authorities and Family Health Service Authorities merged to make New Health Authorities and GP Fundholding was extended.

Source: Adapted from Ham (1994).

These changes alone require sufficient adjustment and understanding on the part of the nurse – on the part of anyone, indeed, engaged in health service work. Most aspects (not all) of the NHS have certainly been affected and some changed utterly by the reforms. But this is not all. They are further accompanied by changes and developments in respect of technology in general, health technology and information technology in particular. Furthermore there have been, and continue to be, changes in nurse education, post-registration education and statutory requirements for the profession, and other professional issues of concern, and not only for nurses.

Finally, this is all taking place in an economic climate and national prevailing ethos in which the economic and health status of individuals, families and communities is demonstrating great inequality and division. Taken as a whole, this is the *Sturm und Drang* in which community nurses are required to work sensitively and effectively with their clients and patients together with their colleagues.

The epidemiological factors and needs are reflected throughout this chapter. Quite clearly, the work of the nurse engaged in community health care development will be influenced by the causation, distribution and frequency of disease and other biological or social phenomena. The disease may be infectious or non-infectious, influenced by factors in the environment both physical and social. The epidemiology of accidents, smoking, poor nutrition, teenage pregnancies and mental illness and the poor low-health status arising from poverty will emphasise the areas of work into which energies must be directed. The *Health of the Nation* (DoH, 1991b) strategy concentrates on a number of specific areas but by no means all of them, and one area that we tirelessly and unapologetically repeat here, is the lack of energetic social policies, particularly concerned with housing, influences the epidemiological trends.

During the Thatcher years, budgetary constraint and the growth of demand by the public led to attempts to achieve greater outputs from public services within existing resources leading, as we have seen, to greater competition and a search for resources beyond them, thus encouraging competition (see Taylor-Gooby and Lawson, 1993).

The consequent health care market (managed or not) has introduced fragmentation and pluralism, characterised by a blurring of boundaries between providers, purchasers, professionals and managers and between professionals themselves. There is also a diffusion of power as private and voluntary services increase their role and importance as providers. Important new public–private health care provision partnerships have emerged. The outcomes of the future political elections, however, could influence the role of the private sector in the health service. Although there is a perception that the private sector provides better care than the NHS, this has not been proven, especially for direct ‘basic’ care. Private health care may provide some better facilities but may lack the skills required for complex, chronic and continuing care. There is also a debate about who it is that actually benefits from private health care. Is it the affluent, or financially less-fortunate members of the public, the owners of the private institutions such as nursing homes, or some of the clinicians who may be working for more than one employer, possibly at the same time? (Yates, 1995).

The private sector is largely funded by health insurance. Increasing selectivity and restrictions on cover are emerging and such insurance may not provide value for money for patients. What is important is that patients and their carers are aware of the cover provided. This is the direction of Health Maintenance Organisations and State Benefit funds in the United States. In the United Kingdom, insurance companies are moving away from funding mental health care and chronic care. A person is excluded from joining an insurance system if they have clinical needs. Insurance premiums are cheaper if there is no cover for relapsing illnesses. Insurance cover is more expensive for out-patient activity than in-patient care, leading to difficulty in following up chronic illness. It would seem, therefore, that many insurance-paid health systems lead to a consumer–doctor conspiracy, with patients demanding more and being encouraged by clinicians and insurance cover to ask for expensive and sometimes unnecessary health care.

POVERTY AND HEALTH INEQUALITIES

Although there is an increase in the health status of the population in the UK in general, there is a widening gap between the rich and the poor which may well increase the web of demand for health and social care, such as for those needing continuing care, and not least in areas such as mental health needs. Many environmental situations increase the incidence of mental illness, including the demands of the work-place and changes in work and current labour market patterns. The correlation between unemployment and mental illness is well-known; and the precarious nature of employment situations adds to stress.

The President of the Royal College of Psychiatrists stressed that there was enormous alienation and disengagement from society when individuals, no matter what their age, were not able to achieve their full potential (Hennessy, Ham and Tremblay, 1995). The breakdown in society, especially in family life and community values of corporacy, is reflected and expressed in ill-health. This was pointed out also in 1985 research when discussing the health visitor's role in caring for post-partum mothers and the demands placed on the health care system by post natal depression, which seemed at that time to have a clear link with changes in society such as mobile, nuclear or broken families and the huge societal demands placed on the new mother (Hennessy, 1985).

Citing the work of Benzeval *et al.* (1995) earlier in the chapter, it was stressed that the health inequalities caused by economic inequalities could not be resolved by health care services and personnel alone. The observation has been made, too, by others that there has long been a societal belief that medicine has always been the healer of society's difficulties. Health care professionals are, in fact, seen as licensed patient-touchers and healers for whatever causes discomfort, pain and disease, be it physiological, emotional, mental, social or environmental. It may be of course that doctors and nurses have – albeit unwittingly sometimes – colluded with this to the detriment of all concerned. Benzeval *et al.* have made quite clear whence further impetus is required in terms of social policy and action as we have already shown.

TECHNOLOGICAL INFLUENCES

Developments in health technology are having an exciting impact on health care. This subject includes new drugs for psychotic disorders, improvements in surgical techniques such as keyhole surgery, and nerve transplants for multiple-sclerosis sufferers. Developments in genetics are opening up horizons and challenging the traditional view that we have control over our own health, as well as raising many ethical questions.

This is of course one aspect of the general major technological shift leading to a massive acceleration in the pace of change in society. The industrial age has been replaced by the information age, with a society intent on producing knowledge. Manufacturing employment has been replaced by jobs connected with information. The technology associated with information permits considerable decentralisation of decision-making without loss of administrative control. This therefore leads to a flattening of hierarchies because the middle management communication systems can be replaced by computers. Information technology in particular is growing very rapidly in the health service, and there is increasing potential for the integration of information systems between organisations to improve co-ordination of patient and client care across primary, secondary and other community agency settings. For nursing in the community, inevitably, there will be an increase in momentum for relaying information between nurses and the clinical work and smaller decentralised administrative offices (Ranade, 1994).

It is important, therefore, that nurses in the community (and indeed everywhere) are familiar and confident in using computers for accessing information. For those still reluctant to acknowledge their importance and to develop skills in their usage, it needs to be remembered that knowledge/information is power. A refusal to make the necessary adjustment means a loss both of personal and professional control. The most important aspect of the use of this technology, for both the reluctant nurse and equally for the zealous user, is that these are tools to be used in the service of the work. As Patrick Casement (1994) describes the use of theory, the same words can be applied to this use of technology. It is as servant to the work, not master, and the findings can be used or, if inappropriate, set aside. In the context of Community Health Care Development, information technology is to be used in the service and interest of the client/patient, for epidemiological information, and to assist the practitioner in making an effective contribution to the health of the community. Nurses will already appreciate that information is to be used ethically.

PRIMARY HEALTH CARE AND HEALTH PROMOTION

The development of primary health care, based on general-practice patient registers, has had much attention for more than two decades. This was prompted by concerns that primary health care had open-ended public expenditure and there was no way of imposing cash limits on the amount spent on prescribing, nor the number of people referred by general practitioners to hospitals. The focus of the attention has been to curb expenditure, raise standards and give greater emphasis to health promotion and prevention of illness (Ranade, 1994).

These points were outlined in a number of consultative documents starting with *Primary Health Care* (DHSS, 1986) *Neighbourhood Nursing* (DHSS, 1986a). These were followed by a White Paper, *Promoting Better Health* (DHSS, 1987). These proposals are thought to have been the starting point for the subsequent reforms (see for example Ranade, 1994) and *Working for Patients* (DHSS, 1989). Many of the proposals in the White Paper were introduced into the new GP Contract in April 1990. The way for challenging general practice opened, introducing business plans and contracts and the efficient use of all resources. The contract facilitates scrutiny of the procedures, the use of resources and the commitment to health promotion in general practice.

Ham, quoted earlier, saw the introduction of GP fundholding as one of the most significant elements in the reforms; as GP fundholding is seen by some as 'the real cutting edge of the reforms or alternatively a major source of disruption and inequity' ('Wild Card or Winning Hand', in Robinson and Le Grand, 1994, pp. 105–6). He argued that:

> 'fundholding is probably one of the few parts of the reforms that is having the competitive efficiency effects on the hospital system that the reformers hoped for. On the other hand, it only applies to a minority of patients and is therefore open to criticism for its equity effects. There are also long-term worries about cream skimming or risk selection.'
> (Ibid., pp. 105–6)

In their summary, Benzeval *et al.* (1995) stress 'a fairer system of allocating resources to GP fundholders needs to be established' (p. xxiii), and later, 'it is not at all clear that adequate data and methodologies are available to allocate resources to fundholders in ways that fully reflect the health care needs of their patients. This could exacerbate the phenomenon of "cream skimming"; incentives will be created for fundholders to limit care on the grounds of cost rather than appropriateness or even to exclude some patients altogether' (Benzeval *et al.*, 1995, p. 101).

Whatever the view held concerning GP fundholding, the attention given to primary health care services has increased. It has always taken second place to the hitherto high profile acute sector which has always been allocated and consumed higher funding. Prior to the reforms following the NHS and Community Care Act, very many community units will have known the bitterness of funding being reallocated from their own areas of service provision to overspent acute hospital budgets, whose initial allocation anyway was far in excess of that of the community unit.

This can no longer happen, which perhaps is why the financial plight of so much of the acute sector is more clearly exposed. The spotlight now is much more focused on community health care in general, and primary health care in particular. This has the effect of raising the profile of the work of nurses in the community. There is now much more interest and awareness of the contribution of this massive group of professional clinical staff to community health care development. Such policy changes together with others in nursing *per se*, are providing nurses with numerous opportunities to expand their skills in direct client and patient care, health needs assessment, health promotion, patient protocols, care management and the provision of a greater range of rehabilitative aid specialist services (NHSME, 1993).

Health promotion strategies were devised for the four countries of the UK. Benzeval *et al.* regard the Welsh strategy, as the most advanced, as it takes into account the inequalities in health as well as moves to reduce them. They regard the Northern Ireland strategy as in second place. The English and Scottish documents, although they signal a welcome move towards wider health promotion, have yet to make a commitment and formulate associated policy. Nevertheless, one recent development holds promise for the future: in May 1994 a sub-group of the Chief Medical Officer's Health of the Nation Working Group was established to examine variations in health. They reported in 1995 (DoH, 1995a) and this could be the beginning of more positive moves to tackle inequalities in health in England. This is only to be welcomed. The initial discussion document, *The Health of the Nation* (DoH, 1991b), identified five key areas for attention including the prevention of coronary heart disease and stroke, accident prevention, cancers, mental health and sexual health.

Particular action by professionals and managers for achieving targets in the five key areas was suggested in *The Health of the Nation – First Steps for the NHS* (NHSME, 1992). This document was followed by another addressing, especially, the contribution of nurses, midwives and health visitors (DoH, 1993b). In terms of illness prevention and health promotion, clearly the community nurse has a part to play, but at a glance these targets cannot be met by the practitioner alone.

This was further emphasised by the WHO (1986) in *Nursing and the 38 Targets for Health for All* by the year 2000 in Europe. The focus, 38 targets in all, included the following areas: health for all; lifestyles conducive to health for all; producing healthy environments; providing appropriate care; and support for health development. Within the section dealing with lifestyles, two of the targets were developing healthy public policies and developing social support systems. Within the provision of appropriate care was included the target of a health care system based on primary health care. This demonstrates the primacy given to health care in Europe and the acknowledgement that other appropriate policies are required to contribute to an increase in positive health status within communities. Nurses engaged in community health care development in the UK need to be aware of these European targets and how their own work is part of European community health care development as a whole.

> 'WHO says that community nurses acting as advocates for the community should help in the essential task of involving people in making decisions about health care and speaking for people's interests.'
> (WHO, 1986)

CLIENT/PATIENT INVOLVEMENT IN HEALTH CARE

A major aspect of primary and community health care is the encouragement of more active involvement of individuals, families and groups in contributing to their own care. Some of the country's opinion leaders of health care interviewed early in 1995 believed that there was a shift in the public values and attitudes towards health and well-being (Hennessy, Ham and Tremblay, 1995). This means that the public may take more responsibility for their own health and rely less on medical and organised public health services. It is suggested by some that the public are less concerned with the effectiveness of health care than they are with being involved about the decisions that are taken when the treatment is unpleasant. They also wish to be heard and listened to in respect of when they want health care, and from whom they wish to receive it. For instance, great concern was expressed about the diminution, without public discussion, of long-term caring services for those who are very elderly. There was a feeling that it was immoral considering the public expectation of 50 years of care from the cradle to the grave and their lifetime contribution to the health services through taxation and National Insurance.

The role of pressure, self-help and other consumer groups, and the role of the Community Health Councils created in 1974 are important, but their effectiveness is queried. 'One widespread criticism of consumer groups and Community Health Councils has been the extent to which they truly represent health service users (Bates, 1983; Richardson and Bray, 1987; Pollock, 1992). The consumerism of the 1990s, however, goes further than questioning the representatives of collective bodies by questioning the belief that consumers can exert an influence through such bodies at all. The collectivist approach to consumerism, traditionally associated with the NHS, has been replaced by an individualistic approach that attempts to achieve responsiveness to users through the introduction of a market ethos into the management and structure of the NHS' (Robinson and Le Grand, 1994, p. 109). Regional Health Authorities ceased in April 1996, replaced by an organisation that is part of the civil service. Whether this will have any impact on Community Health Councils, for good or ill, remains to be seen!

The facilitation of active involvement to enable true participation on the part of the community is, again, a focal part of the work of those engaged in community development and Community Health Care Development. These are also the principles of health visiting: the searching for health needs; stimulating awareness of health needs; influencing policies affecting health care; and facilitating health enhancement activities (Council for Education and Training of Health Visitors, 1977).

POLICIES AND THE PEOPLE

Margaret Whitehead's review of international interventions (1995), 'suggests that policy initiatives that can influence inequalities in health exist at four different levels:

- strengthening individuals
- strengthening communities
- improving access to essential facilities and services
- encouraging macro economic and cultural change',

and that,

> '. . . policies that attempt to strengthen individuals aim to change people's behaviour or coping skills through personal education and for empowerment. General health education messages have had a limited impact on people from disadvantaged environments because the pressure of their lives constrain the scope for behavioural change. However, more sensitive interventions that continue education and support can have a positive effect on the health of people in disadvantaged circumstances if they are carefully related to their needs and combined with action at other policy levels.'
>
> 'Policies that aim to strengthen communities have either focused on strengthening their social networks or they have adopted a broader strategy that develops the physical, economic and social structure of an area. Such initiatives can, through involving the community itself in the determination of priorities, change the local environment, services and support systems in ways that promote equity in health.'
> (Margaret Whitehead in Benzeval *et al.*, p. xviii)

The writer goes on to say that this alone does not reduce inequalities in health significantly – it requires work at other levels of policy. The stated principles of health visiting interweave with all of them. People's involvement will be affected by their own self confidence. Empowering individuals, and strengthening communities is an area in which the community nurse must engage.

The use of professional clinical counselling services too, within primary health, can assist in the individual strengthening and empowerment of individuals. Counselling can help people to discover some of their inner resources which may be mobilised with others, in the face of unemployment, emotional crisis and to prevent more serious mental illness, which so often can accompany social and economic deprivation. It is, though, a service provided to assist people in difficulty, and should never seek to deny the reality of deprivation or health inequality. Most assuredly it is not to be used as a sop to prevent the need for policy changes.

When the *Health of the Nation* discussion document (DoH, 1991b) was published, public involvement was invited in respect of comment. Advertisements in the national press gave individuals as well as communities and their representatives, together with health professionals and allied bodies, an opportunity to make a contribution to the debate.

Four years after the launching of *The Patient's Charter, Raising the Standard* (DoH, 1991a), came the 1995 publication *The Patient's Charter and You: A Charter for England* (DoH, 1995a). It referred to the rights 'which all patients will receive all the time', and 'expectations – these are the standards of service which the NHS is aiming to achieve. Exceptional circumstances may sometimes prevent these standards being met.' Amongst other services it referred to GP and community services, including the community nursing services. It referred to the new standards for community care services in which the NHS works together with local authorities.

Ham described both *The Citizen's Charter* and *The Patient's Charter* as 'an attempt to distinguish Majorism from Thatcherism, and served to highlight those aspects of the NHS reforms concerned to improve the quality of services from the patient's perspective' (Ham, 1994, p. 36). Part of the work of the nurse engaged in community health care development is to ensure that whatever the politics, the patient's and client's perspective should always be on the agenda in the purchasing and provision of health care.

PREPARING NURSES FOR THE FUTURE

A Strategy for Nursing (DoH, 1989a), *Vision for the Future* (DoH, 1993a), *The Scope of Professional Practice* (UKCC, 1992a), and *New World, New Opportunities* (NHSME, 1993) are a few of the recent policy documents that herald fundamental change for the work of nurses in the community up to and well into the twenty-first century. Ranade (1994) provided an interesting and logical summary of the educational change in nurses' pre-registration education. Ranade suggested that this educational model will prepare nurses to work in hospitals and the community, and for the changes and demands of twenty-first century health care. Increasingly, nurses and their teams will work in decentralised work patterns in different settings in the community.

The Heathrow Debate (DoH, 1994) discusses the possible future implications for nursing practice in the next century, influenced as it will be by all the changes which are and will be taking place:

> 'To advance confidently nurses need to consider what they are and what they want to be. An important debate must begin at all levels and across the whole spectrum. It must be moulded by the most senior members within the profession, but involve even the

> newest recruits . . . Nurses believe that their own insight should be available at all levels – for the patient, for the local community and where commissioning and policy decisions are taken.'
> (DoH, 1994, p. 23)

Project 2000 (UKCC, 1986) received government approval in 1986. This provided an eighteen-month common core foundation with a strong emphasis on the whole person, community and health. The subsequent eighteen months leading to registration concentrates on one of four specialities: adult, child, mental health and mental handicap/learning disabilities. Importantly, the student nurses were to be supernumerary. Community nurses would still be required to have a post-registration specialty training in district nursing, health visiting and school nursing, together with community psychiatric or learning disability training for specialist nurses.

The *Project 2000* nurse, after registration, is able to work as a first-level nurse in the community, directed by a specialist community health nurse.

HEALTH CARE SUPPORT STAFF

The inevitable shortfall of actual direct-care staff exacerbated by supernumerary students was to be met in some degree by the creation of the health care assistant (HCA). It is hoped that many will be given the opportunity to acquire National Vocational Qualifications (NVQs) in health care. 'HCAs are likely to be in widespread use in the NHS by the mid or late 1990s working in support of and in some situations instead of clinical professionals in nursing and the therapy professions' (Robinson and Le Grand, 1994, p. 185).

Whatever the profession may think of this further dilution of direct hands-on professional care, it is something which is happening, will accelerate, and must be used as an opportunity. Furthermore, without such staff in all aspects of the National Health Service, the service would come to a halt overnight. Sometimes the work such supporting staff do is described as menial or basic, and the word 'task' is usually added. This usually refers to care of an intimate, direct and personal nature, which requires skill, sensitivity, respect, courtesy and compassion. The staff who are doing the work require preparation, guidance, supervision and support which is also sensitive, respectful, courteous and compassionate.

In the community, professional nurses and supporting staff often work unseen, alone with a client, in a client's own home. There is a constant need to continue, maintain and increase/improve standards of care, and the community nurse is required to be mindful of *The Scope of Professional Practice* (UKCC, 1992a) as well of course as *The Code of Professional Conduct* (UKCC, 1992b). The former sets out the boundaries for safe practice and those educational requirements for areas regarded as 'extended nursing practice'. The DoH withdrew its guidance on the extended role of the nurse following the publication.

Concerning HCAs it is unequivocal:

> 'The Council's position in relation to support roles is as follows:
>
> 23.1 Health care assistants to registered nurses, midwives and health visitors must work under the direction and supervision of those registered practitioners;
> 23.2 Registered nurses, midwives and health visitors must remain accountable for assessment, planning and standard of care and for determining the activity of their support staff;
> 23.3 Health care assistants must not be allowed to work beyond their level of competence;
> 23.4 Continuity of care and appropriate skill/staff mix is important, so health care assistants should be integral members of the caring team;
> 23.5 Standards of care must be safeguarded and the need for patients and clients, across the spectrum of health care, to receive skilled professional nursing, midwifery and health visiting assessment and care must be recognised as of primary importance;
> 23.6 Health care assistants with the desire and ability to progress to professional education should be encouraged to obtain vocational qualifications, some of which may be approved by the Council as acceptable entry criteria into programmes of professional education; and
> 23.7 Registered nurses, midwives and health visitors should be involved in these developments so that the support role can be designed to ensure that professional skills are used most appropriately for the benefit of patients and clients.'
>
> (UKCC, 1992a)

As previously mentioned, there is and will be an increase of health care assistants working in the community. Alongside the work in community health care development, the community nurse must remain stringently aware of her responsibilities in respect of both the Code and Scope and to further engage the HCA or support worker in an understanding of community health care development and how the support worker contributes towards such goals.

CLINICAL SUPERVISION

Another significant development is that of clinical supervision. Long overdue, it is a most necessary professional provision for nursing staff, to enable them to reflect on their practice regularly and increase its effectiveness. At the time of writing this is a very recent development and not yet as well understood as it needs to be.

> 'Supervision is a dynamic, inter-personally focused experience which promotes the development of therapeutic proficiency. One of the primary reasons for all supervision is to ensure that the quality of all therapeutic work with the client is of a consistently high standard in relation to the client's needs. Consequently, supervision must be acknowledged as a cornerstone of clinical practice.'
> (Hill, 1989, pp. 9–15)

And:

> 'Our experience is that supervision can be an important part of taking care of oneself, staying open to new learning, and an indispensable part of the helper's on-going self-development, self-awareness and commitment to learning.'
> (Hawkins and Shohet, 1989, p. 5)

The hitherto autocratic and hierarchical organisation of nursing inevitably leads to suspicion concerning the introduction of something which contains the word 'supervision'. Professional clinical supervision has long been established in psychoanalysis, psychotherapy and professional counselling practice, and is regarded as one of the *sine qua non* of such work. It is firmly on the nursing agenda and we can welcome it wholeheartedly.

The provision of a facilitating environment as in clinical supervision 'offers the opportunity for vision to be widened; for the practitioner to take a broader view of professional practice and to apply her own skills and knowledge gained from experience to a given situation' (Swain, 1995, p. 23).

Community health care development requires a vision. Nurses working alongside individuals, families, groups, communities, and so often sharing the pain as well as the pleasure, must be given the opportunity to reflect on their work with a professional other (ibid.).

ONGOING RESEARCH

Post-Registration, Education and Practice (*PREP*, UKCC, 1994), implemented from 1 April 1995, also seeks to ensure that practitioners are in receipt of regular updating, and that they will be able to show evidence of their fitness to practise by virtue of on-going study and personal and professional development in the form of a personal professional profile. All of this is concerned with the raising and maintaining of standards, and the protection of the public and inevitably the practitioner. Community health care development increasingly requires continuing education which develops skills and competencies of practitioners to Masters degree level. These skills are used in research and development, which are very important in identifying the efficiency as well as the cost-effectiveness of using various interventions with limited resources. Community health care development, along with community development, are so crucial that the community nurse should be encouraged to participate in research into these areas. This will lead to an increasing influence on how health interventions are applied, to whom and when.

MATTERS OF ETHICS

Inevitably some ethical issues are raised. An example could be whether it is reasonable to remove a cancerous colon, given the emotional and physical cost to the patient/person, particularly if very old, as well as the financial cost to the State. Such a procedure might enable an elderly person to return to independence in the community, even for a short period of time. On the other hand, should such an invasive procedure be done. Is it unethical not to do so, leaving instead a very frail and unwell person in the community, dependent on family, the community, and the health and social services? Added to these considerations is the increasing role of clinical audit which attempts to ensure that clinicians are practising evidence-based care, even though the latter may not be appropriate in the eyes of the patient (Hopkins, 1993).

The subject of ethics mentioned more than once in this chapter, will be returned to throughout this book since health care reforms has led to many questions about its role.

Brody (1994), in discussing the health reform debate in the United States, pointed out that Clinton's health reform speech to Congress in 1993 carefully identified the most important moral values which justified his reform proposals. Brody stressed that it was important to consider ethics as the:

> '. . . optimistic voter tends to assume that health reform is about the policies and economics of health care; the pessimistic voter tends to assume that the debate is a smoke screen behind which the powerful interest groups will assure that no change in health care cuts too deeply into their profits or privileges . . . The moral values at stake – universal access, reasonable equality of benefits, fairness of burdens, quality and efficiency of care – are readily grasped by most people and form the basis for a serious community discussion of what sort of system best suits the nation and what sort of trade-offs ought to be made in implementing it.'
> (Brody, 1994, p. 7)

These points are highly relevant in the NHS, which on numerous occasions has mirrored the Oregon Health Decisions Project quoted in Brody's article. Many citizens and communities are becoming involved in health debates, and the officials in charge of the distribution of resources are having to answer to the public as well as the clinicians for the rationale behind their distribution of health care resources.

The opportunities for such debates are taking different forms – on the radio, the television, in general-practitioner surgery participation groups and focus groups and health authority–patient focus groups. Although it is difficult to get adequate involvement of the public they are beginning to say they are not consulted enough (see for example NHS Executive, 1994). Here then is yet another challenge for the community nurse in community health care development.

Whether, individually, community nurses would describe themselves as 'optimistic or pessimistic voters' only each person knows. What we do know is that general elections are regularly held with subsequent ramifications for the National Health Service.

END PIECE

Our values were stated at the beginning of this chapter. Wherever changes may lie ahead, and change as we know is inevitable, the values that we hold at the core of our work which are essential to community health care development do not change; they form the backbone of our work, together with a commitment to social justice in the community.

It is eminently sensible to try to link major societal and consequent health policy changes with the reality of their impact on the work of community nurses. Opportunities should be sought by nurses to continue developing compassionate and knowledgeable care.

In this regard the chapter authors in this book have been deliberately chosen to provide a balance of health care personnel. There are a number of nurses, and others who are not nurses, and who may not personally hold or fully understand the eternal values of nursing. It suffices that nurses do. In this state of confidence, then, there is the opportunity to learn from and listen to other colleagues and from other disciplines concerning their approach to community health care development, in which the community health nurse has, and will continue to have, an integral contribution to make.

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CHAPTER TWO

Identifying Health Needs

Lesley E. Armitage

INTRODUCTION

What is health? What are health needs? Who decides who has what needs? Why do these decisions have to be made? What is this to do with community nurses? How are health needs identified?

The covert rationing of health services by the use of waiting lists should be past history, and now the challenge to every health professional in the NHS is to ensure that its resources are prioritised according to need and health outcome. Furthermore, purchasing and commissioning are now at the heart of health service planning and provision. These two factors give health professionals, including community nurses, a dual responsibility:

1. to prioritise the resources available to them according to need and health outcome; and
2. to provide input into purchasing and commissioning which is based on soundly researched fact.

This chapter will discuss how much more far-ranging ill-health and its determinants are than the familiar medical model, how community nurses are ideally placed to observe the effects of these determinants, why and how health needs are determined, and the role of community nurses in identifying health needs and informing the purchasing or commissioning of health care.

HEALTH

What is health? A minimalistic medical model would be 'the absence of disease'. However, health is generally considered to be a much wider concept than this, and the most quoted definition is probably that of the World Health Organisation: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. A criticism of this could be that it is so rarely achieved as to invalidate it on practical grounds, but should this disqualify a definition which provides a goal to aim for? Perhaps a slightly more realistic definition is that of mainstream biological thought: 'Health is a satisfactory adaptation of the individual to his total environment – physical, psychological, and socio-cultural. The optimum use of human powers through this adaptation leads to a sense of well-being' (Royal College of General Practitioners, 1972). The important factor in the second and third definitions is that health is considered to have three dimensions, that it is not just associated with the absence or presence of disease but also results from a successful interaction of the individual with his or her physical and social environment.

ILL HEALTH AND SOME OF ITS DETERMINANTS

It is only necessary to think through an imaginary 24 hours in the lives of a range of people to begin to have some idea of how many factors impact on health, and how relatively small, although important, is the part played by conventional health services. People spend their lives at home, at work, at school, in looking for employment, in aimlessly waiting for the day to pass, in leisure activities, in carrying out chores, in travelling on foot or by vehicle, in social isolation, and so on. Through these they are in contact with a range of environments which influence their health by exposing them to pollution, major and minor accidents, stress, unhealthy lifestyles, and so forth. The deleterious effects of these are compounded by unemployment and poverty, be it absolute or relative, and there is now an abundance of evidence to show that poverty is associated with higher morbidity and mortality rates when compared with those for people of higher socio-economic classes. The Black Report was a seminal document on the effects of poverty on health, and 15 years later, in 1995, The King's Fund and The

Department of Health both produced reports on socio-economic deprivation and health, which serves to show the continuing importance of this topic, despite almost 50 years of health service provision free at the point of delivery (see for example Black *et al.*, 1992; Benzeval, Judge and Whitehead, 1995; and Department of Health, 1995).

The NHS seeks to promote health; to prevent disease – for example, measles and rubella by immunisation, and lung cancer and chronic obstructive airways disease by anti-smoking initiatives; to detect other diseases early so that treatment will be of maximum benefit – for example hypertension, non-insulin-dependent diabetes and breast cancer; to treat trauma and acute illnesses effectively so that patients return to their previous state of health, or one in which impairment, disability or handicap are minimised; and to manage chronic diseases so that their progression and their effect on the sufferers' quality of life are kept to a minimum. However, none of this can happen unless there is contact between the public and the providers of health care, and unless that contact is effective. In the face of illness, people's behaviour varies and is often socially determined. People from lower social classes, when compared with those from higher social classes, tend to seek medical advice more often for relatively minor acute illnesses, and less often for their serious illnesses, and to make less use of preventative services (see for example Black *et al.*, 1992; Forster, 1976; and Pill *et al.*, 1988). This difference has been shown to extend to the quality of the GP consultation, when middle-class patients have longer consultations and discuss more problems than working-class patients (Cartwright and O'Brien, 1976; and Buchan and Richardson, 1973).

There are people whose housing or working conditions expose them to health risks or increased danger from accidents, while the continuing employment and income of others can be jeopardised by time off work due to ill-health or regular appointments with their doctor, and this is especially so for people in low-paid or piece-work, or the black economy, who are often not protected by employment law. For these or other reasons they may delay going to their GP until their condition has become so bad that treatment cannot be avoided, and may then require more time off work than if they had gone earlier. Some people suffer from a physical disability, but their environment then turns that condition into a handicap; for example someone who is wheelchair-bound is unable to take up a job because of lack of transport facilities, or the office is inaccessible to a wheelchair user (WHO, 1980).

The Public Health Alliance's *Charter for Public Health* lists the factors that it considers to be 'the essential basis of every citizen's right to good health'. These factors are not only useful in illustrating how wide-ranging are the social determinants of health, but they also serve as a list of topics requiring responses from health professionals and others (Public Health Alliance, 1993).

WHY IT IS NECESSARY TO IDENTIFY HEALTH NEEDS

There never was, and there is never going to be, enough money for the NHS to meet all the health needs and demands of the public. The increases in available treatments, in patient throughput, in technological development, and in patient expectations mean ever-increasing costs for health care which need to be funded. The Department of Health has to compete with other government departments for its financial allocation, and the amount it receives reflects political and financial expediency as well as health need. For all of these reasons health service provision throughout the NHS will always be constrained by the resources available to it, and this is why health needs must be identified, priorities determined according to clinical need, and resources used to gain the best health outcome.

Who assesses health need?

Until the advent in the 1980s of the changes recommended by the Griffiths Report (DHSS, 1983), the NHS was administered rather than managed; consultants effectively made the decisions which determined the use of the majority of its resources; and there was little or no management of those resources to ensure that they were used according to the greatest patient need and health outcome, and that the service was provided efficiently and effectively. With the advent of 'the new NHS' in the 1990s came management and the purchaser–provider split. This gave health authorities and GP fundholders (GPFHs) the power to decide which services they were going to purchase for their patient populations; the opportunity to base their decisions on health need and health gain; and the chance to demand better value for money and improvements in the quality of the services provided. Although these two bodies have the direct power to place service contracts with the providers of their choice, district health authorities (DHAs) are often in a better position to make their decisions if they receive input from the health professionals in daily contact with patients. Many DHAs therefore work with non-fundholding GPs, who form commissioning groups and advise their DHAs of the services they would like purchased on behalf of their patients, and from which Trust they would like them purchased. Community nurses are employed by GPs and community trusts, and are in an ideal position to provide advice on the need for services.

Tensions in the assessment process

Unfortunately it has not always been possible to base purchasing decisions on health need and health gain for a variety of reasons. Ideally, departments of public health should assess the health needs of their authority's population and use it to drive that health authority's agenda, but they may have difficulty in achieving this because of the tension between the dual roles of such departments; that is, the tension between being independent advocates on behalf of the public's health, and the need to respond to the demands of their health authority. The situation with GPFHs is variable, as they are in the potentially awkward situation of being responsible for rationing the health care they provide for their patients, while having personal contact with their patients and their patients' demands. As a result there is a greater chance that they may find it difficult to refuse the loud voice of consumerism in favour of what may be the almost silent voice of need. Already there are criticisms that some GPFHs are purchasing services from the limited 'pool' available in their district, so that their patients receive the services at a low threshold of need, and this reduces the health outcome and the services available for the rest of the authority's population, who therefore do not gain access to them until they reach a higher threshold of need.

Meeting incessant needs

The changing working structure for community nurses is from a rigid nursing hierarchy towards a loose framework consisting of community nurses and other health professionals. This gives exciting opportunities to community nurses for controlling and promoting their own work and for innovative ideas, including the effective management of their caseloads. The hazard of the loose framework is its lack of controls. For instance, if a nurse is providing a poor quality service to her clients because of health or social problems, burnout, or increasing disinterest, there is a greater potential for this problem to go undetected. It is therefore important to recognise the greater professional responsibility required if community nurses are to work in the more challenging and exciting environment of modern nursing practice, and it is especially important to have sensitive and constructive systems in place which will enable nurses in difficulties to have access to the support they need, and their clients to regain access to professional care of a standard that they have a right to expect.

Matching resources to need

All health professionals have at least one commodity at their disposal, and that is the hours that they are employed to work. Some may also be responsible for how equipment, operating theatres, and so on are used, while others are gatekeepers to further services, for example, GPs to consultant outpatient clinics, community nurses to, perhaps, bathing attendants, speech therapists or chiropodists. The decision for the individual health professional to make is how to allocate their time, their resources or access to another service, to those patients with the greatest need.

It is important to recognise that when time, equipment and services are used on one patient they are then no longer available for another patient. In an environment of scarce resources economists describe this concept as 'opportunity cost', which is the cost of not doing the next best thing because the resource has been used on the first choice. This 'cost' can be measured in many ways, for example health outcome, years of life lost, the consequences of not being able to provide, say, hospice care because the resources have been used on increasing the district nursing service, carrying out home visits to mothers of young children, and so on. The key point is, was the first choice the best choice, and if so, for what reasons, and what was its opportunity cost? By thinking this through when reviewing one's own decisions on matching resources to need, it becomes possible to consider the criteria that were used in the decision-making process, to reconsider their relative importance, and to decide whether alterations to those criteria need to be made. It is, therefore, important to keep the concept of opportunity cost in mind when making decisions on resource use, including professional time.

MATCHING DEMAND AND NEED

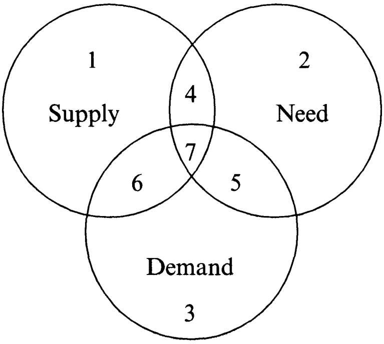
The definition of health need favoured by the NHS Executive is 'the ability to benefit from a health intervention' and is distinct from both demand and supply, although there is a relationship between the three concepts, as illustrated below in Figure 2.1 (Stevens, 1991). Incumbent in this definition of need are three factors:

1. there is a health problem;
2. there is available an effective treatment or intervention for that health problem; and
3. people with that health problem believe that the resultant health gain is worth their input of time, effort and/or money to receive that treatment.

It is important to distinguish between the need for health care and the need for health. The need for health care indicates the potential to benefit from an intervention, and therefore requires a relevant intervention and a corresponding improvement in health. The need for health is a more general term for which it is often not possible to determine an effective health intervention; for example the health consequences of social deprivation.

The services currently provided by the NHS are controlled by the three factors shown in Figure 2.1, demand, need and supply. The ideal is for any one service to be needed, demanded and supplied (sector 7 of Figure 2.1), but this is by no means always the case, and

Figure 2.1 Diagram showing the relationship between need, supply and demand



Source: Stevens (1991)

services can reflect any one of the seven situations illustrated by Figure 2.1:

1. supplied and not needed or demanded;
2. needed and not demanded or supplied;
3. demanded and not supplied or needed;
4. needed and supplied and not demanded;
5. demanded and needed and not supplied;
6. demanded and supplied and not needed;
7. needed, demanded and supplied.

Childhood immunisation is an example of a service that is needed, demanded and supplied (Figure 2.1, sector 7). However, although always needed, measles immunisation is an example of a service that used not to be in great demand (Figure 2.1, sector 4). Before the introduction of the measles/mumps/rubella (MMR) immunisation in 1988, the uptake of the measles immunisation was low in some districts. Measles is an unpleasant childhood illness, which used to be common, and from which most sufferers made a full recovery. It caused the death of some children, however, and left others permanently disabled, was unpleasant for the sufferers and carers alike, and for some of the latter caused difficulties with their employers. One of the factors that contributed to the low immunisation uptake was the relative insignificance given to such a common complaint by both parents and health professionals. In the meantime, the danger to the unborn child of maternal rubella infection during early pregnancy was a well-known and feared hazard. The addition of rubella to the measles immunisation resulted in an increase in its uptake due to the demand for MMR from both parents and health professionals (Figure 2.1, sector 7); (Miller *et al.*, 1991).

Screening for osteoporosis in post-menopausal women is a service for which there are repeated demands. However, the current state of knowledge of osteoporosis and its treatment, and the lack of an effective screening test, mean that the criteria for population screening cannot be fulfilled, and the hoped-for health gain in this population is not yet possible (see for example School of Public Health, 1992). Therefore, although there is a demand, there is no need for health care, and no service provision (supply) for screening this population for osteoporosis (Figure 2.1, sector 3).

In most situations there is some demand and some need. In the past, the relationship between the two was often ill-balanced, but it is improving continuously since the introduction of management and the purchaser–provider split in the NHS. The professional demand for, and supply of, dilatation and curettage as a gynaecological investigation in women under 40 years of age is being reduced by the introduction of guidelines which limit its use to situations in which it has proved to be effective in this age group (that is, proved to meet a need). Many school nurses, health visitors and school doctors have spent a great deal of time in the routine examination of children, for example school entry medicals which were historically determined and whose usefulness or need was not questioned. The Hall Report (Hall, 1991) reviewed the effectiveness of this type of routine examination and found much of it to be unnecessary, ineffective and a waste of resources, as it was not meeting a health need but reflecting what had become a cultural norm, or demand, of community health professionals and parents (Figure 2.1, sector 6). The opportunity cost of this must have been considerable. As a result, in many health districts the school health service was completely restructured in order to meet more effectively the health care needs of school pupils.

As indicated above, the ability to benefit from a health intervention probably requires services designed so that potential recipients can access them without difficulty (Figure 2.1, sector 5). Such access is often socially determined, and can be increased by altering services in such a way as to reduce the effort or cost required to take them up. For example, clinics or appointments timed so that mothers can still take their children to and from school; peripatetic services such as childhood immunisations, chiropody, family planning, and diabetic care for those people who cannot, or will not, go to a health centre or clinic. There are situations in which sympathetic staff attitudes and increasing public awareness can help to increase demand such that it reflects need. In recent years continence services have been introduced in many health districts because of a recognition of the need for them, but the size of the demand can be affected by the embarrassment of the sufferers in making known their need for the service (Figure 2.1, sector 4). The need for services as wide-ranging as travel health advice and cervical screening is not always recognised by the public, or such services avoided by them because of fear, for example of injections or embarrassment (Figure 2.1, sector 4). Sympathetic understanding from health professionals and receptionists is one way of helping to increase demand for these important services (Figure 2.1, sector 7).

CONSUMERISM

How does consumerism link into needs assessment in the NHS? One dictionary definition of consumerism is 'the protection or promotion of consumers' interests in relation to the producer'. The key word in this definition in respect to the health service–patient relationship is 'interests'. Who decides what those interests are? The difficulty with introducing a word from the commercial world into the NHS is the differing nature of their contexts, the implications of this, and the misunderstandings that can arise from it. In both commercial and health service contexts the consumer (patient) makes a transaction (demand) with the supplier (for example nurse) for the provision of an item (service). Implicit in this is that the consumer is demanding something that he/she wants and perhaps needs. In both the commercial and NHS contexts this provision may be the result of the supplier being determined to provide this item for his or her own interests while 'selling' it as being in the consumer's interest, or believing it to be in the consumer's best interests or what the consumer is seeking. However, the main difference between the contexts is the direct relationship between demand and supply in the commercial world, compared with the NHS's more complex responsibility for establishing whether the demand is also a need, and then determining the relative priorities of that need among the many needs competing for resources, and this can only be done when there are adequate data and information to inform the debate and decision-making process.

Sometimes in the past, and it may still be true in some cases, the patient (consumer) was treated as though their presence was for the convenience of the NHS (producer), instead of the NHS being there to serve the patient. For example, it was not in patients' interests to wait many months, and sometimes years, for out-patient appointments or in-patient treatment; nor was it in their interests to give six patients the same appointment time; all common practices in the recent past. It was to protect patients, to promote consumerism, and possibly to help develop a culture in the NHS that was more sympathetic towards patients as people, that *The Patient's Charter* was introduced in 1991/92 and gave patients certain rights (DoH, 1991). However, consumerism is a two-edged sword, and what the *Charter* failed to do was to require responsibilities from patients in response to those rights, for example to cancel their appointments when they know in advance that they will not be able to keep them or no longer need them, or to notify their GP when they change address. Every community nurse knows the frustration of abortive visits, especially when set against the tension of trying to meet the responsibilities of service requirements and the needs of a case load.

A recent example of the debate and difficulties surrounding consumerism and need is the new drug for use in the treatment of multiple sclerosis (MS), beta-interferon. Following early publicity, the expectation of the drug by MS sufferers resulted in very strong demands for District Health Authorities to make it available. The expected cost per course of treatment was very high, causing debate about whether the opportunity cost was unacceptable (Figure 2.1, sector 5). This was a situation where it would be possible to match demand and need by service provision, but the cost of that service would be so high that its priority over other competing service needs had to be determined (Collier, 1996). Another example is the Oregon experiment, which failed, but was a brave attempt to prioritise the health needs to be included in that state's health care programme by involving the public in the prioritising process (Kitzhaber, 1993; and Kitzhaber and Kenny, 1995).

It is important to recognise that consumerism can make a very positive contribution to identification of health need and quality of health care delivery, especially as it is difficult for health professionals and managers to appreciate the less-obvious needs of patients within the NHS without seeking their views. Some common examples are notices written up in writing too small for patients with imperfect eyesight to realise their presence; low chairs without arms, which are difficult for many elderly people and for those with joint problems to get into and out of; the lack of toys or books to entertain children when they accompany their parents or grandparents; and instructions on bottles of tablets too faint to be read easily. There are also larger issues such as the lack of services, timing and siting of clinics, lack of interpreters, and health professionals giving explanations that are not understood by the service-users.

Consumers are a valuable resource in helping any aspect of the NHS to improve the quality of its services, and should be encouraged to report on their experiences as users of these services so that this information can be judged, and, if appropriate, acted upon. At present much of this role is taken on by the Community Health Council, but many organisations within the voluntary sector have a wealth of information built up from the experiences of their members, which are a useful resource in terms of assessing health needs. However, it must be remembered that these voluntary sector organisations are, first and foremost, consumer groups set up to meet their own ends, and it is the responsibility of health professionals to set such information in the wider context of the needs of the whole population for whom they are responsible.

WHO DETERMINES HEALTH NEEDS?

There are numerous people who can, and do, decide that someone has a health need and then take some sort of action, for example their family, their GP, a community nurse, a social worker, a head teacher, a consultant, a town councillor, and so on. These decisions can range from a grandmother advising her daughter that the grandchild needs to see a doctor, to a social worker recognising non-accidental injury, or a community nurse believing that one of her clients may be clinically depressed due to social isolation, or a local authority councillor recommending that one of their constituents is rehoused on health grounds. There are many families that are in touch with a multitude of medical, educational and social work professionals, all of whom are trying very hard to provide the professional care they believe one or more members of the family need, and many of whom are unknowingly opposing other professionals by their actions. This can be very well demonstrated by using a case history to build up a 'statue' of all the people involved in caring for, or supporting, a family, and then getting all the people forming the statue to pull in the direction they believe their efforts lie on behalf of that family. It can be a very telling lesson.

An example of this would be to imagine an unmarried mother with a partner who has a history of alcohol and violence. She has two children, a nursery-aged child (A) who is failing to thrive, and a child (B) at infant school who is having behavioural problems, largely due to the home situation. The health visitor, consultant paediatrician, GP, nursery school staff and social worker are all involved in supporting child A and its mother. Another group of professionals, consisting of the school nurse, educational psychologist, teacher, head teacher and GP, is concerned with supporting child B, and this support may be extended to its mother. Meanwhile, the heavy drinking, violent partner is jealous of the mother's involvement with her children, and has a probation officer, his own GP, and the local drug dependency unit staff supporting him. The mother is depressed, and receiving her own support from the family GP and a community psychiatric nurse. It sounds confusing because it is confusing. Each professional believes he/she is working in his client's best interests. The problem is that no one is looking at the family as a whole, and as a result each group is working against the needs of the other groups, and the members within each group are in danger of competing with each other unless they have ensured, through effective communication, that they are working together within an agreed structure which is truly in the interests of their client. This sort of problem is not uncommon, in part because the independence of action that many professionals have can make them poor team workers.

On some occasions confused communication can lead to well-meaning but inappropriate efforts on behalf of someone's health needs. For example, take a family in council accommodation whose application for medical points for rehousing was turned down on the basis of insufficient medical need. A subsequent traumatic occurrence in their block of flats set in motion a series of caring professionals who, probably due to enthusiasm and confused information, gave advice which culminated in the tenants being advised to approach their MP, and he, of course, took up their cause and made a complaint about a decision that turned out to have been made long before the upsetting incident had occurred. This series of confused, but well-meaning, actions resulted in a great deal of unnecessary time, effort and stress being expended, and considerable delay in gaining the necessary help, when one telephone call would have elicited the required response.

COMMUNITY NURSES AND ASSESSING HEALTH NEED

Community nurses are in an ideal position to determine health needs. They are all required to prepare a community health care profile, which will give them an overview of the social and health background of the population they will be serving, and assist them in planning their activities according to the theoretical needs of their clients or patients. That profile is a valuable starting point, but how many nurses find the time to reappraise the profile in order to check whether they need to modify their activities, or add further information to the profile in the light of their practical experience?

If community nurses are to be effective, not only in determining the health needs of their clients but also in bringing about change to meet them, they need to work to their own professional strengths and to have a clear understanding of the resources that they can mobilise, both within the primary health care team (PHCT) and among other carers in the network, whether those carers are informal, such as family, friends and support groups, or formal, such as health and social workers. It is, therefore, important for each nurse to have a clear understanding of their own role and its boundaries, as well as of the roles of the other members of their PHCT. There can still be considerable ignorance within PHCTs of the roles of its members, and in particular of the subtle differences arising from the increased independence of nurses from the medical profession. The temptation to behave as social worker, parent, as well as nurse, can be considerable. This does not mean that community nurses should only be concerned with the medical model of health needs, as their patients' health exists within the context of their homes, families, neighbours, neighbourhood, employment, and so forth. A holistic approach is therefore important, but, by attempting to take on the role of other professionals, nurses reduce the time available to them to assess health needs, and are likely to be less effective in an area of work that is not their own. They are also, without realising it, perhaps encouraging dependence and reducing empowerment. The key is to know when to involve another professional.

At present there are many types of community nurse, for example midwife, practice nurse, community psychiatric nurse and health visitor, which can mean that one household may receive visits from several nurses for the care of its members. This is inefficient service delivery, and, with the gradual demographic changes, will not be able to meet the needs of the client groups in future. It might be feasible to maintain the current system if the threshold at which clients qualify for community nursing services is raised, and less nursing care per client is provided, but most health professionals would reject this solution. However, there is a further problem which may arise from a multiplicity of health professionals providing support for one or more members of a family, and that is that each professional focuses on the item of need in their field of expertise, instead of making an overall assessment of their client's health needs. The limitations of this was illustrated by the example of a 'statue' given above. An alternative approach is to train generic nurses who can meet most of the health care needs which arise in the community. *Project 2000* training was begun with this in mind, and is viewed as a very threatening development by some more traditional nurses (UKCC, 1987). However, it provides the challenge and greater satisfaction of being able to provide nursing care for whole families, just as general practitioners prefer to provide medical care for whole families.

Community nurses have access to a range of formal data concerning their patient population and the wider population and environment in which they live, and also to a wealth of informal knowledge gained from seeing many of their clients and patients in their own homes, and from the items of personal information shared with them as a result of their professional relationship with their clients or patients. Such information may be on social isolation, problems with housing and health, lack of health service uptake due to language difficulties, bullying at the local school, fears of pregnancy, to name but a few. Its value is that it raises ideas for further investigation and action by community nurses on behalf of their clients' needs.

DATA AND INFORMATION

Data are the facts from which information is derived.

In recent years there has been concern expressed, particularly among purchasers, about the value of some of the services provided by community nurses. The current vogue, for understandable reasons, is for evidence-based medicine and randomised controlled trials, which require 'hard' and accurate data obtained by strictly-standardised methodology. The difficulty about this is that not all health care work lends itself to such rigidity, and that health care provision which does not meet these tight criteria can be devalued or may not be purchased. However, information derived from data lends weight to any discussion or proposal, and lack of information weakens it. It is important, therefore, to remember that while 'hard' data are the most valued, information is better than no information, and hard information is better than soft information. Good, objective information is certainly a prerequisite if community nurses are to put forward a cogent argument on behalf of their patients' needs, and if their voices are to be heard in the purchasing and commissioning processes.

One of the great advantages community nurses have is the records they keep on their clients or patients; records which contain a gold-mine of information which in many cases has not yet been tapped. Until recent years the NHS had a long history of collecting data which were then almost inaccessible for further use, and although in general this has now changed, it may be fair to suggest that community nursing has been somewhat slow to recognise the value of its own data and to make effective use of it. Its records can be a source of morbidity data; of evaluating wound-management by reviewing the duration of treatment and outcome of different types of wound dressings; of domestic violence; of the prevalence of diabetes by age and ethnic group; of accidents in young children and the appropriate preventive measures required; to give just a few examples. This information source is of considerable help when determining health needs, and it can also be used to monitor the effect of community-nurse interventions, and whether trends are upwards or downwards.

IDENTIFYING HEALTH NEEDS AND ACTION

The heading for this section has been retained as 'health needs' to encourage the idea that health needs are broader than the classic NHS medical model of health care. Health is so multi-faceted, and affected by so many factors, that health needs can range from the need for health promotion, financial resources, companionship, empowerment and problem-sharing, to uptake of screening, and diagnosis and treatment. It must still be emphasised, however, that whether the need is physical, psychological, social or any combination of these, there is no point in using scarce resources to make a response unless there is the potential for benefit.

Informing commissioners

The identification of health needs, as a dynamic process with a practical and beneficial outcome, requires an exploration of the relationship between the health problems in a community and the resources available to address those problems. What form this will take will depend on the individual responsibilities of each community nurse. If community nurses are to make a contribution to purchasing and commissioning at health district level, or to commissioning groups which represent large populations, for example multifunds, it is unrealistic to expect that this process will be able to respond to a multitude of individual issues, each covering the relatively tiny population of a community nurse's caseload, even if they are well-argued and supported by reliable data. However, community nurses working with fundholding practices, or in a total purchasing scheme with GP fundholders (GPFHs), are working much closer to the purchasing process. They are therefore well-placed to have a good understanding of the resources available to meet the health problems of that community, and can more readily combine their efforts to collate and analyse data, determine priorities, and present their case to the GPFHs for purchasing or commissioning services on behalf of their clients. Whatever purchasing environment the community nurse works in, teamwork will be vital. The team could be a nurse's own PHCT, it could be all the community nurses in a health district, all those supporting a commissioning group, or a locality, and so on. The advantage for generic nurses looking after whole families is that they will have an overview of the health needs of all age groups, and the difficulties of sorting out the competing views of different specialist nurse groups are therefore avoided.

Other action

There is no reason why any community nurse should not make an individual response to a need by using the resources for which she has responsibility, including her time. For example, there may be a type of council house peculiar to her geographical patch which has a design fault which makes access to the stairs dangerous, especially to the very young and the elderly. Data can be collated on this and used in representations to the housing authority. Many accident and emergency departments (A&E) have a system of notifying health visitors of children being brought to their department. An appraisal of these may show trends, such as a problem with the local playground. The nurse can then ascertain whether her colleagues have similar problems with other playgrounds, and they can combine to put a case to the relevant authority.

There are still pockets of low childhood immunisation uptake, which may be geographical or relate to a particular GP practice. In many districts community nurses immunise children, and action can therefore be taken by them to meet this need. Every year many children of Asian families return to India or Pakistan to visit their families. Not all these children have received their childhood immunisations, and there have been occasional cases of diphtheria, one fatal, and paralytic poliomyelitis (Efstratiou, George and Healing, 1995; and Hamilton, Healing and Newman, 1994). Community nurses are well-placed to determine this health need in their locality and to meet this deficit. How many pharmacies or practices issue bottles of tablets with labels too faint to read, and what can be done about it? There are numerous ways in which community nurses, by themselves or by sharing their information with their nursing colleagues, can take action to meet the health needs of their clients.

In a similar way, data can be collated on the number of people expected to need services, and a case made for the purchase of further services (see for example Stevens and Raftery, 1994, or any major medical textbook). How many people have continence problems, and does the true prevalence reflect service provision? Another example is for diabetes nurse practitioners to compare with the expected prevalence, the prevalence of diabetes by age, sex and ethnic group in the population for which they are responsible. If there is a discrepancy between the two, how is this accounted for? It may be that maturity-onset diabetes is going unrecognised, and the nurses' data can be used to argue for resources for improved diabetes detection, treatment and management.

Many people suffer from chronic diseases, such as Alzheimer's, stroke, visual handicap, and arthritis, as well as the less-common congenital handicapping conditions such as cystic fibrosis and cerebral palsy. There is a wealth of information, support and companionship available through self-help groups, and community nurses can help put such people in touch with these groups. Even now, in the 1990s, there are men and women and sometimes children who have been struggling alone, sometimes for many years, with severely handicapped partners, children or parents because they did not know that it was possible to get help. Community nurses are a valuable resource in hearing about, and doing something for, such families. It may be that their own nursing skills are inadequate, but they can help put the family in touch with one of the very many self-help groups, social services, or occupational therapists, so that others can provide the support that is appropriate.

Having just touched on a few of the vast number of ways that community nurses can help to meet the health needs of their populations, how should they set about it? All community nurses are trained in how to carry out a community health care profile, so there is no point in reiterating it here. However, there are a few comments that should be made, and there is also the key issue of how to prioritise health needs which are competing for limited resources.

Determining health needs is not a once-and-for-all operation, and it is important in one's daily work always to keep questioning whether there may be other people having the same health difficulties, and whether there is an effective intervention from which they might benefit. There are all sorts of information available to community nurses, and it is important that full use of these resources is made when determining health needs – for example GP computer data (if access is allowed); data on social deprivation; child health data on immunisation and paediatric surveillance; disease prevalence data; local physical handicap registers; census data on factors such as lone parents, lone pensioners, overcrowded households, and ethnic group; screening uptake rates; death and birth data published annually; A&E notifications; and *Health of the Nation* data, which are also published annually.

Equally important is an awareness of the services available to that community, and these go well beyond the traditional doctor–patient services, and include day centres, nurseries, schools, mother and toddler groups, youth clubs, women's groups, family planning and youth health clinics, drop in clubs, self-help groups, religious groups or leaders, and so on (see for example Picken and St Leger, 1993). In order to increase their effectiveness, community nurses should keep an up-to-date file of all such facilities and key contact people within them, and should also liaise and network with these people so that when they need their assistance they do not meet as strangers.

Being fair in responding to, and assessing, health needs is not easy, as it is human nature to want to respond to pleasant and cooperative clients or patients, and to dread dealing with the most querulous or difficult ones. In order to ensure that bias is not introduced by these very human responses, it is important to develop some objective scale of need so that, if challenged, the decisions made can be defended by facts.

The outcomes of health interventions need to be reviewed and evaluated against objective criteria, so that if they prove not to be beneficial, it is possible to use this information to decide whether to withdraw the intervention. Such criteria will vary with the topic, but it is not necessary to have highly complicated criteria. They can be as simple as whether or not mothers thought a mother and toddler group was definitely beneficial both to them and their toddlers, or how long it took wounds to reach a defined stage in healing when they were randomly allocated to different treatment regimens.

HOW TO PRIORITISE

This should be done objectively, and is probably most easily carried out using a simple scoring grid (Figure 2.2).

Figure 2.2 Scoring grid to assist in the determination of priorities

CRITERIA	**TOPIC**				
	Smoking	Carers' support	Immunisation	Lonely mothers	Diabetes
Prevalence/incidence					
Severity of problem					
Effective intervention					
Acceptability/feasibility					
Community involvement					
Cost and resources					
TOTAL SCORE					

Source: By kind permission of Dr C. A. Birt, Health Services Management Centre, University of Birmingham

A score of 0 to 4 is allocated to each topic for each criterion (Figure 2.2). A score of 0 is for very low priority, and 4 is for very high priority.

It is important to consider the potential for a positive outcome for each item when allocating scores. An item may be a significant problem, but if resources are already in place to deal with it, so that little additional benefit can be envisaged from the input of further resources, then it should be allocated a low priority.

Prevalence/incidence

$$\text{Incidence rate} = \frac{\text{Number of new cases in period}}{\text{Number at risk in period}}$$

$$\text{Point prevalence rate} = \frac{\begin{array}{c}\text{Number of persons with the}\\ \text{disease at a point in time}\end{array}}{\text{Total population}}$$

Severity of problem

Severity can be measured in terms of morbidity and mortality. The former includes the effect on quality of life and whether it is a major drain on resources, either medically or socially.

Effective intervention

There is no point in allocating resources to a health problem if there is no effective intervention; in such a case the score would be low.

Acceptability/feasibility

Is the intervention feasible: for example is it too large, likely to be successful, are there time and skills available for it, and is it culturally acceptable?

Community involvement

Community involvement can be an asset, not only as a resource to be tapped, but as a means of empowerment and confidence-raising.

Cost and resources

What are the resource implications in terms of staff time, skills, equipment, training and so forth?

Once such a grid has been completed, it gives an indication of priorities set in the context of feasibility and resources, and it can then be used to aid the decision-making process.

ADVOCACY AND EMPOWERMENT

Whether health professionals like it or not, their relationship with patients or clients is generally disempowering. This is partly determined by four factors:

1. the patient or client is seeking help for a health problem;
2. the health professional is the provider of help, either directly or indirectly;
3. the health professional encourages the patient or client to seek help, for example screening programmes and immunisation;
4. overtly or subliminally health professionals encourage dependency, and rarely seek to build up their patient's or client's confidence in their own ability to cope with, or take control of, their own health.

Another subtle means of disempowering people is to act as their advocates. There are times when it is essential that health professionals act as advocates for those who are incapable, for one reason or another, of taking on this role for themselves, or because the status bestowed on them by their professional role also bestows the power and influence to gain the desired outcome. But, how often are patients involved in the decision-making processes for health service provision, such as assessing and prioritising health need? Whilst reading this chapter, how often have you, the reader, thought, 'I would ask the client', or, 'If I brought X along with me to that meeting, they could contribute by presenting the patient's viewpoint'?

PURCHASING AND COMMISSIONING

Many things can be done without extra resources, as suggested in this chapter. Many health professionals have had ideas or plans to meet health needs but have not taken them forward. It is not enough to produce proposals, however well-researched, and expect them to be accepted and implemented, especially in a climate of limited resources. To be effective it is important to have a full understanding of the local purchasing and commissioning procedures, and how to bring proposals to them.

In the first instance find out how purchasing and commissioning operates in your locality. If you work with GPFHs it is they who will be purchasing services on behalf of their patient population. If the GPs you work with are not fundholders, then they may be aligned in commissioning groups which advise the DHA on the services they wish to have purchased for their patients. In some cases it is the Director of Public Health who takes the lead role in advising the DHA on such matters, or the director of a community trust.

The larger the health need is perceived to be by the purchasers or commissioners, and the greater the potential outcome, the more likely it is that action will be taken to meet it. Therefore see if collaboration with other community nurses or voluntary groups will provide a greater weight of data to support your case.

The next stage is to know who will be presenting your case, and to whom. It may be yourself, especially in a fundholding practice, or it may be a nurse manager if purchasing occurs through the DHA or a community unit. In either case it is probably helpful to prepare the ground in advance. This can be done by raising awareness of the issues with GPFHs, nurse managers, or whoever else you feel may be in a position to support your ideas. It can be done in casual conversation, in practice meetings, in sector meetings, and so on. It is necessary to know who are the key players within these procedures, and the people most likely to oppose your ideas and why they would want to do so, so that you can prepare counter-arguments.

If you are the one to present your own case, find out how it will be done, for example a formal oral presentation using an overhead projector, or a written presentation, and then make sure your visual aids, written report or verbal presentation skills are of high quality. If a nurse manager is to promote your ideas, ensure she/he has the necessary information to gain a clear understanding of your case so that it is easy for her/him to put it over with conviction. If you think that alliances with other professionals, community or voluntary groups will help your cause, find out how, or if, they can become involved in presenting your case to the relevant purchasers. The local purchasing process may allow them to make an oral or written report supporting the need for the provision of a service.

After all your efforts, the competing needs within the NHS may still mean that your attempts to ensure that a health need is met do not succeed. Do not be daunted by this, but use the experience to help make yourself more effective next time.

Determining health needs, and being involved in the challenging process of meeting them, can be very stimulating and satisfying. Enjoy it.

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CHAPTER THREE

Commissioning Services to Meet Identified Needs

Liz Haggard

COMMISSIONING AND COMPETITION

The introduction of commissioning purchasing and services as an activity which is organisationally separated from the provision of services is the mechanism which brings a form of competition into the National Health Service. The belief is that once the purchaser/commissioner organisation has established which services are needed for a population, they can then use competition between providers as the lever to ensure best value for money for the available resources. The commissioning/purchasing lever operates at health authority level seeking best value from health service provider trusts, and also at general practice level where fundholders and general practice total purchasers use their buying power to get best value.

There are a number of different stages in the health authority commissioning/providing cycle, and in theory community health nurses could be involved at all levels.

The commissioning cycle

- Assessing health needs in the local population;
- *Deciding* which health needs are most *important;*
- *Deciding* the most *effective* ways of meeting the health needs identified as most important;
- *Commissioning* (stating for which health needs service provision will be made, given the resources available);

- *Specifying* for each service to be provided details about the volume, quality and style of service required;
- *Inviting potential providers* to reply to the specification with their plans for service provision to give best value for money, outcomes and satisfaction;
- *Evaluation provider proposals* received;
- *Contracting* (working with the selected providers to agree cost, volume and quality standards for providing services);
- *Monitoring* the contract once awarded;
- *Reviewing* the whole process to improve the next cycle.

In practice, there is a small nursing team at health authority commissioning level and it may be that only one member of the team will have a community or primary care background. Community health nurses in provider trusts have therefore often been involved in helping commissioning health authorities to work up a specification for community health services. Most Family Health Services Authorities (FHSAs) have some staff from a community nursing background, often employed initially as primary care facilitators. As health authorities and FHSAs became one organisation in April 1996, health authority awareness of community nursing issues may have increased.

Identifying health needs can be thought of as a survey of all the known health problems in a given population; it will include information about age at death, causes of death, incidence of different health problems, hospitalisation rates and will use a wide range of information. Commissioning is the process of deciding which ways of intervening where there is ill-health, reducing the amount of ill-health and improving well-being for that population will be most effective. Services to deliver the commissioners' chosen pattern of service will then be purchased to give best value for money. If there is good understanding of community health nursing issues at commissioning and purchasing levels it is more likely that local providers will feel that the decisions are fair.

In the previous chapter we have seen that there are many ways in which need can be identified. The result of any survey of need is likely to be open to a number of interpretations, debate about the value of particular interventions in their own right, the comparative value of interventions and in particular which should be given priority.

From this survey of possible ways of intervening and knowledge of the health finance available, the decision about which services to provide begins to highlight choices based on value judgements, imperfect evidence, local feelings, past patterns of expenditure and service provision, professional and political preferences and a whole range of other factors.

Commissioning services was the key role of the District Health Authorities, now merged with the FHSAs. With this merger commissioning decisions about how to spend health money have brought the secondary, primary and community health services together for the first time. Some commentators outside Britain (see for example Thomasson, 1995) see this as a unique opportunity to develop care services where they provide best value for patients and pounds. Although many of the boundaries which have made it difficult to shift services in the past will still exist, the bringing together of secondary, primary and community health care will sharpen the question: 'If we wish to commission this service for our local population, where is it best provided and by whom?' Community and primary care services may hope that more services will be provided out of the acute sector, although so far resource shifts have been small (Thomasson, 1995) and take-up of schemes like hospital-at-home has been slow (Iliffe and Gould, 1995).

Evidence-based commissioning

However, what is a good solution for one part of the system may have disbenefits for another part of the system. For example, patients may prefer treatment in their own homes, but the opportunity cost of home treatment for one person when clinic treatment could be offered to four patients for the same time-cost, may not be a good commissioning decision for the majority of patients.

In many cases we do not have enough high-quality evidence to justify major shifts in care. The increasing emphasis on evidence-based commissioning has revealed how difficult it is to find evidence which gives a clear enough answer to justify major change. The York Centre for Reviews and Dissemination is responsible for 'systematic reviews' on issues felt to be of major importance to commissioners; the term 'systematic review' describes a process of careful evaluation of the type and quality of research on which current knowledge is based. By bringing together studies which have been done, evaluating them and summarising the conclusions in which we can have confidence, the York Centre has been able to give guidance to commissioners on a range of important issues (see for example Chapter 7 in this book).

In time it may be possible to look to systematic reviews to give answers to community health care issues, but good research design in community settings is difficult given the influence of complex social factors. Research results may also question the value of community care. We all prefer to believe evidence which supports our current practice and point of view. With the increasing focus on primary and community health services, the effectiveness and value for money of community health services will be under scrutiny and community health professionals need to be prepared to change or abandon ways of practising when there is convincing evidence that these are not effective.

Recent examples of effectiveness studies which have affected community health services include the Hall Report (1996) on child health screening, which showed that some traditional screening activities were not reliable or valid enough to be retained. A number of studies have focused on the appropriate skill level for different community health activities; where it is not possible to prove that the use of higher-grade nurses is necessary, it is likely that commissioners will choose providers who use the lowest grade shown to be necessary for effective care. Managers of community health services have a particular responsibility to be aware of new research which questions current practice and to work with staff to re-shape services.

Comparative information and pressure for change

Commissioning will rely increasingly on research-based evidence. It will also have increasing access to comparative information to enable providers of community health services in similar geographical areas to be compared. This approach is used for example by the Audit Commission in its reports, and it is increasingly likely that at national, regional and local commissioner level such approaches will expose variation between community health services providers. The development of Read codes (a standardised set of terms for nursing use in computerised patient records) will enable patient care to be compared more easily. Some degree of variation is, of course, necessary and expected – service provision will vary where population and geographical characteristics vary. However, when similar services delivered to similar populations in similar geographical areas are found to have wide variation this will increasingly be seen as unacceptable (Harley, 1995). Community health professionals will need increasingly to make sure that they have access to comparative information, so that they are alerted if their performance is out of line and therefore likely to be the target of commissioner pressure.

GPs as commissioners

Community health services will not only be under increasing pressure from health authority commissioners, but also from GP fundholders and GP fundholders in total purchasing schemes. Health authorities have often found community health services hard to understand, but GPs are more familiar with the realities of work in the community and feel better placed to require changes either in direct negotiations with community health services providers, or through influencing health authorities as commissioners.

The current intention is to move towards a primary care led NHS (NHS Executive, 1994) where GPs will have an increasing influence on what services will be commissioned and where and how they will be provided. It will be increasingly important for community health service providers to predict the likely requirements of general practitioners and meet them. The move stimulated by the Cumberlege Report (DHSS, 1986) to establish neighbourhood nursing teams lost considerable goodwill with general practitioners where it led to community health staff working in neighbourhood teams rather than attached to general practice. Most community health providers have now moved to general practice attachment, but strong feelings can remain based on historic difficulties which GPs felt they had in accessing community health services. Sometimes GPs' apparent over-reaction to a current proposal can be traced back to memories like these.

In some ways the achievement of establishing community health district nursing, health visiting and psychiatric nursing as branches of the profession with their own qualification routes may make it harder for community services to recognise the need to work with, and for, general practice. During the establishment of professional disciplines and training for community nursing, it was seen as important to establish independence from doctors. The establishment of community trusts as separate organisations may also initially have led community nurses to focus on their own professional and organisational issues and encouraged a 'stand-alone' position.

With the rapid doubling of the numbers of practice nurses made possible by the new GP contract, there were fears that nurses who worked directly for general practitioners would in some way be 'handmaidens' and less likely to have their professional judgement respected. Recent results show that while there may have been some justification for such fears, practice nurses now feel generally satisfied with their role and their relationship with general practitioners (Atkin and Lunt, 1995). Although there is as yet no nationally-accepted practice nurse qualification, there are now a number of training opportunities. Studies of practices working with attached district nurses, health visitors, community psychiatric nurses (CPNs) and midwives show a high rate of satisfaction for staff, GP and patient; given that attachment is usually made to 'better' practices this is understandable, but it also indicates that it will become the preferred delivery pattern as standards in general practice rise.

Because the general practice serves patients, not populations, there are real problems for both commissioners and providers in organising services focused on general practice (Gordon, 1995). The Cumberlege Report felt that the balance of advantage lay with serving a population rather that attaching staff to GP patients. The balance of advantage is now seen to be with attachment to GPs. There are inherent disbenefits in GP attachment, but in many places these are over-ridden by the advantage of the GP as the most easily accessible first point of contact with health services. However, in areas where it is acknowledged that current general practice is not at an acceptable level (particularly in deprived sectors of large cities), there will continue to be a role for some form of geographically-organised community health service acting as a safety net and substitute for local general practice. It is likely that current changes in the general practice contract, and developments enabling salaried GPs to work in inner city areas will reduce the number and proportion of inadequate general practices. This means that most community health services will see their role change from that of independent organisation to something more like that of an agency providing appropriately skilled staff to work with and for general practitioners, health authorities and others.

The pressure to be 'business-like'

There is no doubt that the health service of the future will be required to be business-like. Although there is now a swing away from applying commercial business principles to the health service without acknowledging key differences, nevertheless the requirement that services be managed in a cost-effective, consumer-focused and well-organised way will remain. This means that staff may have to accept limitations to their preferred practice. Commissioner decisions may be based on cost and patient satisfaction measures rather than clinically preferred measures, and a continuing pressure to demonstrate value for money will include collecting non-clinical information on a regular basis.

Although at one level staff accept the need to be business-like, at another level they resist the invasion of the professional practice area by finance and performance measures. Patient preferences may appear to focus on cosmetic or *Patient's Charter* elements whose value is not given priority by community health staff. Professional staff and managers working in community health services need to be able to point out the consequences of making changes purely for 'business' reasons, without appearing defensive. They also need to accept that as fundholders and innovative community trusts elsewhere show that changes can be made, it will be harder to defend local custom and practice.

MARKETING COMMUNITY HEALTH SERVICES

A marketing orientation is a key part of commercial business practice. Developing an appropriate marketing approach is increasingly important in the health service and community health services. The purchaser–provider split on which commissioning is based means that the commissioner seeks to have a *choice* of providers; a good provider who fails to demonstrate that their services are good may not be chosen; a provider who may be less good but who has paid more attention to 'marketing' may well be chosen.

It is easy to dismiss marketing as commercially-driven, with glitzy advertising and unnecessary expense. Community health professionals who take this view are avoiding the real issue. Marketing is generally defined as the process whereby a business finds out what people want to purchase, provides goods or services tailored along those lines, and thereby develops services which will sell and satisfy customers. Using this definition of marketing, community health services which fail to have a marketing orientation will not meet customer needs and will not be successful.

In providing health services there is no single customer – the patient is one customer, the GP who has the responsibility for the primary health care of the patient is another customer, the fundholder and total purchasing GP who can choose from whom to purchase community health services is another customer, and the health authorities as commissioners are customers; the media locally and nationally, and politicians locally and nationally, can influence all these customers.

In the current climate the general practitioner is emerging as the key customer for community health services, either as direct purchaser through fundholding and total purchasing, or as a key influencer of the health authority through involvement in locality commissioning work. GPs increasingly wish to be involved in the appointment of community health staff to their practices, and are unwilling to work with staff whom they perceive as not working as part of their primary health care team.

The market orientation in health has also to take into account the values of those who deliver community and other health services. There are some services which health professionals are not willing to deliver even though a number of customers may wish them to be provided, and it will remain important to have routes which staff can safely use to alert commissioners to unsafe practice, misuse of funds and unmet need.

If community health professionals work increasingly as autonomous professionals selling their services to general practices, they will need the ability to market themselves as individual professionals worth employing and able to work in a team, with a range of specialist skills. Each community health service professional has to understand what marketing in their context means and, increasingly, the subtle and complex skills which are appropriate to marketing of this kind will be the hallmark of the successful community health professional. Community trusts will need to market the added value of employing staff who work in the trust, emphasising quality, training, support and access to other services. In so far as they are successful and learn these skills, community health services will be seen as successful and effective ways of using health resources.

From universal to personalised service

The health service when it was founded in 1948 prided itself on *not* treating people differently. A key value of the National Health Service was that everyone would receive treatment, without distinction based on ability to pay, social background or cost of their treatment. For many years the uniformity of services was regarded as a sign that the NHS was achieving this objective. Rows of beds with identical bed covers, and rows of identically uncomfortable seats in out-patient departments reflected one interpretation of equity. In the early years of the NHS the public valued and accepted this uniformity.

However, economic, social and technological changes increasingly meant that in other aspects of their life people came to expect a much wider range of choice and a personalised service. The impersonality of the NHS and its uniformity began to contrast unfavourably with the way other services were provided. Other political and social trends encouraged people to think of themselves as individuals with rights, rather than as citizens sharing commonly-provided services. The development of *The Citizen's Charter* and *The Patient's Charter* (DoH, 1991a, 1991b) reflect this trend. Patients prefer to feel services are personalised and their personal needs have been understood. The right of patients and carers to know when a district nurse will call are an example of this trend; ten years ago it was thought acceptable that the nurse could call at any time which she decided – this clearly valued the district nurse's time and assumed that time was of no importance to the patient and carer, who would be happy to have their ongoing activity disrupted to suit the district nurse. We no longer think that this is acceptable. Community health professionals need to project these changes forward to imagine what further changes will be needed as currently acceptable practice moves into the realm of the unacceptable.

So far we have looked at how the commissioning process, which centrally involves decisions, choices and priorities, is going to be increasingly influenced by services appearing to be 'business-like', marketing themselves so that they are perceived as good value for money, showing that they are meeting general-practice customer needs, and delivering an increasingly personalised service.

Commissioning, specification and service delivery

The post-commissioning stage of specifying in more detail the services which the commissioners have decided to purchase also has an impact on community health service professionals. The specification will cover a range of aspects under the general headings of volume and quality; some specifications run to many pages and are very detailed. At the moment we have probably not got the balance right in specifications. Too much time and resources can go into attempting to write detailed, water-tight specifications which are then not followed up and monitored in any comparable detail.

In the past, services were delivered within broad parameters based on a combination of professional decisions balanced by administrative and financial requirements. There has been a move away from these broad agreements based on trusting professionals to do their best. However, specification of complex services delivered in multiple settings, such as community health services, are unlikely to be successful if they hope to pin down the complexity in point-by-point specifications. Probably the middle road will turn out to be a broad description of the services which should be provided, with a small number of measurable standards specified and more closely monitored. The proposed contract of minimum data set for community health services may meet this need.

At a local level it is becoming increasingly vital for each community health professional to understand the specification for the services he/she is paid to deliver. For example, if the specification requires that a given percentage of new patients be seen, every community health professional involved in that contract needs to be aware of this requirement so that they encourage self-help and discharge as soon as possible for existing patients, and achieve the required percentage of new patients. Similarly, if the specification is based on the majority of treatments being carried out in the clinic and community health professionals instead choose to carry out treatment in the patient's own home, the clinic-based target will not be met and costs will be higher than contracted for. Staff also need information on specifications about quality standards and purchasers will increasingly wish them to be monitored.

Costing issues

How services are specified and costed is therefore key information without which it is not possible to practise effectively. If you were running a small community health business yourself and you failed to include the costs of dressings, travel time, annual leave cover and sickness cover when you set prices to charge to customers, you would very soon be a bankrupt small business. Although no health professional wishes to see cost as their first consideration in deciding what treatment to give, no health professional who is a citizen would want public services to be provided without any awareness of cost.

The decision about which services to purchase from amongst a range of providers who all claim to be able to meet the specification will be based on cost and value for money. It is legitimate for purchasers to seek the lowest-cost services, provided quality standards are met, because the more successful purchasers are, in achieving services at less cost than before, the more money will be released for other services and to meet unmet need. Community health professionals in their personal purchasing seek value for money, and it is acceptable that their purchasers should do so too.

It is not always possible for purchasers to find a range of providers to compete, and the term 'contestability' is used to describe a situation where the purchaser has not been able to choose between competing providers, but retains the right to market test services if there is any doubt about the value being offered by the current provider. Some community trusts have begun to market their services to authorities and fundholders well beyond their own headquarters base, and this is a legitimate means of market-testing local services. If there is a growing trend to contract for locally-provided community health services with a distant provider, it will make it difficult for local community trusts to continue to claim that they have a role based on providing services for their local community. It is also likely to make communication and integration with other local services less effective.

Costing community care: complex care packages

The introduction of community care has meant that district nurses and other health professionals working in the community also have to understand costing issues in relation to individual patients.

The community care legislation transferred the funding being spent on social security support to people in private and voluntary sector nursing and residential homes to social services; the aim was to provide an incentive for packages of care to be offered as an alternative to entering a nursing or residential home place. The pre-community care system was not cash-limited: anyone who qualified for social security support and had a place in nursing or residential home care received funding. The new system is cash-limited and therefore offers on the one hand the incentive and possibility of devising imaginative personal care packages in the community, and on the other makes those devising the packages keenly aware of limited resources and costs.

Social services are the lead authority for community care, and the majority of people for whom services are provided are older people, although the system also covers younger people with a disability, and people with mental health and learning disability needs. In some cases health service staff have been given delegated responsibility to be the care manager for individuals, putting together an appropriate mix of health and social care from a range of providers; this role clearly involves making decisions which balance client needs and resources available, and finding ways of meeting needs within resources which offer good value for money and client satisfaction. However, it also makes the health professional aware of the impact on other and future clients of a decision on a current client; if a high-cost care package is put together for a current client, this in a sense makes less care available for future clients, and this impact is particularly important where the current care package may last for some years. This type of decision has always to some degree been a part of the workload management of staff working in the community, but community care makes it explicit. GPs are also now more directly involved through fundholding and total purchasing, and they have a direct interest in how community health resources are used.

Co-ordinating complex packages of care has high overheads in managing contacts with other agencies and professionals involved, in co-ordinating the contributions of a number of different members of staff, and in overseeing care delivery and reviewing client needs to respond to change. The greater the number of such time-absorbing complex packages in which staff are involved, the less-efficient are services likely to seem if they are measured using current performance indicators which record face-to-face contacts with patients as the main indicator.

It is often difficult and inefficient to separate health from social care, and where care is delivered in the patient's home there are high overheads in separating care – if a nursing assistant and a home help both visit to carry out 'health' and 'social care' tasks, the costs of travel and travel time, communication and liaison and employment overheads are doubled. It is likely that there will be an increasing use of generic staff in community care where such staff will be trained to deliver a mix of care needs including elements of care previously seen as requiring qualified health professionals: the private sector may take the lead in offering this kind of care if statutory services are unable to agree ways of providing it. Total purchasing GPs are also more likely to develop care packages using generic staff, co-ordinated by a lead nurse from the practice.

The fact that national health service care is free to clients whereas they can be asked to pay for local authority care on a means-tested basis complicates the picture. The current attempt to agree local eligibility criteria for continuing NHS care is an attempt to ensure that people do not remain in NHS free care if their needs do not require it.

It seems likely for many reasons that more people with greater needs will be cared for in the community in the future. Resources will continue to be limited and staff delivering services will have to be increasingly aware of costs. As care becomes more complex the costs of co-ordination rise and services can appear more costly and less efficient.

Contract monitoring

Contract monitoring in the NHS is still in its infancy. It takes considerable time to build up an understanding of the variation which is inevitable in any service delivery business. In the first years of contracting, variations were sometimes regarded as serious and requiring remedial action when they are now seen to be part of an expected rise and fall which is predictable from past trends. Awareness of what the contract expects, in terms of numbers of patient contacts, length of treatment, case-mix and the like is essential; the contract monitoring process gives feedback on how far the agreed contract is being met, and is an important part of achieving reasonable performance.

The acute sector has found working to contract difficult, and 'over-performing' (carrying out more activity than the contract allows for) is an annual cause for concern. For a number of reasons it may be easier to perform to contract levels in community services, but it may be harder to assess whether the contract is achieving the goal of improving health. There have been repeated criticisms about using number of contacts as the contract currency in community health services, and alternatives such as programmes of care and outcome-based measures have been suggested. However, as information systems improve it is possible to get more detail about the nature of each contact, and more community trusts are now able to show they are targeting services on particular age-groups or patients with more severe conditions.

Measurement of professional health care

In many ways the emphasis on competition, proving that services are value for money, delivering services within an agreed contract, and making value for money of central importance is felt to be a threat by the health professions. Attempts at measurement by people who do not have the daily task of delivering health care and cannot 'understand' what is involved are resented. There is also resentment of assumptions that health professionals are not working as hard as possible, and need to be monitored when most people who work in the health service feel they are highly-motivated and work hard.

Changes in social expectations mean that increasingly the public are willing to ask professionals questions and accept that professionals' work should be monitored in some way – in the past the assumption of superior knowledge held by the professional meant that professional opinions and judgements were less likely to be challenged by the public. Politically and financially, professional knowledge is now also more open to challenge. The fact that professional opinion supports a particular course of action is no longer enough to override objections on the grounds of cost and lack of proven effectiveness. This change in the respect accorded to professional opinion has affected all the professions, including the health professions. The professions are now more aware of the need to explain their actions and justify them in layman's terms, although most people still have trust in health service professionals, and doctors retain their place as senior trusted professionals.

RE-DESIGNING SERVICE DELIVERY

The pressures of competition and value for money have also led to a number of management-led investigations which question current methods of delivering health care. In business and acute hospital services the term 're-engineering' has been used to describe rethinking the way in which the service is delivered to reduce duplication, unproductive time and unnecessary delays (see for example Leicester Royal Infirmary, 1995). The same approach is now an important part of managing and working in community health services. The decision to allow nurse-prescribing is in a sense an example of a re-engineering approach; nurses explained that they often had to repeat a visit to a patient merely because they had been unable to prescribe and use a dressing without returning to the surgery to get the GP's prescription – this process has been re-engineered so that the nurse can herself prescribe and apply the treatment while she is in the patient's home, with clear advantages for the patient who receives immediate treatment, the nurse who saves a time-consuming and non-productive journey, and for the GP who no longer has to write a prescription which does not require his particular level of expertise.

Rethinking the need to have the district nurse visit patients for suture removal is another form of re-engineering; many community health services now use systems which encourage patients to attend their general practice surgery for suture removal if the patient is able to do so. The re-engineering approach focuses on the important outcome – in this example safe and timely suture removal by a health professional who can answer questions and check progress – and then looks for the most effective way of achieving the desired outcome. Typically, improvement results from eliminating a number of steps in the process which on examination are agreed to be unnecessary. For instance, it is unnecessary for the hospital discharge procedure to request a district nurse to make a home visit to remove sutures if it is clear that the patient is able to visit the surgery, and ring up and make their own appointment to do so at a time convenient to them and the surgery.

Purchasers will increasingly be looking for more cost-effective ways of achieving a good outcome for patients. With the increasing ability to compare performance, purchasers will be asking their community health services to match what can be achieved elsewhere. Community health professionals need to understand and respect this approach and adopt a re-engineering way of thinking about their own work. This does not mean abandoning high standards of care or professional judgement. It does mean recognising that many of the ways in which we work have grown up historically for reasons that no longer apply, and that common sense requires historically-based behaviour to be regularly evaluated.

Community nurse managers

Community nurse management and community nurse managers have had to reassess their role in response to changes in general practice and the increase in nursing staff employed directly by GPs.

In the past the role of community nurse manager was not generally valued by general practice. There are some reasons why this is inevitable – community nurse managers had a clear responsibility to the general population which was often in conflict with an individual GP's wishes to improve their share of the community nursing resource. It may have seemed legitimate to a community nurse manager to move a staff member from one practice to another to cover for maternity leave, sickness or vacancy, but it is not surprising that GPs losing 'their' nurse were not pleased. Community nurse managers were often seen by GPs to be unnecessarily restrictive and unwilling to give nurses permission to carry out a range of tasks such as venepuncture or immunisation on the grounds that this was an 'extended role' procedure. Even if nurses were attached to GPs, they were often based in buildings some distance from the practice.

For these and many other reasons even the ablest of community nurse managers found that once GPs had an element of choice through their ability to employ more practice nurses, and the leverage they gained when community health services became part of the fundholding scheme, the inherited hostility many GPs felt meant community nurse managers had to rethink their role. GPs often saw nurse managers as a barrier between them and the nursing services they felt they should have, and they also resented the cost of that barrier.

In business terms, management overheads have to be accepted by customers as adding value; if two firms are in competition and the products seem equally good, the firm whose products are more costly because they have more layers of management which do not seem to add value will be less successful. The influence of the market together with the UKCC *Code of Professional Conduct* (UKCC, 1992) which makes nurses accountable for their own professional practice, the expansion in the range of work which GP-employed practice nurses have undertaken, and the pressure on cost-overheads and the move away from neighbourhood models to GP-focused models of primary and community care, mean that the community nurse manager role has already changed and will continue to change.

GP fundholding means that the day-to-day management of community services staff is largely within the general practice. Although functions like recruitment, personnel and payroll may continue to be carried out by the community health services trust, many of the other roles which used to be part of community nurse management have gone. In the future there will be fewer nurse manager posts linked to community trusts, but an increasing number of opportunities to be the lead nurse within larger primary and community care nursing groups attached to a general practice. Community nurse managers have to convince GPs that they add value. One of their roles may be training.

Clinical nurse grading introduced a new rigour into post-registration training; unless qualifications and training were relevant to current work they were no longer rewarded. There have been significant changes in arrangements for training within the NHS as a result, and training costs have to offer value for money in terms of safer or improved practice. New routes to more focused and effective training are developing with National Vocational Qualifications (NVQs) and distance learning. GPs want short, effective, relevant training for their practice nurses, delivered close to the practice with a content which clearly benefits patient care and enhances the practice.

Specialist nurses

The role of the specialist nurse is also likely to change and expand. As care becomes more focused on the general practice there will be a need for specialist services which recognise that even a large practice will not contain enough cases of less-common conditions to give staff attached to the practice the necessary experience to offer good services. New arrangements will be required to provide specialist services; a specialist practitioner could meet the needs of a group of practices or offer training and advice to staff in the practices. In some cases this specialist service will be provided by national charities (epilepsy for example), or by drug companies with an interest in special conditions.

Acute services are increasingly interested in the specialist outreach nurse as a way of taking acute services out to primary and community care settings. Most community trusts already employ some specialist nurses – diabetic, stoma and palliative care for example. It is likely that there will be a greater number of specialist nurses in the future, working from a number of different organisations. Knowing how to work effectively with specialists, keeping up to date with what specialist nursing services are available and ensuring that referrals are appropriate will be important skills for primary and community nurses in the future, and may require a change in current attitudes (Fawcett-Henesy, 1995; and Hennessy, 1995). For the community nursing manager, trainer or specialist nurse working in a primary care led NHS, the challenge will be to enable nurses to provide services which are flexible enough to meet the needs of individual general practices and primary care teams, of a high enough standard to add value convincingly with minimum management costs, and innovative enough to offer new services and styles of service at short notice without losing the reliability and continuity which are also required.

Technology and community nursing

Advances in technology will also affect the work of community nurses. Communication technology in particular will mean that nurses are contactable when out of surgery. Advances in pharmacology mean that many medicines are safer in use and can be administered in individually-prepared packs which no longer require a qualified nurse to administer them. Other advances in technology have enabled tasks which previously required a high level of skill to be systematised or computerised so that they can be carried out in the home, or by someone with a lower level of skill and appropriate training. If outcomes are shown to be equally good, the use of the higher level of skill is no longer justified.

The acceptance of change is clearly important, and will be a permanent part of the working landscape. Change will, of course, be accepted much more readily if there are understandings that staff will be retrained where new skills are indicated, moved to new work rather than find themselves unemployed, and where the need for the change has been convincingly demonstrated.

Health and social care

The boundary between health and social care will remain an issue for the lifetime of anyone reading this book. For nurses, this boundary has implications which are at the heart of the value of nursing and nursing values. Many nurses argue that it is in the process of caring for patients in the broadest sense that the value of nursing as a relationship between nurse and patient is expressed. Others claim that by being involved in work with patients which is not strictly clinical nursing, nurses have a wide range of opportunities to develop patient self-esteem, promote patient health and observe clinical signs. However, it seems likely that there will be increasing challenges to the claim that 'only nurses can do this task' as non-nurses are shown to be able to carry out the tasks, and patients and carers take on increasingly complex tasks previously done by nurses. There will also be increasing challenges of 'dumping' and cost-shifting as nurses move out of social care tasks. The arguments about medical and social bathing are well-known examples.

The nurses of the future: supply–demand issues

Many of these issues will be linked to the future supply of trained nurses. There are already known difficulties in recruiting nurses for acute-sector specialties such as paediatrics and intensive care. It is becoming harder to be confident about the national training picture as nurse training is also affected by a range of far-reaching changes, and at a time when a new style of basic nurse training, *Project 2000* (UKCC, 1987), is still in its early stages. If an increasing amount of work previously done through the NHS is done by the private sector, it will also make the assessment of the requirements for current and future trained nursing staff more complex.

The availability of other staff will also affect the future role of nurses; the need to organise the hours of junior doctors to meet new restrictions on their working week, the shortage of doctors in some grades, specialties and geographical areas, and the demonstration that some tasks currently undertaken by doctors can be safely delegated to nurses will tend to increase the number of specialist and practitioner nurses.

The title 'nurse practitioner' is used to describe a nurse who chooses to work relatively independently, and who in particular accepts patients directly rather than through a referral process managed by a doctor or a health organisation. There are examples of nurse practitioners offering minor-illness and casualty services to the homeless, clinics in the community, self-referral nurse practitioner clinics within general practice, and nurse practitioners operating within general practice providing agreed services which have been delegated by general practitioners. For some nurses this option will be attractive, offering greater autonomy. Studies show that the service is appreciated by those patients who use it, but that nurse practitioner services do not necessarily represent cost savings (Fawcett-Henesy, 1995).

More opportunities, less freedom?

In some ways community and primary care nurses in the future will therefore have more autonomy, but in other ways they may have less. We have seen that the commissioning role and the purchaser–provider split means that the choices which have always had to be made in deciding which health services to provide are now more explicit. Choices are also more explicit now for community health nurses.

Increasingly nurses will be working within agreed protocols, guidelines or programmes of care where their choice of treatment, length of treatment and follow-up will be made within agreed parameters. Protocols are often developed at a local or individual practice level, although many of them follow similar models so that transferring from one practice protocol to another is unlikely to be difficult. As the use of protocols and guidelines increases, more community health nurses will find themselves moving to posts where they are required to work within a protocol or guideline which they have not been involved in developing.

In this sense nurses will be less autonomous and will have to be able to account for any departures from agreed protocols and guidelines. It is likely that the increased use of protocols to ensure standards of care, threat of litigation favouring adherence to protocols, and the increased use of information technology to prompt agreed protocol use, will lead to less individuality in practice. From the point of the view of the patient this may be an advantage; many patients report that conflicting advice from professionals causes confusion.

There may also be less autonomy in deciding priorities between patients. Health professionals have always been expected to prioritise their own workload, and it is one aspect of working as a professional to be equipped with the knowledge and experience to enable presenting patients and problems to be ranked in terms of their urgency and relative priority. The new issue now facing health professionals is that priorities may also have been decided in contracting terms. In most cases contract priorities will mirror professional judgements, but in cases where they do not there can be real conflict for health professionals. These conflicts may be particularly acute in primary and community care where the patient may well be living in unsupported home conditions such that if the nurse, for example, stops visiting, the patient will not be receiving care from any other source. Community nurses and their managers need to act as advocates for patients who may not be on the contract priority list, but whose health and social circumstances in all their complexity require them to be treated.

One advantage for community nurses of working closely within primary care is that the interaction of health and social circumstances are more likely to be understood by general practitioners. Early signs are that as fundholding extends into total purchasing and GPs are responsible for the whole continuum of care, they acknowledge that health care without social care is not enough. A number of GP fundholders have succeeded in arguing for practice-attached social services staff, and total purchasing is likely to increase this trend as long as savings from acute care allow.

FUTURE TRENDS

As the population ages, more and more health and social care will be delivered to the very old, who will increasingly be living alone without close family support. Although some advances in technology, such as alarm and monitoring systems, improved home equipment and automatic drug dispensing and recording systems, may make maintaining frail elderly people alone at home more feasible, it is unlikely that there will be a significant reduction in the high cost of supporting vulnerable people in their own homes. In some ways nursing care in the patient's own home is likely to become relatively more expensive: cost reductions are less possible in areas of work where the major input is staff time, and there are limited ways of automating staff input and reducing costs.

Although the introduction of the purchaser–provider system has opened up opportunities for private home-care agencies to compete with the statutory sector, it appears that in order to be cost-competitive many private home-care agencies have to offer terms and conditions of service to non-nursing staff which are too low to attract a stable workforce able to give continuity of care. A low wage and serial short-term contract workforce, nearly all women, will itself be unable to build up adequate pension entitlement, and will thus create an increasing number of future elderly people unable to provide for their own old age.

It is likely that more community staff will become directly employed by GPs. If the government's wish to see providers develop is realised, many more community staff will work in new organisations, including voluntary and not-for-profit providers. Some staff will set up provider organisations themselves; the example of the independent midwives is likely to be repeated. A large number of nurses already work in the private nursing home sector, often on a part-time basis, and it is likely that part-time private nursing home and agency nursing in the patient's home will increase. For many nurses the possibility of part-time working to enable them to manage family responsibilities is a key requirement.

This style of working may offer flexibility to community health professionals with other responsibilities, but it will raise issues of access to training, team-working and familiarity with protocols and work-place regulations. The requirement for nurses to demonstrate that they have received relevant training is now a condition of registration, whether employed by the health service, general practice, a private nursing home, an agency or working as a freelance. We are likely to see an increase in the range and types of training on offer. As the role of training expands, issues of quality and comparability of training will become problems too.

The general picture is of a profession whose members are more likely to work outside the current trust-based large organisations with their restrictions, protections, opportunities and regulations. Individual practitioners will increasingly have to prove their values, learn how to work so that their professional contribution is valued, recognise that lifetime employment with one public sector employer is decreasingly likely, and work in a way which expects change to be ongoing. Accountability and responsibility for standards of practice, training, career-management, pensions and insurance are more likely to be issues for each individual nurse.

As community health nurses move away from employment in large community trust-type organisations to working as members of small teams in general practice or as sessional nurses, there will be a wider range of ways in which to work as a community health nurse. Some of the restrictions and problems which are a part of membership of large organisations working within a centralised nationally-directed service will be gladly left behind. Some of the security and protection it offered for staff and patients may be regretted.

There has never been so much national determination to ensure that primary and community care services should be developed. Community health service nurses have the relevant experience and knowledge, and if they are able to understand the reasons for change and adapt their nursing and managing skills appropriately they will also develop. Managers in community health trusts have a responsibility to help staff adapt to the new styles of work required by the changes in health care and the focus on primary care.

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CHAPTER FOUR

The Development of Primary Care

Caroline Taylor and Geoff Meads

A BRIEF HISTORY

Primary care has occupied a pivotal role in the NHS since 1948 with GPs acting as the first contact for over 90 per cent of users of NHS services, and acting as gate-keepers to the majority of other services. At the same time primary care has arguably been at the margin of the organisation, through a combination of the zealously preserved independent contractor status of GPs and the management of community health services by local authorities until 1974. Even after the integration of community health services into the NHS in 1974, family health services remained quite separately managed, although from 1974 until 1982 family practitioner committees (FPCs) were formally committees of the Area Health Authorities. From 1982 until 1990, family practitioner committees reported directly to the Department of Health (DoH).

The Charter for General Practice, produced in 1966, succeeded in raising the status and perceived value of general practice within the NHS. Nonetheless, in 1981 Acheson was still identifying significant problems with the quality and resourcing of general practice in inner London, and the picture which he painted could equally well be applied to other urban areas (Acheson, 1981).

From 1990 onwards, however, primary care has undergone substantial change. The NHS and Community Care Act 1990 (DoH, 1990), through the purchaser–provider split and the establishment of GP fundholding, began to change the balance of power between hospitals and primary care, particularly GPs. Family Health Services Authorities (FHSAs) were created to replace FPCs with an expectation that they would take responsibility for the planning and development of family health services to meet the needs of their populations, rather than being merely administrative bodies to support the practitioners. District Health Authorities (DHAs) also had a population focus without the previous tensions of having to reconcile the interests of the local population and the management of provider units, part of whose role was frequently to serve a different population. GP fundholders began to contract for services for their practice population and to manage a cash-limited budget comprising a mixture of hospital services plus their own prescribing and practice staff. The fundholding scheme was rapidly expanded to include community health services as well.

The Act also reaffirmed the development of community care services as a priority and gave local authorities the formal lead in planning such services. In 1993, local authorities were required to commission social care to meet the needs of the priority client groups, defined as elderly people, people with a mental illness, people with learning difficulties, and people with physical disabilities, and to secure such services for individuals requiring them through the process of care-management. The requirement for individual assessment, followed by the establishment of an appropriate package of care managed by a single person, was designed to produce an appropriate response to individual needs in a historically unco-ordinated area of service provision. The developing role of local authorities as commissioners, albeit in a less defined form than health authorities, and the health authorities' new focus on their populations combined to encourage a variety of approaches to jointly delivering or jointly commissioning services for the community care client groups; while the care-management approach led in a number of areas to increased working across health and social care boundaries in respect of individual clients.

Other changes in emphasis within the NHS were occurring in parallel in the early to mid-1990s.

The *Health of the Nation* (DoH, 1992) formally established a commitment to health promotion and the prevention of ill-health, as well as the more traditional role of the NHS in its response to ill-health. This development had also been signalled in the GP Contract of 1990 which, through its requirement for health checks at regular intervals and reward for health promotion activities, marked a significant change from the previously recognised role of the GP focused mainly on the treatment of illness, although in practice many GPs were already moving in that direction. Similar shifts occurred in oral health and dental services with the publication in 1994 of the Green Paper *Improving NHS Dentistry* (DoH, 1994b) and the *Oral Health Strategy* (DoH, 1994a). Both sought to move away from the general dental services tradition of remedial treatment, towards an emphasis on prevention.

This was a period, too, of increasing emphasis on the rights and responsibilities of the individual, partly reflected in policy statements such as the *Health of the Nation* but most strongly the *Citizen's Charter* initiative (DoH, 1991a) which within the NHS became the *Patient's Charter* (DoH, 1991b). The Children Act 1989 (DoH, 1989a) similarly made clear the paramountcy of the interests of the child in all work with children.

The NHS also began to address the issue of effectiveness in health care. The promotion of medical then clinical audit through designated funding from 1991, and the publication in 1994 of a Research and Development Strategy (DoH, 1993b) for the service and subsequently in 1994 the Culyer Report (DoH, 1994c) on research and development, signalled a recognition of the interrelationship between services and research and the need to focus on the effectiveness of interventions to make the most effective use of resources, while recognising the legitimate role of the NHS in supporting relevant research.

The Tomlinson Report in 1992 (Tomlinson, 1992) followed by the Secretary of State's response *Making London Better* (DoH, 1993), recognised the need to develop primary care in London as complementary to the requirement to rationalise hospital provision to meet changing needs. Similar analyses were undertaken on a local basis in other cities such as Birmingham and Newcastle. These strategies complemented the developing impact of fundholding, which increasingly made primary care the focus of the health service, with secondary care acquiring the role of specialist support. This contrasted with the previous organisational model in which the hospital arguably formed the hub, with community services the spokes and general practice at the rim.

Integration of primary and secondary care began to be reflected at health authority level, with DHAs and FHSAs increasingly working in partnership and often integrating their management organisations to form 'agencies' or 'health commissions'. The overall influences during this period were the need to control public expenditure, the development of a management market approach in health care, deregulation, and the simultaneous promotion both of consumerism and of a population-based approach to health care.

The Health Authorities Act 1995 (DoH, 1995) which abolished Regional Health Authorities and established a single health authority for each area, replacing both DHAs and FHSAs, marked the first formal integration of primary and secondary care structures. Perhaps more significantly, management guidance which accompanied it, from EL(94) *79 Developing NHS Purchasing and GP Fundholding*, established a framework for a primary care-led NHS (NHS Executive, 1994).

Arrangements for GP engagement through fundholding are being extended with the introduction of 51 total purchasing projects from 1 April 1995 on a pilot basis, in which groups of GPs purchase the full range of health care for their practice population; from 1 April 1996 general practitioners with lists as small as 3000 will be engaged through community fundholding (covering community health services, the GP's own prescribing, and practice staff), and the minimum list size for standard fundholding will be reduced to 5000 patients.

The new health authorities have as their main functions the development locally of strategies to meet the health needs of the local population; the commissioning of health care; support to primary care; particularly GPs, in commissioning health care, and monitoring. This takes the involvement of primary care in the overall commissioning of health services a significant step forward, with the strategic intention being that primary care will take the lead with the health authority undertaking a co-ordinating, supporting and regulatory role, but no longer directly responsible for contracting for services. This is undoubtedly a long-term agenda and requires substantial development of primary care in many areas, both in its role as a provider of services and in its capacity to commission. It also assumes that as commissioners GPs will function as part of the corporate NHS, accountable ultimately to parliament for the use of public funds and the delivery of national policies. This is a significant qualitative change in the relationship of GPs with the rest of the NHS; the price of power is the loss of some independence.

PRIMARY CARE – THE TROJAN HORSE

One of the main aims of the reforms described above was to liberate both thinking and practice in the NHS. Prior to 1991, the NHS rivalled the prison service in its preoccupation with institutions. Given that most appointments were drawn from the ranks of ex-hospital administrators the advent of general management following the first Griffiths Report (DHSS, 1983) had actually done little to challenge this insularity of the NHS, particularly as new top-down management techniques, such as the Efficiency Index (which is a tool used by the Treasury to assess NHS productivity), were largely directed towards the secondary care sector. By 1991 the need to break up this closed mind-set had become not only intellectually desirable but a functional imperative. The overall performance of the reformed NHS, with its new responsibilities for health as well as health care, depended upon its capacity to operate effectively both with other public sector enterprises, such as housing and transportation, where market principles had already been introduced in the 1980s, and within a policy framework that was more and more defined externally through such forces as European Community legislation and international developments in managed health care.

The fundamental shift of attention from the hospital to the primary care setting in the 1990s has been a critical factor in this process of freeing up the NHS. The positioning of the general practice as the pivotal role in purchasing as well as the first stop for NHS provider investment has itself compelled a new relationship between the NHS and the private sector, given the continuing independent-contractor status of the former's lead professionals. The rapid expansion of general practice fundholding is spawning a range of organisational alternatives with which health authorities can now contract, from limited companies to legal partnerships, from consortia to charitable trusts. On the back of primary care development the modern NHS has become a mixed economy. As such, both its potential risks and resources – in terms of capital, personnel and finance – have been substantially expanded. And as with all mixed economies the most taxing questions for the new *Primary Care Led NHS* (NHS Executive, 1994) revolve around accountability: how and when to intervene, if at all?

So, GP-led primary care has been the government's Trojan horse. An appreciation of its impact on the NHS cannot be gained simply by understanding the 1990 General Medical Services Contract (DoH, 1989b) or even the constantly changing fundholding regulations. For community nurses and other professionals affected by what often feels, in some cases, like a relentless shift to not just GP-led but GP-dominated primary care, it is important to understand what dividends this shift brings, other than the levels of enhanced patient care that may be far easier to assert than to demonstrate.

Primary care planning is, of course, always a highly participative process, and at least six contributions can be identified in the matrix of motivating forces behind its current development. By looking now at what these are and how they impinge on contemporary models of general practice, a much better understanding may be gained by primary care teams of how their future identities will be formed.

PRIMARY CARE DEVELOPMENT – THE MOTIVATIONAL MATRIX

The small business

The first factor is that of the general practice as a competitive small business. Demand-driven, privately-owned and part-funded, with intrinsically low management overheads as a result of its professional partnership status, the promotion of general practice falls right in the middle of late twentieth-century macro-economic change. As traditional industries have declined and Eastern suppliers have dominated new technology developments, the growth of Western economies has relied heavily on the expansion of small businesses, often into sectors previously taboo for private sector entrepreneurialism. The attachment of the individual to his or her GP, of course, helps legitimise the movement to public service businesses as an integral part of the national health care system.

Parallel developments can be observed in, for example, Holland, where the tradition of publicly-funded independent-sector care has been much stronger. The overriding ethic of the Dutch system is solidarity, and one of the challenges facing the UK in the years ahead is the extent to which the normative consensus on which the NHS has relied for its sense of purpose – as a comprehensive, free and equal public service – can be effectively supplemented by the essentially remunerative incentives that come as a result of a new commercial overlay expressed in terms of increased choice, differing quality standards and, above all, competition.

NHS trusts were devised with close reference to their hospital counterparts in Holland. These are used to operating within EC competitive tendering regulations. In UK primary care these too are now beginning to apply. 1995 witnessed, for example, the first entries in the European Journal from an English health authority (Dorset) wishing to place up to ten contracts (at a value of over

£1.5m) with a general practice in Lyme Regis for a range of facilities from chiropody to hospital-at-home that, in financial terms, at least matched the income from the national General Medical Services Contract.

Consumerism

Small businesses have customers and trade in a market-place. Markets are inherently dynamic responding *inter alia* to changing public fashions and preferences. General practice-based primary care has accordingly been an important vehicle for bringing the forces of consumerism into the wider NHS. Practice brochures, local information directories and patient satisfactory surveys are the most obvious and readily acceptable signs of this new trend.

But the new consumerism of the NHS has its harder edges as well. In an environment of demand outstripping limited financial resources, virtually all national health care systems have looked to deploy their resources to legitimise priority-setting in terms of overall investment and the rationing of individual care. This has taken different forms: from the (refundable) entry fee to see a doctor in Sweden, to the merger of private insurance companies with public Sickness Funds in Holland, and the marketing of different health-care assurance packages to employers in the United States. The public, as individuals, has to select and the primary care business is the first to respond and adjust its services. This means automatically that the consumer must be better informed, and in the UK with the general practice as the gate-keeper to all NHS facilities it is here that the whole fusillade of opinion-forming data, from self-help health promotion booklets to waiting-list league tables, is now being targeted.

The new consumerism is both an antidote to traditional democratic control of public services and a supplement. At its crudest in the UK it creates a new system of checks and balances between local councillors and GPs. The latter's position as the consumer's advocate now has to be taken into account by elected representatives, particularly as local authorities witness both their own roles in direct provision and electoral turnouts dwindle.

Subsidiarity

General practices can only, of course, be agents of a central government's determination to counter fluctuations in local authority positions if they have real and significant resources at their direct disposal. It is here that the NHS's 'new consumerism' and the EC principle of subsidiarity go hand in hand. General practice fundholding (GPFH) is the classic statement of local decision-making with budgetary control.

Although indebted in part to such earlier associated developments in the UK, including the growth of housing associations and the local management of schools, GPFH has far outstripped all other public service initiatives designed to transfer resource allocations and differential funding policy issues from the national to the local level. Its perceived success, in parallel with its counterpart in the New Zealand Independent Primary Care Provider Association, has attracted enormous international interest.

This is not simply because of the opportunities for financial control of prescribing and secondary care that fundholding appears to offer. Recurrent 3 per cent underspends and less-expensive skill-mixes are certainly impressive, but essentially only as by-products of a primary care-led NHS which allows government to move from (escalating) activity-driven to (controlled) population-based health care funding. A future government may begin to contemplate, as the acute sector downsizes and reconfigures, whether public sector capital investment in NHS providers will even be necessary or appropriate in the future.

In short, a primary care led NHS starts to look like a best buy.

Value for money

The value for money (VFM) banner has been raised since 1980 as a series of professional monopolies have been challenged. Consultants, lawyers, teachers and social workers have each seen their exclusive claims to determine services reduced as the focus has moved to the individual and his or her needs. The principle of individual needs assessment is at the heart, of course, of the conventional general practice consultation. Since the 1990 legislation introduced care management, it is now similarly located for community care. Operational convergence may well only be a matter of time, and with GPs and care managers increasingly occupying the same primary care setting the prospect of combined health and social care organisations superseding conventional GP partnerships becomes a tenable proposition. Local authorities such as Wiltshire and Somerset are already directly funding staff in primary care teams, which in turn are having to sign up to the local authority's service level agreements or contracts.

Anti-bureaucracy

The outcome of such joint commissioning is a set of contractual relationships which converts the individual GP from independent contractor status. He or she becomes another part of a service unit, the extended primary care team, in the independent sector. The continuous shift of service-delivery responsibilities from being publicly-accountable and directly-managed bureaucracies to the independent sector is the fifth underlying factor in contemporary primary care development. This is the anti-bureaucracy dimension to the motivational matrix.

In the simplest terms, with the post-1991 division of functions, purchasing is seen as a direct public responsibility whilst, increasingly, providing is not. Released from most of their obligations for the latter, health and local authorities have been able to develop a new range of service specifications reflected in a wide range of contracts of differing lengths and scope, each with their own incentives and penalties. For social services departments the attraction of primary care as its independent sector is increasingly irresistible given central injunctions to direct 80 per cent of its community care investments in this direction, and the paucity of alternatives. Whilst the UK independent sector can embrace private and commercial enterprises as well as voluntary and not-for-profit organisations, in reality all forms of independent sector care provision have been underdeveloped. Agencies such as Mind, Mencap and the National Schizophrenia Fellowship, to name but three, have their histories as representative bodies, not providers. With commercial banks having their fingers burnt in the early 1990s, the estate agency fiasco, residential benefits cash-limited for the first time, and the property market remaining flat, major private companies have yet to make a major entrance on to the provider stage. Expanding general practices is an altogether better bet, especially as the scarcely visible transfer of management-overhead costs is usually only part-funded and always justifiable in terms of reducing public bureaucracy.

Primary care development has become, as a result, a convenient home for difficult causes. In the last analysis it offers, through GPs, an acceptable face for decisions on priorities, or in other words the rationing of care.

The principle of diversity

In parallel with the anti-bureaucratic tendency, over the past ten years throughout the public services the restrictive practices of professional monopolies have been addressed by central government. The introduction of the national curriculum in teaching is the classic example, but medical consultants and lawyers would equally feel that their hegemonies have been eroded.

This trend has also applied to general practice. At the heart of fundholding is the direct attachment of financial control to clinical responsibilities, and the change in the role of authorities described above increasingly challenges the self-regulating status of general practitioners, as the latter move away from a single national General Medical Services Contract to arrangements which involve the former increasingly as the regulators and performance monitors of primary care.

In the NHS these trends are driven by the growing legitimacy given to the principle of diversity. Presented as the other side of the coin to consumer choice, this can be identified as the sixth main driver behind primary care development. Primary care led purchasing itself is creating a new diversity of organisations and organisational status in primary care: multifunds, preferred providers, community care centres, charitable trusts, limited companies, total fundholders and so on. With diversity comes competition as the illusion of a standardised NHS collapses and the latter transmutes into a complex of health care markets operating within an increasingly diminishing national framework of strategic priorities – the first of which in 1996/97 is primary care development.

In the following section we offer examples of four different practices which illustrate this increased diversity. Table 4.1 illustrates how the six dimensions of the motivational matrix behind primary care development, described in this section, impact differently on these four practices. There are no universal truths in today's NHS; different histories, geography and cultures can now much more easily mould development. Staff and patients may have to be much more discerning as a result.

PRACTICE A: STANDARD INNER CITY

A three-partner practice working from a converted house in an area predominantly residential with some light industry and near to a

Table 4.1 Primary care development (a motivational matrix)

Factors	*A Standard inner city*	*B Street team*	*C Rural market town*	*D Suburban managed care*
Small Business	Determines economic survival: conflicts with local service ethos	Not currently an issue, but may be important in future	Comes naturally; at heart of local culture	Driving force behind expansionist tendencies
Consumerism	Increasingly responsive, but on its own terms	Expressed as protective paternalism	Legitimises extra payments for services	Harnesses local public support to counter central accountability
Subsidiarity	Reluctant to have to take on decisions priorities	Driving force; resent any external controls	Consolidates position as leader of local public service	Maximises market potential
Value for money	Fulfil requirements but object in principle	Justified by need more than outcomes	Assumed as natural quality	Key indicator versus health authorities and trusts
Anti-bureaucracy	Opposed to bureaucracy in principle, dependent in practice	Releases local freedoms	Basis for local alliances with patients	Important at start-up, but at risk of becoming the new bureaucracy
Diversity	Unaware of wider developments	At leading edge, and proud of it	At leading edge, and proud of it	Survival depends on this

local shopping centre. The list size is 6300, with moderate to high levels of social deprivation, 20 per cent mobility within the practice population, approximately 300 refugees on the list, a similar number of homeless people, a total of some 1600 patients from ethnic minority groups including the refugees, and some 20 registered drug addicts. The GPs earn approximately £40 000 each before personal tax (just below the current national average for GPs of £43 000).

The practice team comprises three doctors, a manager, a practice nurse and receptionist. A counsellor attends for two sessions a week. Health visiting and district nursing teams are attached to the practice despite significant initial resistance from the local community trust. Community mental health services and midwifery are practice linked. The practice has a dietician attending for one session a week and is developing links with a local community pharmacist who is working with the partners to provide prescribing advice and develop a practice formulary.

The practice would like to see linked or attached social workers and physiotherapists, and is contemplating the employment of a nurse practitioner. The practice is not fundholding but wants to have better control of the services it uses, particularly community health services. It has begun a community-orientated primary care project with the intention of strengthening the working of the primary care team and developing a better understanding of the needs of its local population for mental health services. It is also working with the health authority on developing practice-based needs assessment and, in conjunction with other practices in the area, to pilot an intensive home nursing service.

The nursing members of the team enjoy being part of a practice team and appreciate the continuity of service which they are able to offer to individuals and to communities. They share the team's general philosophy of providing a holistic approach. There remain some issues of role definition to be resolved in the team, particularly between the practice nurse and the district nurses and health visitors, and there is some ambivalence among the existing team about the employment of a nurse practitioner who might deprive them of some of their more interesting work and perhaps lead to a skill-mix review, although in principle they support the idea of an extended role for the profession. The nurses and health visitors generally would wish to see more focus on promotion of health and prevention of ill-health. They have some feelings that the medical model is too treatment-focused.

PRACTICE B: PRIMARY CARE STREET TEAM

One part-time principal salaried by the Department of Health plus doctors working on sessional basis from local practices. Three nurse practitioners or clinical nurse specialists, two 'E' grade and two 'B' grade nurses recently recruited. Community health services and social services provide sessional input. The team is based in an inner-city district and works from a number of sites including drop-in centres and the premises of a range of organisations, many of them voluntary, working with their client group. It provides both a direct service to unregistered street people (defined as homeless people, prostitutes and marginalised groups, often with HIV and/or drug-related health care needs) and support to other professionals in working with these groups. It has some long-term clients, but with many changing, either as they move away from the area or, more positively, as they register with local practices.

The team is committed to integrating services for street people with mainstream services rather than developing a ghetto or marginalised service, but team members at present are ambivalent about the desire or capacity of mainstream services to provide appropriate responses. There are increasingly links with specialist services particularly in relation to TB, HIV and drug use. The style of the team is co-operative, although the most senior nurse has recently been appointed as team manager following the first yearly review, which indicated that the team lacked coherent direction and that there were serious tensions between the different professionals, particularly the doctors and nurses. The team has enjoyed its relative autonomy and is ambivalent about the development of a more hierarchical approach with the appointment of the manager and the lower-grade nurses, although most team members would acknowledge privately that the previous arrangement was inefficient, requiring very frequent team meetings to resolve relatively minor issues and highly-graded nurses undertaking work of a basic nature which did not make use of their skills.

The team is currently directly managed by the health authority, although there is a recognition by both parties that this should be an interim arrangement. The team is resistant to being managed by the local community trust and would prefer to be recognised as a local practice in contract with the health authority.

Other options include joint commissioning by the health authority, and the local authority or the commissioning of services by GP fundholders and other devolved purchasers. The team recognises the need to respond to changing circumstances and to target its services at otherwise unmet needs, but there is some frustration at what are perceived to be increasing external controls and the loss of previous freedom to set the agenda. The staff worry that others will not fully value their client group or their own work, but they also acknowledge that their present arrangements may leave them marginalised. They want to contribute to developing a model of primary care led services which include those who have previously been poorly served by conventional general practice.

PRACTICE C: RURAL MARKET TOWN

A six-partner practice based in the new and spacious premises of a large medical centre, partly funded through the FHSA-administered cost–rent scheme and partly through the capital investment of a major retail pharmacy. The latter has a community pharmacy on the premises. The overall list size is 11 500 and includes patients from surrounding villages. The town itself has an 18 000 population and there are two other small practices which combine with practice C on the out-of-hours rota.

Although there are no deprivation areas in Jarman terms, rural unemployment is a growing issue and the lack of public transport services is one of the most persistent complaints. Having initially opposed the scheme, the practice is a community fundholder and the district nurses and health visitors operate as part of one team with the practice nurses. A combined patient's record is used by all professionals, supported by a single information technology network in the practice.

The senior partner is the lead fundholding partner. His father was also a local GP and in the past he has served on the district council. Two of the other partners are on the board of a local charity, the fundraising from which helps support the range of services provided at practice C. These include both homeopathy and a number of alternative therapies. Practice-based physiotherapy, chiropody and counselling are long-established. Fifteen per cent of Practice C's patients make use of private medicine. Despite this, both secondary-care referrals and prescribing costs are a little above the district averages.

The practice is keen to preserve its good local name for medical and paramedical services. It wants the district general hospital in the next town five miles away to be retained despite growing doubts about its critical mass in terms of both clinical expertise and population catchment area. The practice is closely involved in discussions about the future of the A&E department and has reluctantly agreed to consider becoming the town's primary-care emergency centre supported by all GPs.

Working relations with the divisional social services department are functional but relatively distant, following a long series of changes in social worker personnel. Most contact is around referrals for residential care. The practice has considered taking proprietorship of the large local nursing home since the community care reforms developments (DoH, 1990).

PRACTICE D: SUBURBAN MANAGED CARE ORGANISATION

A seven-partner training practice with two assistants and a registered list of 17 000 including 2 000 college students. Operates from a 1970s health centre bought from the community trust with FHSA support, and recently extended through DHA capital investment to allow for the provision of day-surgery and X-ray facilities. The practice population covers a wide social mixture including both significant commuter and council-estate elements.

The centre is served now by a limited company, of which the full-time partners are the board members. The company has eight service contracts with the health authority which include dermatology, hospital-at-home, audiology and respite care services. The community nurses are employed direct by the company, having previously been part of the local NHS trust. They are now responsible for the social services department's local care-management allocation which has been delegated to the practice. The latter terms itself a 'community care centre' and its significant public information service includes welfare rights and benefits advice.

One of the partners is a member of the local health commission, which is encouraging the practice to become a total fundholding pilot. The partners are, however, divided on this subject with some reluctant to become part of the General Practice Fundholding (GPFH) accountability arrangements. One partner writes in the professional press on the potential benefits of an insurance-based NHS with a patient-voucher subscriber system.

The strategic vision of the practice (not published) is ultimately to take on employment responsibility for several of the clinical functions now provided at the town's hospital. It believes the latter has a limited life expectancy, under pressure from a major teaching hospital 12 miles away. It is in negotiation with the Rowntree and Nuffield Foundations on joint ventures designed to extend its range of service outlets.

WHERE NEXT?

The developing model of a primary care-led NHS has a number of inherent tensions. Most obviously there is the need to deliver national policies and strategies across the country, but a potentially conflicting expectation that health authorities will respond specifically to differing local needs and to the wishes of their own communities. This tension is replicated at local level with health authorities held accountable for the development of local strategies and the co-ordination of their implementation, but with a strong emphasis on the value of primary care-led commissioning reflecting the ability of practices to respond to the differing needs of their populations.

Diversity is therefore an increasing theme, but within a national framework. The very nature of local health-care markets varies considerably. Some, particularly in city areas, can be highly competitive with commissioners having easy access to a range of providers, both NHS and independent, and a degree of spare capacity allowing the movement of work, although traditional loyalties to particular institutions, the complexities of obtaining a consensus for major change, and the policy decision to maintain a degree of management in the market have so far mitigated the extreme consequences of a purely competitive approach. In significant parts of the country there effectively remain monopoly or near monopoly supplies for most services, the imperative of geographical access preventing competition from any distance, and the cost of entering the market, combined perhaps with conservative behaviour by commissioners, leading to relatively few alternative providers developing.

Within each local market there is significant diversity in the provision of primary care, linked to the independent nature of GPs as contractors and as individuals providing personal services to a particular group of patients, the needs of different populations within a particular area, and historical and cultural factors affecting the baseline from which primary care is developing and the influences on practices and individual practitioners. Thus, for example, a large inner-city practice meeting the needs of a highly-deprived and mobile population, with GPs paid less than the national average but with consultation rates higher, may have very different motivations and work within very different networks from a similarly-sized practice located in a reasonably affluent market town and serving a relatively stable and homogeneous population.

Historically, general practices have been very small organisations, at one extreme a single GP with little or no support staff. The complexity of managing and developing primary care in the late twentieth century, together with the costs of investing in premises and other support, has generally led to an increase in practice size and the development of sometimes very extensive primary health care teams. But even a large practice is unlikely to have a total personnel complement of more than 30. The trend nationally towards larger practices and a decline in single-handed practitioners is hard to discern in many cities, and the increasing tendency of FHSAs or health authorities not to replace retiring single-handers is frequently offset by splits of larger practices.

New vocationally-trained GPs tend to have trained in larger practices and to have an expectation of working in a medium to large practice in order to develop a range of services which they believe appropriate, and to avoid too onerous a burden of out-of-hours cover. But there is evidence that many patients prefer the personal services of smaller practices, and the general need for good geographical access to primary care means that in many parts of the country the maximum size of a practice is constrained by the dispersed nature of the population it serves. In addition, the nature of the GP partnership and the individualistic nature of many practitioners, together with the need to maintain a personal service, are drivers towards small to medium-sized practices.

As GP fundholding develops, both in population coverage and range of services commissioned, there is increasing evidence of collaboration amongst purchasers to achieve greater leverage with providers and thereby to secure change. It would, however, be simplistic to forecast the early development of managed care organisations along the lines of the American health maintenance organisations (HMOs). HMOs assume a defined population and effectively a single organisation in which all the players have an interest in containing health care requirements within available resources, and meeting those requirements within the organisation. The nature of primary care in Britain is likely to preclude such an approach on a number of counts. The right of every individual to register with a GP and the promulgation of choice between practitioners, combined with the independence of such practitioners, is enshrined in the current regulatory framework. Furthermore, one of the motivations for many GPs to enter fundholding has been to exercise greater control over what happens to their patients across the full range of health services, and particularly to maintain their right of freedom of referral to a hospital of their choice.

Multifunds may be relatively large purchasing organisations but practices within them, as within fundholding consortia or locality projects, tend to maintain quite strongly their independence within the larger organisation. In the cities, particularly, single-handed and double-handed practices remain common, often the result of a split in larger practices, and arrangements of consortia, locality projects and other collaborative but non-collective arrangements prevail.

As has already been indicated, primary care is by its nature highly diverse in terms of the population served by a practice, the personal nature of the relationship between the practice and its patients and the personal services offered, the smallness of individual practices and their independence from direct managerial control, and the highly individualistic nature of many doctors who choose to enter primary care. This diversity can be both a strength and a weakness. It offers patient choice and the possibility of a personal service closely aligned with the patients' own aspirations. Its weaknesses lie in the risk of too wide a range of quality as well as of services, the lack of controls on performance, and the historical pattern of marginalising some groups such as homeless people and ethnic minorities.

It is arguable that the primary care agenda has until recently been led by the counties, and that the model of the primary care-led NHS may feel more comfortable in a county town with a relatively homogeneous population and general practices as a key part of the local infrastructure. But as this chapter has illustrated there are a range of developments now in the cities addressing the needs of a far more diverse, mobile and geographically-concentrated population, which may signal some of the future directions for primary care and a primary care-led NHS. Tackling the inclusion of historically-marginalised groups, for example, or developing consensus on change in an environment with many diverse providers of secondary as well as primary care will offer some interesting lessons, as will the need to develop the networks of primary care with social care, housing, and other contributors to health in the broadest sense.

Organisationally the NHS has moved visibly from a monolithic hierarchy to a network of much smaller, flatter and highly-varied organisations, although secondary and tertiary-care providers still offer examples of large institutional management. This means that conventional career pathways up a very visible management ladder no longer exist. Accompanying the diversity of organisations is clearly a diversity of roles whether clinical, managerial or both. The significant determinants of roles may lie in geography, history and the culture of particular organisations. Organisational values and philosophy may become the most significant links in career progression. Diversity at its worst may lead to fragmentation and offer too great an opportunity for the exercise of personal power. More positively it may offer an enormous range of opportunities and the potential for the development of personal leadership which the imperative to improve services requires.

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CHAPTER FIVE

Inner-City Changes: Health Care Services in Britain's Inner Cities

Ainna Fawcett-Henesy

INTRODUCTION

The ideal of health care provision based on prior assessment of health needs has long been aspired to by health planners. The Acheson Report (London Health Planning Consortium, 1981) laid the foundation for a radical approach to public health, and in 1989 the government set out the basis for a greatly altered national health service in which the clear identification of the population's health care needs and the channelling of resources to meet those needs emerged as complex and challenging tasks.

Target 27 of the WHO programmes *Health for all by the year 2000* (WHO, 1988) is concerned with the provision of health care according to need, and of adequate access for all persons. Though the systematic and objective assessment of needs is considered to be the logical point to break into the purchasing cycle and, by extension, the basis for setting priorities (in a resource-limited NHS), there are a number of differing perspectives on these issues which have to be reconciled before it is possible to arrive at rational judgements relevant to the targeting of resources and the provision of health care according to need. Needs assessment as Cunningham (1990) reminds us may not be new. What is emerging, however, is the requirement for a coherent and more explicit approach to this task at a very local level.

Much of the literature on health-needs assessment and resource allocation relates back to a wider debate about the causes of health inequality. A model of needs assessment based on the concept of deficiency reflected in the writings of nineteenth-century social reformers and writers like Engels, Dickens and Rowntree, is robust and persistent. The Black Report (DHSS, 1980) drew attention to the relationship between disadvantage and poor health, summarising the differentials in the health experiences of different groups according to social class, housing tenure, region and ethnicity. Subsequent research during the 1980s has demonstrated that, far from exaggerating, the Black Report may have actually underestimated the strength of the relationship between poor health and various indicators of social and material deprivation in a country still caught in the grips of a severe economic recession. Studies based on small area variations make a convincing case for the existence of multiple deprivation which impacts on the health of local communities (Smith, Bartley and Blance, 1990; Judge and Benzeval, 1990). In what are, in common parlance, termed 'inner city' areas, the effects of poor social and material conditions on health are seen at their worst.

The Royal Commission on the NHS (1979) stated, quite unequivocally, that improving the quality of care in inner city areas was the most urgent problem which the National Health Service had to address. Other studies have voiced similar concerns (Bolden, 1981; Carstairs, 1981; Wood, 1983).

Adding a further dimension to the debate, the Archbishop of Canterbury set up a Commission in 1983 to examine social and economic conditions in urban areas. The Commission's report entitled 'Faith in the City, A Case for Action by Church and Nation' (Archbishop of Canterbury's Commission, 1985) was influential in focusing public attention on the plight of the inner cities. In graphic detail it set out the structure of inequality within cities, the economic and physical decline and social disintegration experienced in the outer housing estates as well as in the central urban areas.

The key messages from this report suggest first, that a growing number of people are excluded from sharing in the common life of the nation, because of poverty and powerlessness, and second, that a considerable number of the nation's population are forced to live on the margins of society and below an acceptable standard of living. The report challenges the nation and questions whether there is any serious political will to change the present situation.

The recommendations emerging from the study were in tune with the spirit of the Black Report, with radical proposals for concerted action on poverty, unemployment, housing conditions, homelessness, community care, public safety and national policies on health.

Big city changes continue to be a key issue of concern to the National Health Service management and health care professionals. The Tomlinson Inquiry into London's health service, medical education and research, drew attention to particular sub-groups in the capital's population whose characteristics and access to health services have for long caused concern to policy-makers and social and political activists. The Inquiry concluded that:

> 'Londoners are no less healthy than people elsewhere. However, it is quite clear from the available reports and statistical material, and from the visits and discussions we have had . . . that the population of inner London presents a *range* of need unparalleled in the rest of England.'
> (Tomlinson, 1992, p. 6)

When it reported in 1992, it would appear that the Tomlinson Inquiry had taken the cold calculation of the market as well as the conclusions of other researchers to recommend the most radical shake-up of London's health service for more than 100 years.

Other cities in Britain are facing similar challenges and perceive a need to effect radical improvements in the health of their most deprived populations. Almost every large city has had, or is carrying out, a review of services and all reviews implicitly see a role for planning with the market mechanisms and the need for rationalisation of services in order for the internal market to function more effectively.

While other contributors to this book consider in detail the implications of commissioning, the effects of changes in hospital care on the community, the development of primary care and continuing care/primary care interface issues, this chapter will focus on the challenge of meeting the health needs of multiple deprived populations in Britain's major cities in ways which achieve equality of access and which also compensate for social or economic factors which severely restrict individuals' abilities to choose a healthy lifestyle and prevent illness. However, before considering how needs and services can best be brought into strategic balance, it is necessary to conceptualise more clearly the nature and extent of inner city deprivation.

BRITAIN'S INNER CITIES: SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS

Inner city areas share a number of characteristics. The concentration of these characteristics in any one area is reflected in the need for most types of health services, particularly those which are able to deal with the health problems most strongly associated with poverty.

The 1991 Census suggests that populations in all major conurbations in England, show a pronounced polarisation between young and old. The large number of children below the age of five is more than counter-balanced, at the opposite end of the age gradient, by the increase in the population aged 65 or over. As a group, the elderly living in inner city areas are not wealthy. Many of the difficulties of economic vulnerability and social isolation are enhanced in the elderly. For most, the greater part of their income comes from state benefits; many live on or below the poverty line. Fewer older people in all the major urban areas of Britain are owner occupiers. The majority live in rented accommodation, usually of a poor quality.

The 1991 Census indicates a higher rate of over-75s living alone, both in inner London and other conurbations, than England as a whole. Dependants are more likely to live without a carer or in a lone-carer household in inner London and other inner city areas than in England as a whole. Importantly and unsurprisingly, older people use the health service more often than other groups living in inner cities and record great levels of chronic illness. Data from the General Household Survey (OPCS, 1993) suggest that over half of those above the age of 75 report some form of long-standing limiting illness, with higher levels amongst the poorest groups.

A survey of very old people in Hackney, an Inner London borough, undertaken in 1991 with a sample aged over 85 showed a substantial shift taking place in the attitudes of elderly people to preferred sources of support. The vast majority (88 per cent) of those surveyed wanted more help with tasks they found difficult and preferred this help to come from formal services. Only 6 per cent wanted more help from relatives and friends (Bowling, Farquhar and Grundy, 1991).

Inner cities households tend, on the whole, to have much higher rates of overcrowding. Inner London has more households which lack basic amenities than the rest of the country.

Unemployment rates in the inner city areas of all major metropolitan centres are higher than the national average. A higher than average rate of gross national product per head is contributed overall by Londoners to the UK economy. Paradoxically, the unemployment rate in some of the capital's inner city census enumeration districts is also well above the national average.

Inner London's resident population numbers approximately 2.5 million people. They are joined every weekday by about 1.3 million commuters who come to work in the city and, during the course of the year, by around 8 million tourists. Population turnover is also high. As a result of migration from city centres, all the major cities in England are significantly weighted capitation-losers under their respective regional formulae.

London has a markedly higher proportion of individuals from minority ethnic groups than other cities in Britain. Inner London has over four times the national proportion. People from ethnic minority communities account for 18 per cent of Birmingham's population, and areas in Small Heath and Handsworth where they are heavily concentrated are among the most deprived in the country. Non-English-speaking minority ethnic groups have special needs and experience major difficulties in accessing appropriate health care and advice.

London also has a high number of refugees from all over the world. Their patterns of settlement indicate that new arrivals tend, by and large, to gravitate to the inner London boroughs where there are longer established, more settled minority ethnic and refugee communities.

Despite inadequacies in the system of collecting and collating information, figures from the Department of the Environment indicate a steep increase, since 1986/87 in the size of the official homeless population in Britain (DoE, 1985). The decline, nationally, of private sector renting, the steep increase in rents which have put such accommodation above the reach of people with low incomes, the decline in public sector rented accommodation due to the sale of local authority-owned properties, the cutbacks in state investment in public sector housing, negative equity, and the dramatic increase in the numbers of repossessions by banks and mortgage lending companies, have contributed to the growing problems of homelessness.

However, the scale of the problem is far greater in big cities, with London heading the league tables in this respect largely because the capital has traditionally acted as a magnet for homeless people from across the country. In some inner London boroughs, as many as one in twenty people are homeless and the numbers are steadily increasing.

HEALTH NEEDS OF PEOPLE LIVING IN INNER CITY AREAS

The relative health needs of the residents of deprived areas can be established most clearly by mortality statistics contained in the Department of Health's Public Health Common Dataset (DoH, 1992). These confirm that regional differences in mortality range from high in the north and west to low in the south and east for both males and females. Inner London, however, is a major exception with above average mortality.

Two useful summary measures of mortality are avoidable and premature deaths. The former was developed as an indicator of the quality of medical treatment; the latter based on an assumption that normal human life expectancy is 75 years. The overall health status of people living in inner city areas as represented by these two measures is poor when compared to the rest of the country. Under the age of 65, premature mortality is much higher in inner London and other conurbations compared to the national average, although over the age of 65, the Standard Mortality Rate (SMR) is lower in inner London than elsewhere. Over the age of 75, it is lower than the ratio for England as a whole.

Infant and neonatal mortality are as high in inner London as in other conurbations, as is the number of years of potential life lost, an alternative mortality indicator. The Office of Population Census Statistics (OPCS) identified three parts of the country – Tyneside and Teesside, greater Manchester and Merseyside, and inner London, as having the worst overall mortality experience.

Levels of morbidity are high with a particular concentration of stress and morbidity in some inner city areas. Inner London, for instance, has a poorer health experience than England as a whole, although as the Tomlinson Inquiry concluded, the health status of Londoners overall is similar to that experienced in the country as a whole.

In all urban areas, certain groups are more likely than others to be adversely affected by higher morbidity and have higher than average consultation rates. A local survey in Ladywood, Birmingham, showed that single mothers have an incidence rate for episodes of new illness which is 63 per cent above the national average. Unemployed people in all areas are more likely to consult their family doctors, as do people from minority ethnic groups living in inner urban areas.

In an attempt to disentangle the influence of socio-economic and environmental factors on geographic variation in mortality, Britton *et al.* (1990) identified inner city council estates as areas which have the highest SMRs for both males and females, typically in excess of 120 (1 per 10 000). The environment on some estates, characterised by higher than average crime rates, overcrowding, overpowering greyness and dog litter, also provides the setting for higher than average morbidity levels.

There have been several attempts to combine a number of presumed indicators of need or relative deprivation into a single score or composite index. These scores are then computed for the population at either district or electoral-ward level to be used as a guide to where additional health or social resources need to be targeted. Townsend's Overall Deprivation Index and Overall Health Index (Townsend *et al.*, 1988) combines the score on four census variables (the percentage unemployed; in overcrowded households; in households without a car; and in households not owner-occupied). Each variable is given equal weighting and regression analysis is used to relate the variation in the level of health, to variation in the level of material deprivation.

The Department of the Environment's Inner Cities Directorate has produced a measure of urban deprivation by combining six indicators. Equal weights are given to each indicator, except for unemployment which has a double weighting (DoE, 1985).

The Jarman index (Jarman *et al.*, 1991) was designed to measure the workload effects of providing services for groups of people 'at risk' of deprivation. Given the high proportion of elderly people living alone, of households suffering overcrowding, single-parent households, the higher proportion of ethnic minorities and highly mobile people, all inner London districts score higher in terms of the Jarman under-privileged area (UPA) score, compared to an England average of zero.

Recent qualitative community-based needs assessment in several inner urban areas have identified crime, noise and traffic pollution, poor local facilities for shopping, sport and recreation, inadequate public transport and travel connections to the other areas of the city, as important concerns in the general health environment of the resident population. In all areas where there is severe social and economic deprivation, the needs of young people, lonely older people, the mentally ill and the homeless tend to be more acute. Within the inner city, however, deprivation levels are not necessarily uniform. In London and Birmingham and other cities, for instance, socio-economic conditions vary dramatically within small geographical zones. Often pockets of severe deprivation exist adjacent to very affluent areas (DHSS, 1986).

The operation of Tudor Hart's inverse care law (Hart, 1971) is clearly manifested in inner cities where need has tended to impact most where there is greater pressure on services. The main features of health care provision in inner cities are described next.

HEALTH CARE SERVICES IN INNER CITY AREAS

Health services in all big cities in Britain have been dominated by acute hospital provision. Almost all have big teaching hospitals which have traditionally attracted patients into the city from the surrounding area. During the early period of the NHS's existence, both revenue and capital funding were determined by the historical pattern of hospital provision. Cities like London, which were well-endowed with hospitals, also gained in terms of the funding allocated to keep services running. The consequence has been more hospital beds per 1000 of the population, and duplicated specialist services.

The Tomlinson Inquiry (1992) noted that London had 43 major acute hospitals with over 250 beds each, far more than any other major city, and inner London had 3.3 acute hospital beds (excluding Special Health Authorities) for every 1000 people as against the national average of 2.3 (1992/93). London also had an over-abundance of specialist services: 14 cardiac centres; 13 cancer; 13 neuro sciences; 11 renal; and 9 plastic surgery. The average length of stay in London's teaching hospitals was 15 per cent above that for provincial teaching hospitals (in 1991/92) and the average cost per case (1992/93) in inner London teaching hospitals was 46 per cent higher than provincial teaching hospitals.

Medical manpower in relation to resident population has also tended to be in relatively abundant supply in major cities, particularly in teaching districts. A Department of Health and Social Security paper (DHSS, 1988) noted that 'hospitalisation rates increase with the number of junior doctors in relation to the number of consultants, after allowing for social and health factors and bed availability'.

With the introduction of market forces, big city teaching hospitals have come under pressure as the funding they used to receive from their host health authority now has to be won in contracts from health authorities further afield who may wish to use their own local hospitals. Medical advances increasingly enable procedures which used to require a stay in hospital to be dealt with on a day-case basis or in a primary or community-based setting. Bed numbers have been declining all over the country, but the process has been noticeably sharp in London, particularly since it has been compressed into a relatively short timescale, without the back-up of well-developed primary and community health services.

Primary health care provision in most big cities has tended to be patchy. Issues highlighted in 1981 by the Acheson review of primary health care services in inner London were reiterated by the Tomlinson Inquiry and indeed by recent reviews of health services in other big cities. Generally speaking, in areas with major social problems, the primary care services are less well able to cope, mainly because of the large numbers of single-handed practitioners and the higher incidence of large lists. London has three times the national average of GPs over the age of 65, and inner cities in general are characterised by an older age profile for GPs still practising as compared with other parts of the country.

The problems of accessibility and availability of GPs in inner city areas has long been noted. Certain groups, like the homeless, have traditionally experienced difficulties in being accepted on general practitioners' lists, and the non-availability of GP services outside normal hours has resulted in inappropriate attendance at accident and emergency departments.

The quality of practice premises in big cities is variable. Up to 50 per cent of GP premises in inner London were found to be below standard by the Tomlinson Inquiry. Elsewhere, too, the greater proportion of low-income practices situated in inner city areas led Bosanquet and Leese (1988) to conclude that general practice was becoming increasingly polarised between high-income, high-cost practices and those with low incomes and few resources.

Practices with few resources naturally face greater disincentives to investment. Lack of adequate premises has prevented many inner city practices from taking on partners or support staff and from developing primary health-care teams. Lack of space has also prevented many of these practices expanding into the full range of primary health-care services, including health promotion, screening, minor surgery and hospital outreach clinics. Bosanquet and Leese (1988) noted that fewer general practitioners responded to professional and economic incentives in deprived areas than in more affluent areas, and observed that practices in deprived areas had a smaller margin for developing services.

By adopting the World Health Organisation's target of 90 per cent immunization and 80 per cent cytology uptake, the government effectively excluded many inner city practices from payment. Although the subsequent agreement to introduce a lower stage payment at the 70 per cent and 50 per cent levels respectively was a more realistic target, even these proved difficult to achieve in areas of severe deprivation. A significant proportion of the street homeless and of occupants of hostels and other forms of temporary accommodation in large cities are vulnerable people with mental illness, drug addiction problems, alcoholism and multiple social problems. Although such individuals have the same rights of access to good medical care and social support, mental health care provision in many large cities has not met demand. Many inner London areas lack fully-resourced community mental health teams and the number of easy access, drop-in facilities for the homeless and socially deprived has been falling. A marked lack of non-NHS continuing-care facilities in inner London and other comparable areas has resulted in patients staying in hospital longer than necessary, adding to the high cost of providing health care.

Emergency admission to hospital is one extreme of a continuum of forms of support and care for people facing potential medical crisis. At the other end lies the care provided by members of the family or household. In between lies the support provided by GPs and social and community health services.

Given the social characteristics of inner city populations, the high proportion of people living alone, particularly the number of people aged 75 and over living alone and the higher incidence of single-parent families, it is hardly surprising that the level of support and care which can be provided from within the household is negligible. All forms of social care are also known to be under pressure in areas with high levels of social and material deprivation.

In order to demonstrate how the health services have responded to the problems of social deprivation and health in inner cities, I shall draw extensively, although not exclusively, upon post-Tomlinson developments in London.

DELIVERING EFFECTIVE HEALTH SERVICES IN INNER CITIES

Most diagnoses of inner London's health care problems have pointed to the over-supply of acute hospital beds and the impact of the internal market on the major hospitals, compounded by expensive, but inadequate community health and primary care services. As a result, inner London residents have tended to rely on hospital services more than people elsewhere.

The reports produced by the King's Fund London Commission (Benzeval, Judge and Solomon, 1992; Royle and Smaje, 1993) set out in detail many of these issues. The Tomlinson Inquiry reached a similar set of conclusions, and recommended substantial investment in and improvement of primary care as the way forward.

The government's response, *Making London Better* (Department of Health, 1993) incorporated the Tomlinson recommendations as well as many of the King's Fund London Commission's views in its strategy for future developments. Along with acute-sector rationalisation, the development of specialist services and the merging of medical schools into multi-faculty colleges affiliated to London University, the substantial development of primary care services was seen as essential to resolving the crisis facing London's health care.

Making London Better recognised that changes in London's health service on the scale envisaged required careful management. The London Implementation Group was established for an initial period of three years to co-ordinate implementation of Ministers' decisions on a cost-effective hospital service and improved primary care in London. Furthermore, the London Initiative Zone (LIZ), covering part or the whole of 12 inner London health districts was created for fast-track health developments in primary care – the focus for new investment, new approaches and new ideas. LIZ has a five-year time-frame and the range and speed of development planned within its boundary was substantial.

It was clear from the very outset that the scale and scope of the development programme needed to go beyond simple investments in bricks and mortar, conventional methods of professional development, or the traditional means of spreading good practice within the NHS. The depth of London's problems and their persistence required specialist treatment and the first priority was to get the basics right, that is to improve premises and to attract and maintain high quality staff in London.

Given the diversity and the high level of need among the inner city population, particularly that of marginalised groups such as homeless families and individuals, refugees and minority ethnic groups, people with mental health problems and substance misusers, close collaboration between health, social and voluntary-sector agencies was envisaged as well as with a range of health care professionals, including nurse practitioners, salaried GPs and community nursing services. Other key players who had to be engaged with included Regional Health Authorities, Family Health Services Authorities (FHSAs), District Health Authorities (DHAs), Community Trusts, professionals, local authorities as well as the Treasury, NHS Executive and Ministers.

The pace of change as well as the detailed way forward for primary care services in London had to be synchronised with the rationalisation of the acute sector. As hospitals merged or closed, it was essential that the primary care sector, as well as community health and social services, were capable of handling the increased demands made as a direct consequence. If things were to change in London, and the problems of social deprivation and health were to be addressed, the piecemeal experimentation of the past had to give way to a sustained programme of planned development.

Never before has primary care occupied the pre-eminent position that it does today. Work undertaken by the London Implementation Group in the mid-1990s demonstrated that the management of primary care is full of complexities and that greater clarity is needed about the expected overall impact of changes, both in the mode and location of services as well as the interface between primary and secondary care (Fawcett-Henesy, 1994).

A recent report from the National Association for Health Authorities and Trusts (NAHAT, 1995) suggests that health authorities throughout the country are, for the first time, explicitly addressing the question of how resources are to be distributed socially as well as geographically. Sixty per cent of the strategy plans give equality of access to services as their guiding principle, and 42 per cent cite what they call 'equitable services'.

The primary care strategy for South East London Health Authority, for instance, stresses that health and social care needs must be assessed and primary care services planned very locally to cope with variations in levels of deprivation and the need for health care services (Lambeth, Southwark, Lewisham Health Commission, 1995). Locality commissioning is seen as an important way for a community and its interest groups to give their views and to become involved in the purchasing of health and social care. However, consumer groups warn that if there is a real desire to involve people in the changes happening to health services, it is essential that they are given high-quality information, not fed propaganda, that there is less use of jargon and that there is genuine dialogue and consultation with the public (Joule, 1994).

The increased demand for out-of-hours services in many inner city areas reflects increasing consumer expectation and some specific difficulties in accessing services during normal working hours. Several research studies have shown that between a quarter and a third of out-of-hours calls relate to children under five. Social deprivation and lack of support networks also lead to high contact rates. If health services are to be made more accessible to inner-city residents then a number of key issues, including the personal safety of service providers, communication between users and service-providers and referral processes between GPs and members of primary health care teams and other agencies, have to be clarified.

Preliminary findings from a four-year project in Lambeth, Southwark and Lewisham (an area characterised by marked deprivation in south-east London) to tackle these issues in the inner city indicate that there is great potential for improving the quality of out-of-hours medical and other services through inter-agency working, local rotas and a unified telephone answering and advice service to simplify access for patients. Better liaison at the non-statutory/statutory interface to enable local agencies and community groups to work together more effectively and to develop more culturally sensitive services has been stressed (Department of General Practice, King's College, 1995).

The theme of inter-agency collaboration reverberates throughout other radical approaches to improve the health of inner city populations. As part of their Inner Cities Initiative, 14 mental health trusts plan to provide a 'guarantee of care comprising a package of services to severely mentally ill people. This would include the entire range of services, from clinical care through to employment schemes and housing support, and a wide group of providers such as housing associations and carer groups would be involved (Fawcett-Henesy, 1995a).

Making London Better saw the voluntary sector playing an integral role in the development of primary care services across London. £7.5 million was made available over three years to fund 40 projects (selected through a competitive tendering process) aimed at facilitating early discharge from hospital and preventing inappropriate admission in the first place. While a number of innovative and imaginative schemes have taken off with the injection of extra funding, and a range of client groups have been offered greater choices of services in more appropriate locations, consumer watchdog groups warn that competitive bidding for resources tends, by its very nature, to favour larger more-established voluntary groups at the expense of those sections of the community that are most disadvantaged, for example black and minority ethnic people, people with disabilities and other historically underfunded groups (Levenson, 1995).

Socially deprived populations have complex health needs which call for a radical shift in the philosophy of care and the re-configuration of professional roles and responsibilities. The shift of services and resources across the acute primary care interface is also a priority. The substitution debate, however, is not simply about shifting 'resources' or for providing a more cost-effective service. It is also about enhancing patients' choice for a more holistic range of care options nearer to their own home environments and the provision of services which are appropriate as well as cost-effective.

Effective substitution policies not only redistribute the delivery of services or identify the need for currently unprovided services. In some cases they may, in fact, demonstrate that a medical model of 'cure' is not appropriate and that other forms of 'care', support and health education are a more effective substitute. Substitution policies may also reveal large areas of unmet need.

Substitution has the potential to reconfigure a wide range of professional roles and responsibilities. The emerging evidence suggests that nurse practitioners will be among the professionals at the leading edge of new models of health care.

A recent evaluation of 20 nurse practitioners working in a range of primary care settings – single-handed and group general practices, specialist and generalist accident and emergency departments and in the community in pharmacies, fixed and mobile clinics and a centre for homeless people – has shown that nurses could play a much more prominent role in primary care by providing a directly accessible service in their own right (Fawcett-Henesy, 1995b). The study reaffirmed the importance of general practice as the focal point for most health care services and concluded that nurse practitioners could not only effectively manage a comprehensive case-load jointly with general practitioners, but that they also have a key role in meeting a 'care gap' in primary care. This gap might constitute the lack of a service altogether such as where deprived populations are involved, or the difficulties of providing time for patients to discuss ambiguous, trivial or non-specific problems. Filling these gaps might appear to be uncovering a problem best left alone. However, by addressing the poor health of disadvantaged and marginalised people, it is likely that more serious problems could be avoided in the future.

CONCLUSION

Britain is a signatory to the WHO *Health for all by the Year 2000* declaration (WHO, 1988) and as we approach the end of the millennium it is appropriate to pause and take stock of the progress made towards achieving this target. The problems faced by people living in deprived urban areas are complex and by no means uniform, but the Health Service response, in the past, has been one of unco-ordinated action.

Following recent reviews, there is a general intention to invest in primary care, as a way of providing equitable, accessible and appropriate health care in the cities. However, the shift of activity or funding from acute to primary care is unlikely to proceed smoothly. The strategic direction for tackling inner city health problems can be set by answers to the question 'what is the best way of providing health care services to these populations', rather than examining whether primary care and community services can complement or substitute for hospital-based care. Users of health services and potential client groups also need to be convinced that effective health services can be developed within a reasonable time-frame and the benefits of such developments need to be communicated clearly.

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CHAPTER SIX

Interprofessional Education and Curriculum Development: 'A Model for the Future'

Rita Bell, Kath Johnson
and Heather Scott

A climate of political change and reform is having a profound effect upon the provision of community health care in the United Kingdom, particularly in relation to the professional skills and competencies necessary to support quality community care (Fletcher, 1994; Bowman, 1995; Clifton, 1995).

According to Clark (1995), the resulting stress and turbulence in the health care system and in society as a whole is placing heavy demands on all health care professionals involved in the delivery of health and social care in the community. It is suggested that the new market-orientated culture of the NHS challenges traditional values and requires new approaches to professional practice in the community. In addition, James (1994) draws attention to an important dimension in this climate of change which must be given careful consideration by health and social care educationalists. It is the change in the social structure of the environment which includes a number of trends including a current population with an increase in higher formal qualifications which it is suggested may influence their expectations and understanding of health care issues.

In practice, these challenges highlight the importance of enhanced collaboration and partnerships in the delivery of care. This in turn has major implications for educationalists striving to offer innovative programmes and 'fitness for purpose' curriculum models designed to meet the actual competency requirements of the rapidly changing work-place. Moreover, the recent interest in National and Vocational Qualifications (NVQs), occupational standards, competency levels and the promotion of transferable skills has emphasised the importance of teamwork at all levels. (Fletcher, 1994; NHS Executive Letters, EL (95)27, EL (95)84). Bahrami (1995) goes further and highlights the importance of continuing education for professional development and suggests the use of personal education plans (PEPs) for professionals as a positive approach to rapid change and developments in the NHS.

This chapter proposes that effective teamwork in the community rests heavily upon common understanding of the principles underpinning the complexity of the working environment of primary health care as a means of fostering a collaborative and flexible approach to community care delivery. Therefore, the authors recommend an innovative but uncomplicated approach to planning and developing interprofessional education for all involved in the delivery of primary health care as the way forward. This raises the question:

> *What are the key principles inherent in primary health and community care which need to be taken into account by course planners and those involved in professional development for a range of practitioners?*

According to the World Health Organisation (1979, 1988), the key elements of any primary health care system are defined as *accessibility*, *availability*, *cost-effectiveness* and *client acceptability* if we are to secure client-sensitive care provision (Fry and Hasler, 1986).

Education has an essential part to play in service development, and the NHS Executive stated in August 1995, that 'it is essential that the National Health Service must secure an adequate number of appropriately qualified and prepared health care professionals if it is to achieve its purpose and objectives' (NHS Executive, 1995c).

Subsequently, this chapter proposes that the development of interprofessional education to support the community working environment should reflect the basic principles of primary health care. In practical terms, this suggests that those involved in education should use the key elements of a recognised definition of primary health care as a flexible and realistic framework to guide curriculum development. This would ensure a mechanism capable of establishing relevant continuing education which could be applied to professional development for disciplines involved in the delivery of primary health care. It is argued that in the current climate this requires an emphasis on health promotion and subsequently relies upon a fundamental shift from individualistic approaches which have been the cornerstone of medicine, to a model which includes promotative/preventative/curative and rehabilitative elements (O'Keefe *et al.*, 1992).

This change of stance has subsequently given urgency to making a reality of multidisciplinary teamwork to support primary health care. This presents an unenviable challenge to professionals to rethink their occupational purpose and reconsider the value of education in achieving change and growth (Horder, 1995). Support for interprofessional education is growing and considerable opportunities to work together abound to share ideas and approaches (Barr, 1995). On reflection, growth appears to have been 'patchy' which indicates that although teamwork and collaboration have been the focus of attention in practice for 20 years, the concept has failed to materialise beyond isolated experiences in reality (Nocan, 1994). A recent project funded by the Social Services Inspectorate of the Department of Health raises some crucial issues worthy of consideration when examining the potential of collaborative education, particularly in relation to:

- Why collaboration works well in some areas and not others?
- Why despite knowing how to run good joint training is it still so difficult and rare for social workers and general practitioners to work effectively together? (Vanclay and Hingston, 1995)

Nevertheless, this chapter recognises the importance of learning from past experiences and supports the view of James (1994), who states that the challenge is to take that learning with us. Therefore, this chapter intends to use World Health Organisation criteria designed to clarify the meaning of primary health care (WHO, 1979, 1988) to address the following questions:

- How can professional education/training for community health care ensure the development of professionals who have the ability to work effectively in partnership across professional and agency boundaries?
- What would an educational framework designed to encourage collaboration and change in service delivery look like?

The chapter will firstly identify current forces for change from the perspectives of community nursing and social work in terms of the context of care delivery, before expanding upon the World Health Organisation criteria as a framework to promote advances in interprofessional education and training for all care professionals engaged in the delivery of primary health care.

THE CHANGING FACE OF PRIMARY HEALTH CARE

The current climate of service delivery presents community practitioners with a complex working environment which will stretch their management abilities and evaluation skills if they are to influence the health status of the community population. This is particularly important in these times of inequalities of health, the introduction of competition within a quasi-market economy, and the importance of consumer participation to name but a few. This level of complexity demands community practitioners who have a high level of competence to cope with the heavy demands of practice in non-institutional settings and to support the delivery of care to clients in their own homes. Undoubtedly, the caring community agencies are at present faced with the challenge of how best to manage innovation and change and expand their ability to work in partnerships with others.

Evidence suggests that primary health care is not about the contribution of any one professional but relies upon a collaborative approach to care. Furthermore, good quality primary health care is not simply based upon the clinical skills of general practitioners, but relies upon effective relationships between all members of the primary health care team (Talbot, 1995).

Partnerships are, therefore, crucial in this day and age, and interprofessional collaboration is seen as central to the success of government health and social care reforms. In addition, the challenge of the 1990s is one of recognising the importance of transferable skills in the health and social care sectors (NHS Executive, 1995b). In reality, however, the complexity and sophistication of modern health care means that most clients will be assessed by a number of different professionals who will need to work as a team (Cain 1995).

Overall, the need for change in the 1990s is underpinned by a range of crucial issues which should influence interprofessional education and be taken into account when planning professional development. This is summarised as follows:

> 'Firstly, evidence predicts a potential health crisis over the next decade, and, secondly a range of barriers and hazards in primary health care are facing practitioners which could impede service delivery. These pressures are emerging from the acute and independent sectors and include moves towards deprofessionalisation and the return to informal care, difficulties in collaboration and limited structured interprofessional education for primary health care. Furthermore, many would argue that interprofessional education is fragmented and not service led.'
> (Talbot, 1995, p. 16)

FORCES FOR CHANGE IN COMMUNITY HEALTH CARE

The reality of the working environment in primary health care is posing a series of problems for professionals responsible for care delivery, including pressures on resources and escalating health care costs, but it is clear that attempts to improve service needs must be supported by changes in training and education (Mackay *et al.* 1995). It is essential, therefore, that the first step in the process must be to grasp an appreciation of the contextual position when considering interprofessional education for primary health care. In the first instance this can be related to the global environment and presents an intimidating picture as follows.

Health crisis by the year 2000

According to O'Keefe *et al.* (1992) there is a potential health crisis in the next decade which must be taken seriously by professionals in primary health care. This is deemed to be 'no idle threat' and is underpinned by clear evidence in relation to:

- a 'demographic timebomb';
- widening gaps between demand and supply;
- environmental pollution;
- user dissatisfaction;
- an 'iceberg of sickness';
- an 'epidemiological transition' from childhood illnesses to chronic and degenerative disorders;
- a shift in emphasis to prevention.

Many people also predict that the community care changes will result in some confusion which could place vulnerable and frail people at greater risk (RCN, 1995).

In Britain, this crisis is exacerbated by poor levels of health care in comparison to other western countries, particularly when variations in health by class, race and region, and aspects of quality and quantity are considered (George and Miller, 1994).

Positive action relies upon teamwork and a pooling of knowledge and skills in order to respond to this crisis, but evidence suggests that partnerships and effective collaboration are still presenting problems in the United Kingdom particularly in relation to professional ideologies, power struggles, organisational structures and poor communication (Howkins, 1995).

The way forward must be through more effective means of education which, in turn, call for an immediate strategy to promote effective interprofessional education. It is abundantly clear, however, that any strategy of this nature must be supported by a realistic and acceptable curriculum designed to address all parties in the 'framework' or work setting. It is essential that education for primary health care is built upon a co-ordinated approach to curriculum development which takes full account of the urgency of the current situation and ensures flexible, appropriate programmes which are designed to ensure collaboration in practice.

Barriers and hazards to progress

It is also essential to analyse the hindrances and challenges which exist and which may inhibit progress in the immediate and diverse working environment. In relation to primary health care and community care, it is possible to categorise two important dimensions which should be given careful attention when considering future education and training.

Challenges from the 'centre'

A range of challenges imposed by the current socio-political climate of health and social care delivery has serious implications for the nature and pace of change, and consequently educational initiatives. Francombe and Marks (1996) go further and propose that the introduction of a market culture in the NHS and the notion of competition interferes with the whole public service ethos. Undoubtedly, the impact of NHS reforms and the Community Care Act

1990, with the subsequent shift to primary health care, has resulted in review and role development of health care professionals to match the complexity of the working environment (Hugman, 1995).

This has required a profound and painful ideological shift for many professionals working in the community, and requires them to expand and develop their range of managerial and political skills. In reality, many tensions exist as a result of the increased emphasis upon partnerships and collaboration which are proving difficult to handle (Titterton, 1994). These dilemmas are caused by the policy-makers on the one hand, and the implications of GP fundholding for multidisciplinary teamwork on the other (Department of Health, 1989; Glennester, 1992). In addition, the current legislative thinking promotes employer involvement in education and training as an impetus to the development of service-led programmes of study.

According to Glynn and Perkins (1995), 'In the view of the government and National Health Service Executive, it should be the employer who should determine patterns of training that are required.' (pp. 104 and 249). Furthermore, the notion of consumerism which is central to current government thinking (Department of Health, 1989) is placing heavy demands on professionals in the community; not only do they have to respond to Charter initiatives, but they are expected to advocate on behalf of the most vulnerable members of society in their care.

Undoubtedly, practitioners are functioning in a changing climate in the community which requires both collaborative approaches and a rethinking of their role. This reflects the importance of *relevant* professional development and the need for more effective interprofessional education in this field (Department of Health, 1993; NHS Executive, 1995d). Reorientation and innovation is a necessary phenomenon in the current climate and policy-makers are explicit about the way forward, believing that targets for progress must include taking account of advances in technology, shifting patterns of care and changes in the expectations of the public (NHS Executive, 1995f).

Inevitably, this will create dilemmas and tensions for the professionals with diverse professional backgrounds. O'Keefe *et al.* (1992) note the complexity of professional practice and draw attention to the implications of the 'powerful actors in the game'. This is a crucial dimension which should be given particular attention by those wishing to reduce the barriers and encourage interprofessional growth in primary health care. Tribalism has a longstanding reputation in the National Health Service which many would argue has hampered progress. However, according to Beattie (1995), traditional boundaries appear to be under attack as never before.

Interprofessional collaboration

According to Howkins (1995), it is a generally held belief that collaborative working is a good thing both for clients and professionals, but the evidence suggests the process can be fraught with difficulties (Nocan, 1994). Furthermore, it is widely recognised that joint working of all kinds has been an area of disappointment in the recent history of community care (Mackay *et al.*, 1995). This raises the crucial questions of,

- why is it such a struggle? and,
- to what extent does this reflect on patterns of professional education and inappropriate curriculum development?

There appears, however, to be support for collaboration as a means of securing quality service provision. According to Howkins (1995), the main message from both clients and professionals is that working together has real benefits for everyone.

Specifically, it is argued that there are three main strengths in support of collaboration which should be acknowledged:

1. Users are not concerned with professional demarcations but simple efficiency and effectiveness;
2. The 'contract culture' of the 1990s emphasises outcomes rather than assigning responsibility for quality to specific professionals;
3. Reduction of overlap and duplication with subsequent financial savings.

Cumberlege (1990), however, recognises the complexities of working together and argues that structural changes are not enough. Progress also requires a change of attitude, noting that there are fundamental issues around collaboration which require careful consideration, for example power, gender differences, professional ideologies and indeed tribalism (Howkins, 1995).

The NVQ revolution and occupational standards movement

Over the last few years, there has been a steady shift towards a changing work-force in health and social care which demands a flexible and innovative approach to education and training. This work-force has introduced skill-mix into situations in the community which have been traditionally supported by health care professionals carrying recognised and statutory qualifications (Hennessy, 1995). Indeed, it is suggested that care in the 1990s has highlighted a skill-mix gap which is particularly significant in primary health care. This will require a radical change to secure a flexible and adaptable work-force to accommodate the complex range of care packages required in the community at this time (James, 1994).

Furthermore, the development of National Vocational Qualifications (NVQs) and the introduction of General National Vocational Qualifications (GNVQs) in schools and colleges are considered to be key components in achieving a learning society which can be competitive in the global marketplace. This is a consideration which can readily be applied to the health and social care field, and it has become a development which requires diligent thought when planning education and training for the health care professions. It is essential for educationalists to recognise that the revolution in vocational qualifications in Britain is now gathering pace (Ollin and Tucker, 1994).

Moreover, according to Fletcher (1994), these changes have major implications for both providers and users of vocational qualifications. For example, in the community, the introduction of care or support workers has led to a rethink in terms of professional education and training for primary health care particularly in relation to methods and modes of training, work-based learning, revision of curriculum, and credit accumulation initiatives.

> 'For employers, the potential is enormous for flexibility of training and development provision, increased co-operation and involvement with providers, better targeted training and performance assessment, improved recruitment, selection and manpower planning and ultimately, improved economic performance.'
>
> (Fletcher, 1994, p. 36)

However, the question remains, what does this mean in terms of health and social care?

According to the NHS Executive (1995b), NVQs made up of occupational standards, are a key aspect of government policy, which suggests that they must be given careful consideration by those designing education in this arena. In this context, occupational standards are defined as agreed benchmarks specifying performance outcomes expected in employment for specific occupational areas. Functional analysis is used to identify key roles which in turn are broken down into units, elements, performance criteria and range statements (NHS Executive, 1995b). This framework of NVQs based upon occupational standards is intended to improve the work-force competence and develop staff with transferable skills. Furthermore, it is viewed as staff development in some instances as it is pointed out that many NHS staff have not had access to qualifications, and it is suggested that staff obtaining NVQs may find they provide a useful entry point to some professional programmes. In addition, it is proposed that some professionals may find NVQs useful as a means of professional development or 'ladders of opportunity', particularly in areas such as management and information technology.

How this fits with the Occupational Standards Council's proposals for health and social care is indicated in Table 6.1.

What do these developments mean in the field of primary health and community care and interprofessional education initiatives? What do they mean in 'real terms' in a climate of financial restraint?

In spite of assurances that these developments will not promote the emergence of alternatives to current programmes of training leading to registration with statutory bodies, do they signal an erosion of the role of professional bodies in standard-setting for entry to education and training in primary health care? How can the new concept of occupational standards be translated effectively in community health care?

Table 6.1 National occupational standards and associated qualifications

National occupational standards	*NVQs/SVQs*		
Residential, domiciliary, day-care		Level 2	Level 3
Health care support workers	Level 1	Level 2	Level 3
Integrated care awards, Care awards		Level 2	Level 3
Child care and education		Level 2	Level 3
Operating department practice		Level 2	Level 3
Physiological measurement			Level 3
Criminal justice			Level 3/4
Ambulance	not accredited yet as NVQs/SVQs but currently being implemented as basis of the revised NHS ambulance awards.		

Source: NHS Executive (1995b), EL(95)84.

Furthermore, what does the concept of competence mean in the context of primary health care? Hyland notes the complexity of the competency debate and urges caution, stressing the importance of more research:

> '. . . it is time to inspect more closely the alleged flaws, weaknesses and inconsistencies in competence based education and NVQs in the areas of learning, assessment and knowledge before looking at the impact upon vocational education, adult, further and higher education and professional courses.'
> (Hyland, 1994, p. 18)

Fletcher notes that new occupational standards are based on a concept of competence which has emerged through long debate. In reality, however, there appear to be many ambiguities surrounding the concept of competence which should be given careful consideration by educationalists at this point in time. This highlights the importance of dialogue between all parties involved to ensure conceptual understanding of terms and to avoid disagreement about definitions and differing views on role performance.

> 'Competence and competence talk may have powerful persuasive powers at slogan level but it is conceptually imprecise, logically equivocal and systematically ambiguous.'
> (Hyland, 1994, p. 31)

These criticisms and concerns have major implications for those responsible for education and training for the caring professions. Hennessy and Hicks (1996) discuss the importance of a systematic and rational approach to identifying and prioritising training and updating needs, as well as the organisational developments to support this. The latter process is essential for the strategic management of cost-effective education.

How can quality of community service be assured? How does this development fit in relation to professional accountability for health and social care in the community setting where there is limited direct monitoring or scrutiny of standards of care?

In conclusion, the impact of the volume, pace and complexity of policy directives and legislation is presenting practitioners in the work-place with unprecedented challenges to their adaptability and their repertoire of skills. According to Health Care 2000,

> ‘Professionals are likely to work for increasingly autonomous providers who are more accountable to purchasers and patients in the future. The pattern of general and specialist skills will change and there will be a demand for more highly skilled specialists and more multi-skilled teams. It is likely that tasks and skills will be increasingly shared by professions and specialties.’
> (Health Care 2000, 1995, p. 8)

Mackay *et al.* (1995) state that there has been a surge of interest in interprofessional working in recent years which in turn has led to a number of initiatives designed to promote shared learning to enhance closer working relationships. There is a common-sense attractiveness to the view that enhanced service delivery will result if those who work together learn together (Funnell, 1995). However, according to Horder (1995) we have no accurate knowledge of the present state of interprofessional education for primary and community care. What this means in relation to the education and training of community nurses and social workers will be discussed in the following sections.

THE CONTEXT OF PROFESSIONAL EDUCATION FOR PRIMARY HEALTH AND COMMUNITY CARE

Primary health care delivery is a complex and challenging activity, depending upon a team approach to care. However, it is clear that interprofessional working is a goal that is not easy to achieve. The current working environment and professional influences present a tremendous challenge to educationalists, and this challenge is the centre of a great deal of debate particularly in relation to interprofessional education opportunities and initiatives. This is a perplexing situation for educationalists who are charged with the task of presenting innovative programmes which match the requirements of clients, professionals and service providers, as well as the requirements of higher education.

According to National Health Service Training and Development, ‘Not only are they obliged to deliver a curriculum that prepares students to respond to these changes, but they must do so while equipping students with an education that is solid in the provision of the specialist knowledge, skills and principles which define their professional identities' (NHSTD, 1995, p. 2000). The current environment is indicating a radical shift in professional education in order to meet the challenges of the 1990s.

It must be appreciated that the new community care policies represent a challenge to the health and social care professions to develop fresh ways of defining their skills around the tasks of purchasing and providing, rather than formal professional identities. It is suggested that the overlap between health and social care professions is such that what is required is a new professional mix, and the possibility of new professions emerging (Hugman, 1995).

Howkins (1995) reminds us that the difficulties of working together are substantial and the whole issue is far more complex and more deeply embedded in professional ideologies than originally envisaged. Nevertheless, if collaborative work is an essential development for health and social care, it is imperative to promote the way forward through education based upon shared learning.

Examples of integrated and interdisciplinary training programmes exist nationally and across the professions as shown in Table 6.2. However, there is a danger that joint endeavours will only be developed in the less-problematic areas of practice, leaving areas of conflict between different professional groups unexamined and unresolved. There are indications (NHSTD, 1995) not only that experiments in shared learning are sometimes limited to peripheral concerns, but also that leading-edge practice responds more quickly and is more advanced in more problematic areas than education programmes.

The need to develop a core curriculum is, therefore, urgent and it would appear essential that everyone involved in growth and development in the field of interprofessional education shares a common goal to make progress. This raises the crucial question: what is the meaning of interprofessional education? According to one definition:

> 'Interprofessional education is an approach to teaching and learning that develops professional expertise, encourages collaboration between health and social care, integrates opportunities for shared learning and development opportunities in partnership with service providers and users and carers of the primary health care.'
> (Horder, 1995, p. 11)

Table 6.2 Interprofessional initiatives by geographical distribution and combination of professions

Location of activity by NHS region	*Number of initiatives*
Geographical by NHS region	
Northern	39 (6%)
Yorkshire	35 (5%)
Trent	46 (7%)
East Anglia	19 (3%)
North West Thames	59 (8%)
North East Thames	43 (6%)
South East Thames	37 (5%)
South West Thames	21 (3%)
Wessex	39 (6%)
Oxford	31 (5%)
South Western	73 (11%)
West Midlands	52 (8%)
Mersey	28 (4%)
North Western	67 (10%)
Wales	59 (9%)
Scotland	40 (6%)
More than one region	7 (1%)
Combination of professions	
Combination of professions	*Percentage of initiatives*
DN and HV	20
DN, HV and MW	11
DN, HV and SW	11
HV and SW	8
DN, HV and GP	7
DN, HV, SW and GP	7
DN, HV, MW, SW and GP	6
HV and MW	6

Note: DN = district nurses, GP = general practitioners, HV = health visitors, MW = community midwives, SW = social workers.
Source: Horder (1995).

CHANGES IN COMMUNITY NURSE EDUCATION

Howkins (1995) states that 'the world of community nursing is one of constant change and changes that will continue and magnify'. Inevitably this has shaped the way in which nurses are educated and has had a major impact on post-registration programmes for the community.

In the 1990s, community nurse education has necessarily changed in response to major developments in pre-registration nurse education in the form of *Project 2000* (UKCC, 1987). Although this new programme was introduced in 1986, its impact has only just started to take effect in the community setting, particularly in terms of the recruitment of staff nurses with diploma level qualifications and a limited level of community experience. Inevitably this has had major implications for the future of specialist practitioners such as health visitors and district nurses who currently undergo professionally recognised post-registration education to work in the primary health care setting. The introduction of first level nurses directly into the community as a result of *Project 2000* is having a profound effect upon skill-mix initiatives in the community, and undoubtedly calls for role development of specialist practitioners particularly in relation to leadership qualities, clinical competencies and managerial skills.

This challenge has been recently addressed to some extent by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) who recommend major changes in community nurse education (UKCC, 1994). In other words, the profession recognises the critical contribution specialist community nurses are capable of making to the health and well-being of the community in the 1990s and beyond. There is, however, little doubt that a radical rethink of skills is necessary to address effectively the changing health needs of the community in the closing years of the twentieth century and subsequently lead community nurses into the next millennium (Trnobranski, 1994; Carey, 1994; Department of Health, 1993).

Education will play a crucial part in these developments, and appropriate study programmes are imperative to ensure safe and autonomous nursing practice in the community (Department of Health, 1995). In recent years, common core initiatives have become the norm for community nurse education in relation to the nursing disciplines, but the development of shared learning with other disciplines in primary health care has been less frequent, particularly in relation to shared learning initiatives with general practitioners undergoing vocational training.

In the United Kingdom, historically, it has been necessary to create a number of health care professionals to address the health needs of the community. In turn problems of role overlap, misunderstanding and stress in the work-place have been created which above all has resulted in gaps in service. These historical problems have supported the need to rethink the way in which community nurses are prepared at post-registration level (UKCC, 1994). The introduction of the new regulations for post-registration education and training for community specialist practitioners will ensure further development of common-core programmes for all community nurses including school nurses, occupational health nurses, community psychiatric nurses, community learning disability and general practice nurses. This is viewed as a positive means of developing teamwork and understanding of roles in primary health care in the final years of the decade, and could be a valiant attempt by the professional body, the UKCC, to address the nursing requirements of the community into the next millennium. The current literature, however, appears to be suggesting that 'generalism' should go further and incorporate other professional groups to consider the introduction of a 'generalist' community worker. This is stimulating great debate (Hugman, 1995).

The future is still uncertain, and many would argue that the way forward should include the development of the concept of a generalist community health care professional who is capable of responding to the initial and immediate health and social care needs of the community in a more practical and comprehensive way, taking responsibility for decision-making and referring on to general practitioners and colleagues involved in secondary levels of care where necessary.

What is clear, is that community nurse education must develop practitioners capable of becoming autonomous professionals, skilled in high-level decision-making, with the ability to take risks and take full responsibility for all their work activities (Howkins, 1995).

CHANGES IN SOCIAL WORK AND EDUCATION

The shift from institutional care and the increased emphasis on care in the community has in some ways meant fewer changes for social workers. Social services departments have the lead responsibility for implementing care in the community, and social workers have long been primarily community-based, with a greater degree of autonomy and responsibility for decision-making than many of their colleagues in nursing and other professions supplementary to medicine.

In other ways, however, the changes are particularly challenging. They have required social workers to develop closer and more formal working relationships with health professionals. Many social workers value highly their hard-won independence from the perceived domination of doctors and the medical model. Furthermore, the ideological shift required by community care legislation, particularly the requirement on local authorities to purchase a high proportion of provision from the independent sector, has for many been great. There is also widespread concern about the diminished opportunities for a direct therapeutic role under the care management system (Payne, 1995).

The changes are taking place in a climate in which government and the media have long been hostile to social work: in addition to critical comment, particularly in relation to issues around child protection and mental illness, there was antagonism towards social workers in general and their statutory training body, the Council for Education and Training of Social Workers, in particular. This antagonism persisted throughout the 1980s over social work's commitment to challenging policies and structures which were perceived as oppressive. This has had direct consequences for social work education and training. In 1989, the government rejected proposals to increase the length of social work qualifying training from two to three years, and currently plans to drop the requirement for probation officers to have a social work qualification.

These issues have affected both the structure and content of training. In common with other professions there has been a shift towards competence-based training and assessment. However, a number of established features of social work training mean that it is relatively well placed to respond to the need to produce professionals with the required diversity of skills. These include:

1. The *requirement* that training programmes are developed and managed by a partnership of the educational institution(s) and employing agencies, both statutory and independent (CCETSW, 1992a, Paper 30).
2. The development of the range and quality of practice-learning opportunities. The education–employer partnerships have played a key role here. Training programmes at post-qualifying level for practice teachers are well-established and can provide a model for other professions: in our own university, a joint programme for training clinical supervisors in five professions building on the existing programmes for practice teachers has recently come into operation.

3. The creation of an integrated framework of training and qualifications encompassing pre-qualifying, qualifying and post-qualifying levels (CCETSW, 1992b, Paper 31).

CHANGES IN THE PLANNING AND COMMISSIONING OF EDUCATION AND TRAINING IN HEALTH AND SOCIAL CARE

This discussion would not be complete without specific reference to the current impact of changes in the way education and training for health and social care services is purchased. In 1994, the impact of the publication of the government document *Managing the New NHS: Functions and Responsibilities in the New NHS* had a profound effect on educationalists in the higher education sector. This review of education and training has presented a number of challenges to those with responsibility for the professional education of community nursing and social work (NHS Executive, 1995c). For example, the introduction of local consortia with budget-holding powers who are charged with the responsibility for robust workforce planning and cost-effective education and training measures has challenged educationalists to articulate effectively the rationales underpinning professional courses in a number of ways.

They will be required to introduce credit accumulation systems and expand work-based teaching and learning strategies as part of the norm. In addition, the consortia will seek evidence that the outcome competencies of programmes will support service delivery and developments. Furthermore, according to the NHS Executive:

> 'Consortia will increasingly commission education direct from education providers. For this purpose they will need to be operational budgetholders. This will enable them to influence not only numbers but also quality, admission policies and "fitness for purpose".'
> (NHS Executive, 1995a, para. 9)

The power base of consortia and the implications of education commissioning on educational developments for primary health care including interprofessional initiatives must not be underestimated. According to Jarrold, the NHS Executive (1995a) is committed to an employer-led process to ensure that plans take sufficient account of the local labour market and secure the best value for money and achieve the best return for investment in education and training (NHS Executive, 1995c).

The current government strategy however, appears to encourage positive links between professional, academic and vocational education. This is evident by the introduction of the commissioning process which highlights collaboration and partnerships as a priority, in their planning guidelines published in August 1995, as a means of supporting the implementation of education-commissioning in non-medical education and training (NHS Executive, 1995c).

Furthermore, these guidelines could offer strong support for innovative interprofessional projects including primary health care if full account is taken of priority 5, which is documented as follows:

> '. . . to influence the development of multidisciplinary education and training'.

Specific reference is made to the promotion of multidisciplinary practice, the importance of co-operation and collaboration between agencies and institutions, and the need to capitalise upon shared learning opportunities which to some extent have already been developed in the form of common core developments for community nurses in recent years.

It is stressed that this priority does not imply a threat to existing professional courses or to independent professional self-regulation. This may be viewed with some scepticism in community professional areas. Nevertheless, it is proposed that this development will benefit subsequent professional practice and assist cost-effective joint education and training which could offer some interesting opportunities for innovative curricula. This has great potential in the community setting but raises some crucial issues such as practice teaching of clinical competence in the community and fragmentation of programmes.

What is abundantly clear is that educationalists must take up the challenge presented in the new planning and commissioning guidelines laid down by the centre for education and training in health and social care. Review of the current climate of change sends a crucial signal to those educationalists preparing programmes for the next century which have distinct implications for primary health and community care. It appears essential to support the development of a hierarchy of qualifications providing links and ladders of opportunity leading to a continuum of qualifications designed to meet the needs of individual localities in the community.

THE FUTURE OF PRIMARY HEALTH CARE EDUCATION: A MODEL FOR CHANGE

The issue of a common core curriculum for community health care professionals has generated much debate and provided the focus for innovative developments in higher education. According to Vanclay (1995), the challenge that remains is how to tackle implementation difficulties and develop processes, relationships and systems that will really help to create and sustain increased understanding and collaboration between users, practitioners, educators, managers, purchasers and policy-makers. This debate is now extended to include the hypotheses of an 'NVQ revolution' and 'occupational standards movement' in the education commissioning process.

In spite of many uncertainties and challenges, Health Care 2000 (1995) has recently drawn attention to some clearly-identified trends which are likely to challenge educators over the coming decade. In particular, the shift towards the community is raising key questions about the way in which health and social care professionals are educated to practise in the community setting. The document identifies key areas which should be given careful consideration by planners and policy makers in the immediate future. These areas are as follows:

- Exploring the merits of a common core curriculum, such as understanding the ethics of health care and quality assurances, for all health care professions.
- Facilitating greater flexibility between professions in the acquisition of new skills and performance of tasks (Health Care 2000, 1995).

Skillbeck (1982) argued that:

> '. . . core learnings are basic and essential, in that they are intended to provide a foundation or base upon which subsequent and related learnings may be built and this should provide learners with conceptual and methodological tools to continue their own learning.'
> (Skillbeck, 1982, cited in Gilling, 1989, p. 82)

Hugman (1995) also recognises the potential of shared learning in community health care, and notes that it is possible to define the core of both professions in the field of child protection in similar terms. Examples include assessment skills, especially in relation to risk factors, knowledge of child development and family dynamics, skills in intervention in families, anti-discriminatory values and legal knowledge.

It would therefore appear from the literature that there is the potential in the immediate future to introduce innovative and exciting programmes of study to facilitate the preparation of professionals fully competent to work in the primary health care setting and able to cope efficiently with the diversity of community needs into the next century (Department of Health, 1993; SNMAC, 1995).

This complexity and diversity presents a major challenge to educationalists whose key aim is to provide flexible and innovative study programmes designed to assist practitioners to cope with change in day-to-day practice (NHS Executive, 1995c).

It is clear that many would argue that the way forward should be determined through common core approaches to education and training as a means of capitalising on the perceived advantages of shared learning. Furthermore, if it is agreed that, as proposed by Howkins (1995), professional ideology relates to particular sets of values and moral attitudes which are generally acquired through training and induction processes, it is essential to progress with interprofessional education for primary health care. This poses the question:

- Why is it so difficult to provide interprofessional education?

With two additional questions raised by Horder (1995):

- What is needed to advance interprofessional education?
- What are the factors that should be taken into account to ensure a curriculum for collaboration?

Experience of joint preparation programmes suggests that considerable planning is required from the onset (Bell, 1988). Credence must be paid to the long-established histories of some aspects of community education involving strong professional interests. Hyde (1989) reminded us that a definition of curriculum encompasses an attempt to communicate essential features of an educational programme in such a form that it is open to scrutiny and yet is capable of translation into practice. It involves both content and method in its widest senses taking account of problems of implementation in higher education establishments. The corollary of this is that careful planning should be applied to curriculum development.

- What does this mean for interprofessional education for primary health care?

INTERPROFESSIONAL EDUCATION FOR COMMUNITY CARE: THE CONCEPT OF PLANNING

Over the years, many attempts have been made to clarify the meaning of planning. Lee and Mills (1982), described planning as the process of deciding how the future should be different from the present, what changes are necessary and how should they be implemented. In theory it is a detailed, rational and corporate attempt to handle broad societal problems (Lee and Mills, 1982).

Furthermore, Hoare *et al.* (1984) point out that the practice of planning is a process whereby choices and alternatives are considered and evaluated according to the likelihood that this will result in the achievement of the desired objectives. Whilst concurring with the previous points, it is proposed that the definition fails to take into account:

- Different actors/participants and interest groups;
- Mechanisms that exist for them to negotiate and thereby identify objectives and resolve conflict;
- The context in which the planning takes place in terms of political economic and technical structures;
- Problems of implementing plans;
- The degree to which planning constitutes a separate discipline from other methods of decision-making and thought processes.

Nevertheless, there are number of planning theories which could assist curriculum planning involved in community care education. According to the literature there appear to be two polar extremes:

1. A rational comprehensive model which assumes that the planner is able to identify objectives and systematically evaluate all the options.
2. An incrementalist model, the other extreme, emphasising the practical difficulties of the rational approach and focusing on

> marginal or incremental steps, often referred to as 'muddling through' (Hoare *et al.*, 1984)

However, there is a third approach which could be effectively applied to curriculum development of interprofessional education for community health and social care professionals: the process of 'mixed scanning'. This model views the planning process as a continuum and confines itself to the use of key areas of the decision-making process. Lee and Mills (1982) quotes Etzioni, who coined the term 'mixed scanning' indicating that such a strategy would employ two 'cameras', one wide-angled camera that would cover all parts of the landscape but not in detail, and a second which would zoom in on all those areas indicated by the first as worthy of more detailed examination. In relation to education for community health care, the first would involve a review of the totality of the working environment including the diversity of health care professionals involved in care delivery, with the second zooming in on all those key areas indicated by the first process which reflect common factors and which warrant consideration in order to move forward.

Using a 'mixed scanning' approach to review community health education it is possible to utilise the aims of primary health care identified by WHO (1978) as a rational framework for curriculum development. This definition implies that primary health care is about *accessibility, availability, cost-effectiveness* and *acceptability.*

Educationalists in the field of health care delivery should use these key elements as a focus to develop a framework incorporating the essential features which must be taken into account when developing a curriculum to secure interprofessional education and shared learning for collaborative community health care.

Justification for this proposal is as follows: firstly, change is essential. Changes are already taking place in education and radical approaches are required which encourage the sharing of skills and effective collaboration in health care (Health Care 2000, 1995; NHS Executive, 1995c). An acceptable framework to encourage the development of common core programmes which support the development of a continuum of qualifications appears essential as we approach the next century.

Secondly, the main objective of education and training is to promote standards of care and to motivate people to provide optimum service, while securing maximum cost-effectiveness in times of financial constraints (Talbot, 1995; Mackay and Webb, 1995; NHS Executive, 1995c).

This rests heavily on producing education and training that reflects the service environment and takes full account of workforce planning projections. In this context both community nurses and social workers are subject to many influences in common and therefore the aims of primary health care as defined by the World Health Organisation (1978) are relevant to both. Using the key elements of the definition of primary health care, it is possible to categorise crucial issues which must be taken into account when attempting to develop appropriate interprofessional education for primary health and community care workers. This will ensure that planners reflect upon pertinent issues which reflect the overall aims of primary health care. Essentially, this should also encourage all participants in primary health care to generate care delivery based upon globally-accepted aims in accordance with policy-makers' directives.

We propose that planning offers a simple yet effective approach to curriculum development and design in support of interprofessional education for primary health and community care. It recognises that interprofessional education offers a means of 'bridging the gap' between services and promoting collaboration, but also that it is essential to make programmes contextually meaningful to encourage true understanding and collaborative growth (Nocan, 1994). Moreover, this proposal acknowledges the importance of educationalists endeavouring to assist organisations to analyse locality needs and to identify gaps in learning-needs of a range of health care professionals (NHS Executive, 1995c).

In addition, we recommend that curriculum planners should base their curriculum design around a model reflecting the crucial elements of primary health care as illustrated in the universally accepted definition of primary health care which is promoted by the World Health Organisation. It is argued that this model will give an easily-recognised sense of direction to interprofessional educational strategies for this important working environment, and offer a framework by which to measure the effectiveness of programmes of study and indeed interprofessional education *per se*.

- What will this mean in terms of practical developments in interprofessional education?

The main purpose of this approach is to ensure a sound and relevant 'bedrock' for interprofessional education which maximises the potential for shared learning and takes on board the importance of robust work-force-planning in the health and social care sectors (NHS Executive, 1995c). According to Funnell (1995), shared learning is more likely to generate value when all participants are united by a common and commonly-perceived task with clear end products. The fulfilment of the WHO aims appears to be meaningful to groups from diverse professional backgrounds. It is suggested that use of this model by curriculum planners will produce a contextual environment and encourage modes of learning that are perceived as relevant. The recent CAIPE project (Vanclay, 1995) proposed the following reasons for shared learning which give an insight into the benefits of developments in this field:

- The desire to increase trust and communication;
- Economy of scale;
- Responding to education changes;
- Updating knowledge together;
- Breaking down the professional boundaries (Vanclay, 1995).

Building upon the 'mixed scanning' approach to curriculum development, and scanning the broad arena of primary health care and current education, suggests that, in reality, primary health care is about a cluster of activities which can be viewed as a taxonomy of primary health care, as shown in Figure 6.1. These clusters of activities centre around *accessibility, availability, cost-effectiveness* and *acceptability*. Each cluster could be used to identify many complex aspects and factors inherent in, and relevant to, planning of interprofessional education for primary health care. The components of the taxonomy can act as catalysts for curriculum development and encourage the development of interprofessional education which is meaningful and relevant to the range of health care professionals engaged in the delivery of care.

The following text gives examples of, and insight into, the application of the taxonomy and is presented as a model for debate. It is intended to simply reflect the breadth and complexity of the issues which face those involved in primary health and community education in today's climate, and gives a flavour to the kinds of issues which require consideration. It should be noted that this framework is not exhaustive but should be viewed as a starting point for collaborative ventures in this field.

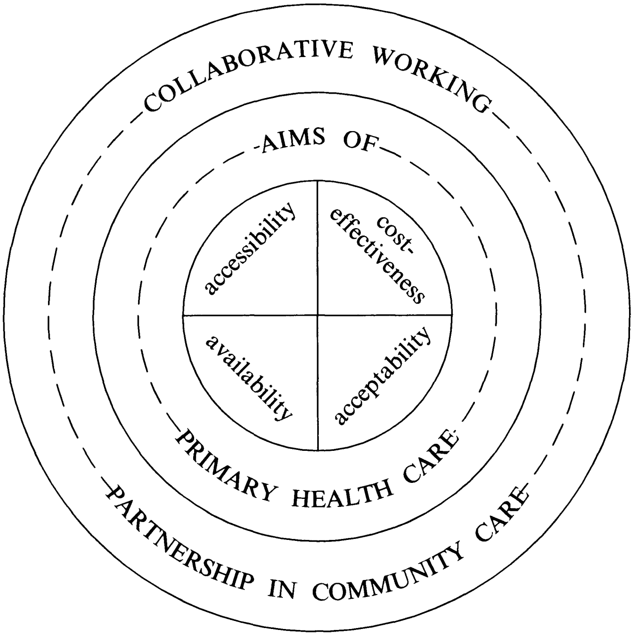
Accessibility

Curriculum planners must pay strict attention to the complexity of accessibility issues and recognise that education must be practice or service-based where possible (Horder, 1995). In addition, this model addresses the necessity to provide 'ladders of opportunity' across the continuum of qualifications at all levels (NHS Executive, 1995b).

In relation to curriculum planning, this will involve taking full account of preferences in relation to, for example, modes of delivery: recognising that the range of alternatives is wide, including full-time/part-time/modular programmes; accredited workshops and distance/work-based learning; entry profiles and selection criteria; equal opportunities issues; information technology advances and Internet systems; learning packages and interactive teaching methods; timing of programmes and units of learning; institutional policies and regulations.

See for example Barr (1995), Horder (1995), Funnell (1995), CETSW Paper 31 (1992), NHS Executive (1995c).

Figure 6.1 Taxonomy of primary health care: a framework for interprofessional education



Availability

According to the literature, evaluation of interprofessional education in the UK indicates that shared learning can improve attitudes and perceptions between professionals (Barr and Shaw, 1995) in a way which rests heavily upon the appropriateness of the curriculum. Focusing on the issue of availability would provide the opportunity to examine the central concept of competency as perceived by all groups in greater detail, thus ensuring levels of dialogue that complement the complexity of the debate (Hyland, 1994).

This component of the taxonomy could facilitate review of the curriculum and the professional requirements of the different professional groups in order to devise a relevant programme of study. This could include:

- Models of care and professional competencies;
- Generic and core skills;
- Reflective practice and quality assurance;
- User-centred philosophies;
- Academic studies to encourage understanding of communication and management skills, as well as socio-economic and political aspects of care delivery, for example child protection;
- Epidemiology, health needs analysis and collaborative inquiry;
- Multidisciplinary outcomes;
- Professional requirements and regulatory mechanisms;
- Legal aspects of primary health and social care;
- Health economics;
- Health ethics and values;
- Profession-specific studies.

See for example Barr (1995), Howkins (1995), Cain *et al.* (1995), SNMAC (1995), Department of Health (1994), Hyland (1994), Thornton (1995), Home Office, Department of Health, Department of Education and Science and Welsh Office (1991), NHS Executive (1994).

Cost-effectiveness

According to Soothill, Mackay and Webb (1995) exploring the reality of current professional working is complex for there are many sites and situations where one could focus on the effectiveness or otherwise of interprofessional relationships. However, it is clear that in all professions cost-effectiveness is high on the agenda, both in terms of actual and 'hidden' costs of service delivery. It is abundantly clear that, in the future, education-commissioning will focus upon cost-effectiveness as a crucial consideration (NHS Executive, 1995b).

This component of the taxonomy will provide the opportunity for curriculum planners to address crucial issues which influence the current patterns of education provision for primary health care. These issues should involve:

- Value for money;
- Work-force planning and human resource strategies,;
- Labour replacement costs;
- Rationalisation issues;
- Credit accumulation and transfer systems;
- Skill-mix bundles and professional development;
- Purchaser consortia.

See for example NHS Executive (1995d), UKCC (1992), Soothill *et al.* (1995), Hugman (1995), NHS Executive (1995e), NHS Executive (1995f).

Acceptability

The National Consumer Council in 1995 reminded us that we must listen to the views of the users, and yet it could be argued that lay representation on professional committees is token. It is essential that education for primary health and community care involves the community it serves; therefore, opportunities must be made available for users to influence educational developments. This element of the model should ensure that the user's voice is given a high priority in the planning process.

According to Elliott (1995), separate education of different professionals and their distinctive philosophies makes for difficulties in working relationships which can present serious difficulties when planning interprofessional education. This requires careful handling from the outset and it is proposed that this final component of the taxonomy will provide a forum to discuss contentious issues surrounding profession ideologies, not least to encourage the use of a common language to support the understanding of roles and responsibilities (NHS Executive, 1995c). This aspect of the model should also encourage consideration of flexibility and the redefining of roles, if appropriate drawing attention to professional monitoring mechanisms already in place. Ultimately, this element recognises quite clearly, that it is possible to develop strategies for primary health care which are *available, accessible* and *cost-effective*, but are totally unacceptable to the professionals and service-providers involved. Consideration of this final component of the taxonomy will ensure that in-depth consideration is given to 'acceptability' issues including:

- Quality assurance and standards;
- Competencies and professional guidelines;
- The constitution of planning teams;
- The concept of patients/clients as partners;
- The status of user/service involvement;
- Professional representation;
- Continuing education and professional development agendas;
- Profiles of teachers;
- Research questions and opportunities.

See for example DoH (1991), Hennessy (1994), Hyland (1994), Bloomfield (1996), Berlin (1995).

CONCLUSIONS: CHALLENGES AND PRIORITIES

Firstly, the notion of an impending health crisis must be used positively in that there is an increased willingness to work together to promote health in the primary health and community setting (Vanclay, 1995). Interprofessional education rests heavily upon the willingness of all involved, so present trends (Hennessy and Tomlinson, 1994) indicate that the current environment should prove extremely supportive in developing education for collaboration. This must be capitalised upon!

In addition everyone will need to work together in a spirit of goodwill so that service users and carers can gain access to the ideal of 'seamless packages' of community care, which are designed to ensure that each individual receives sensible, caring treatment regardless of the status of the provider (Spurgeon, 1991).

Finally, the challenges facing professionals must be recognised and responded to:

> 'Change may be slow but professions must adapt to changing trends and needs . . . the distinctions in status will have to be less and more varied bundles of skills accommodated.'
> (Normand, 1993, p. 244)

The proposed taxonomy of Primary Health Care as a curriculum framework for interprofessional education is flexible and will take account of the diversity of professional interests in primary health and community care and encourage security and commitment to the development of broad-based primary health care. It acknowledges that learning takes place in a range of settings and recognises the importance of competence-based professional development for all members of the primary health care team. According to Berlin (1995), competence is common educational currency in all disciplines, particularly health, and must feature highly in all interprofessional developments. Interprofessional education must be practice or service-based focusing on the real tasks of service delivery for improved patient/client care (Horder, 1995).

In addition, this model will prove a useful tool with which to measure the outcomes of interprofessional programmes, and evaluation skills will play an essential part in moving forward in this crucial field.

According to Darvill (1995), perhaps the greatest challenge of all now is to involve users and carers as co-learners in order to achieve 'real feedback'. This is essential if education is to develop quality service delivery.

In addition, evaluation of interprofessional learning is crucial – the proposed taxonomy does not preclude the importance of evaluation of interprofessional initiatives in education – it is imperative that we gain more evidence about the value of interprofessional education as a way of improving collaboration. Horder (1995) reminds us that further studies are needed to demonstrate what shared learning can and cannot achieve. We need more evidence to prove its capacity to change behaviour as well as attitudes. In addition, the introduction of NVQs and occupational standards has heightened the competency debate. This is of crucial importance particularly in the field of primary health and community care if we are to take seriously the concept of quality service delivery.

This poses the questions :

- What do people need to learn about?
- Do they need to learn together?
- Is it possible to provide the level of flexibility demanded in the current market-place as well as safeguarding the interests of those entrusted to our care?

The challenges are great – primary health and community care, traditionally the Cinderella area of services, is at the start of a phase of great development in which interprofessional education and training will play a major part (Burton, 1995).

EDUCATIONALISTS MUST GRASP THE NETTLE NOW!

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Clinical Effectiveness: The Challenge for Community Nursing

Kieran Walshe

If this chapter were solely to report, concisely but fairly, the available evidence for the clinical effectiveness of community nursing services, it might be very short indeed. It is often said that there is little or no scientific evidence to support many health care interventions, but this evidentiary vacuum is more marked in some professions and care settings than in others. It seems to an outside observer that those working in community nursing services, such as district nursing, health visiting, practice nursing and school nursing, have remarkably little formal evidence with which to justify their patterns of clinical practice, or even in some cases their continued employment. There is a growing pressure on health care professionals in all disciplines and specialties, not just in the UK but internationally, to demonstrate the value of the services they provide. For community nurses in the NHS this challenge is particularly serious, because many of the services they deliver are already threatened by continuing changes resulting from the NHS reforms of 1989. In the 1990s, health care professions and organisations will increasingly have to demonstrate not only that they provide good quality care, at a low cost, but that their care is clinically and cost effective. Those who cannot or do not prove the effectiveness of what they do may not be doing it for much longer.

This chapter is structured into four main parts. It begins by examining the growing importance of clinical and cost-effectiveness in health care, and the development of what is becoming called the evidence-based health care movement. It then sets out some of the limited available evidence on the effectiveness of community nursing, and argues that the need for a more evidence-based community nursing service is almost self-evident. With that aim in mind, it then explores the quality and usefulness of research into community nursing, the arrangements for disseminating and communicating the findings of that research, and the challenges of changing clinical practice. Finally, some conclusions are presented on the implications of clinical effectiveness and evidence-based health care for community nurses.

THE DEVELOPMENT OF EVIDENCE-BASED HEALTH CARE

It is a truism that more or less all health care professionals would wish to provide the most effective care they can to the patients they serve. But what does 'effective' really mean in this context? Cochrane, an epidemiologist who was one of the founders of the science of evaluating health care interventions, suggested that effectiveness should be measured in terms of 'the benefit and the cost to the population of a particular type of activity' (Cochrane, 1972). Put another way, a health care intervention might be said to be effective if it can be demonstrated that it produces benefits (such as improved health status, reduced morbidity and mortality, or greater life satisfaction) for patients which justify its costs. It seems eminently reasonable that we should expect there to be evidence of the effectiveness of all health care interventions in regular use, but there is not. In practice, we seem a long way away from having a health care system which is 'evidence-based'.

Evidence-based health care is a relatively new term – at least in regular use – and there is no single and agreed definition of what it means. One of the leading advocates of the evidence-based health care movement, Canadian general physician David Sackett, argues that the term is shorthand for five linked ideas (Sackett, 1995). Firstly, clinical decision-making should be based on the best available information about effectiveness, from individual patients and from epidemiological, research and laboratory sources. Secondly, the clinical situation facing the professional should determine the nature and source of evidence used to make decisions, rather than habits, precedent or tradition. Thirdly, clinicians should be more willing to use epidemiological and statistical ways of thinking, and more able to integrate such evidence with their own personal experience. Fourthly, the evidence must be translated into actions which improve the effectiveness and quality of care for patients. Fifthly, clinicians should continually evaluate their own performance against these ideas. Sackett argues that practising evidence-based health care requires clinicians both to learn to find and use evidence of clinical effectiveness for themselves, and to make use of tools like guide-lines and protocols which others have produced and based on the best available information on the effectiveness of interventions.

Appleby, Walshe and Ham (1995) offer a simpler and more direct definition of evidence-based health care – that it involves researching the clinical and cost-effectiveness of health care interventions rigorously; disseminating the findings of that research proactively to clinicians and others with an interest in them; and applying those findings to change the patterns of clinical practice. These three stages are illustrated in Figure 7.1. Of course, the process is not as simple nor as linear as this diagram suggests, but it provides a useful model. Appleby *et al.* (1995) argue that traditionally, the NHS has been poor at each of these three stages. They suggest that research, not just in nursing but in all clinical disciplines, has been badly planned and inadequately resourced, and has failed to target the key research questions of importance to the health service. They assert that the dissemination of research findings has relied largely on publication in academic journals, despite plentiful evidence that such publications are a very poor way of getting information to clinicians who lack the time, skills or inclination to read them. Finally, they argue that the application of research findings to clinical practice has been almost wholly left up to the individual clinician, with the result that some have adopted new practices and kept up to date while many others have not.

The assertion at the start of this chapter, that there is little or no scientific evidence to support many common health care

Figure 7.1 Definition of evidence-based health care

interventions, is rarely challenged but it deserves to be. Leaving aside for the moment the question of what constitutes evidence (which is discussed later on), the US Office of Technology Assessment (1983) estimated that only about 10–20 per cent of medical practice was supported by experimental evidence from randomised controlled trials. In another study, Williamson, Goldschmidt and Jullson (1979) suggested that fewer than 10 per cent of common medical procedures were based on such research, while Dubinsky and Ferguson (1990) reported that only 21 per cent of a sample of 126 therapeutic and diagnostic technologies were firmly based on research evidence. All these available estimates relate to acute medical care, but it seems likely that, if anything, the figures for nursing, physiotherapy and community-based services would be lower still. Ellis and colleagues (1995) demonstrated that it does not have to be thus. They found that in a general medical team which was making strenuous efforts to practice evidence-based medicine, 82 per cent of treatments used had strong research evidence to support them. In other words, where the will to seek out and use evidence exists, the balance between interventions with research evidence to support them and those without can be dramatically reversed.

If the absence of research evidence to support many health care interventions does not convince health care professionals of the need for more evidence-based practice, then some examples of ineffective care which at best waste resources and at worst result in avoidable death and injury to patients should be considered. Such instances can generally be divided into three types. Firstly, there are health care interventions which are known to be effective, but which are not being used sufficiently or appropriately. It has been known for many years now that thrombolytic therapy given as soon as possible to people who have a myocardial infarction reduces the likelihood of further infarcts, and saves lives. However, there is plenty of evidence that some patients never get the thrombolytic drugs they need, and a proportion suffer and die as a result (Ketley and Woods, 1993). Another example is the use of steroids for women in pre-term labour. Giving steroids helps to prevent respiratory distress in the neonate, but although the research evidence is clear, many women do not get this therapy and the inevitable result is that some babies suffer avoidable morbidity or even mortality (Donaldson, 1992).

Secondly, there are health care interventions which are known to be ineffective, but which nevertheless continue to be used inappropriately. There is now good research evidence to suggest that dilatation and curettage is of no diagnostic or therapeutic benefit to women under 40 (Lewis, 1993), yet it continues to be the fourth commonest operation performed in the NHS (Yates, 1995). The insertion of grommets to treat glue ear in children, one of the commonest operations that ENT surgeons perform, has been much criticised as providing only temporary and limited improvements in hearing for many children, in whom the condition often spontaneously resolves anyway (*Lancet*, 1992). Surgical intervention to treat benign prostatic hyperplasia (BPH) is increasingly recognised as being inappropriate in men with mild or moderate symptoms because the procedure often does not improve things and can have serious adverse effects, yet many men in this category are still being advised to have a transurethral resection of prostate (TURP) (Donovan *et al.*, 1994).

Thirdly, there are many health care interventions of unknown or doubtful effectiveness, whose usage varies so much, from area to area or practitioner to practitioner, that they must be being used inappropriately in many cases. There is relatively little evidence for the effectiveness of different forms of stroke care and rehabilitation services, and tremendous variation around the UK in the proportion of patients with strokes who are admitted to hospital, the investigations used to confirm the diagnosis (such as CT scans, lumbar punctures and angiography), the treatments used to avoid further strokes (oral aspirin, oral anticoagulation, and carotid endarterectomy), and the treatments used in rehabilitation (such as speech therapy and physiotherapy) (Wade, 1994).

Of course there is some overlap between these categories, especially between the third category and the first or second. Even when the evidence seems relatively clear-cut, it is still possible for health care professionals to interpret it quite differently, which tends to move interventions from the first and second categories into the third.

THE EFFECTIVENESS OF COMMUNITY NURSING

Of course, many interventions by community nurses are effective, and there is research to demonstrate their effectiveness (Deal, 1994), but many others are of doubtful or unproven value. While the examples of ineffective clinical practice cited above are largely medical, similar instances can be sought and found in most disciplines, including community nursing. For example, compression bandaging for venous leg ulceration is an effective health care intervention which is still grossly under-used by district nurses (Moffat and O'Hare, 1995). Patients whose leg ulcers are being subjected to a wide range of other therapies are being denied the benefit of effective therapy, and their continuing treatment represents an avoidable and wasteful deployment of nursing resources.

There are also some ineffective health care interventions, which should probably be used less often than they are at present. Some nurses persist in undertaking frequent bladder washouts on patients with indwelling catheters with the intention of preventing blockages and infections, despite evidence that the untargetted use of this procedure is probably unnecessary and ineffective, and might even be harmful (Pomfret, 1995). Health visitors continue to make eight-month hearing checks on all babies, despite evidence that this is an ineffective way to identify children with significant hearing loss (Mott and Emond, 1994).

In community nursing it is the unexplained and unexplainable variations in practice in areas where there is little or no evidence that are most striking. Nurses working from the same office, let alone those from different parts of the country, often have quite difference approaches to dealing with similar referrals, and will devote very different numbers of visits to patients with the same condition. For example, Harley (1995) reported that the average episode of care by district nurses (from referral to eventual discharge) varied from four visits in one health authority to 63 visits in another, a massive difference which cannot be explained by differences in case-mix. The first-contact rate for patients over the age of 75 ranged from under 100 to over 800 contacts per thousand population per annum, and there was no relationship with measures of deprivation or need. In the face of this evidence, one has to conclude that some community nurses must be providing ineffective and inappropriate care.

Patients might be understandably confused and concerned if they realised how much of what health care professionals do is not based on strong scientific evidence. They would certainly be alarmed by the examples of demonstrably ineffective practices cited above. And they would probably find it difficult to reconcile such apparent negligence with their personal experience of their nurses as dedicated, hard-working and concerned professionals. Of course, no clinician sets out to deliver ineffective care, so there must be reasons for the persistence of ineffective patterns of practice which relate to the system of care itself – the way in which we organise, fund and manage health care. The problems seem partly to relate to the quality of research itself, partly to the way in which research findings are disseminated and brought to the attention of clinicians, and partly to the mechanisms for securing change in clinical practice where a change is indicated.

THE QUALITY AND USEFULNESS OF RESEARCH

The first, and most fundamental reason why non-research based practices persist is the poor quality, quantity and utility of the research on which community nurses and other health care professions are expected to base their clinical practice. Nursing research is a relatively young discipline, with a history of not much more than 30 years in the UK. It still struggles to compete with other health care disciplines, particularly medicine, for status and research funding. In a review of nursing research in 1992, Smith (1994) reported that nursing departments in UK universities had the dubious distinction of an average rating for the quality of their research that was lower than any other subject area. She also highlighted the shortage of clinical research, the predominance of theoretical papers and research into nurses themselves (rather than their patients), and the obsessive methodological debate about the relative merits of qualitative and quantitative research methods. In passing, she noted the scarcity of community research, and she concluded that there was a need to make nursing research more clinically relevant and useful.

Hopps (1994), reviewing the development of nursing research in the UK, pointed to a number of developments which bode well for the future of research in nursing such as recent changes to nurse education and the organisation of academic nursing departments, and argued that nursing was starting to build the effective repository of research-based knowledge it needed. But she too highlighted the problems of available research not being taken up and used by practising nurses. In a wider-ranging review of the literature on the effectiveness of nursing interventions, Thomas and Bond (1995) found that while there were a variety of studies reported in the literature, they were frequently methodologically flawed, based on inadequate sample sizes, and unable to support wider generalisation of their results. They argued for greater attention to methodological rigour, more experimental studies because they provide the best evidence of effectiveness, greater attention to theory development, concerted action to build up a coherent body of research knowledge in any particular topic, and more clinically focused research.

Nursing is not alone in being unhappy with the quality of its research base. Other clinical professions, such as physiotherapy and speech therapy, have similar problems. And although the volume of research into medical care is much greater, and there is a much longer history of such work taking place, the quality of much of that research and its usefulness to clinicians is just as questionable.

The weaknesses which have been described above are found in all areas of health care research and development, and they led the House of Lords Select Committee on Science and Technology to observe in 1988 that there were serious problems which needed to be addressed by the NHS as a whole, concerning the quality, relevance and utility of research in health care (Coulter, 1995). It particularly highlighted the absence of any mechanism by which the NHS could articulate its own research needs, fund and organise research programmes to meet those needs, or ensure that the findings from such research were disseminated and acted on.

As a result, in 1991 the first ever Director of Research and Development for the NHS was appointed, with the remit to create a research and development strategy for the NHS which was relevant to NHS needs, was multidisciplinary, and which particularly addressed the evaluation of the effectiveness of clinical interventions and approaches to service-delivery and organisation. In the last five years that ambitious strategy has done much to transform the place of research in the NHS, through a number of large new programmes of commissioned research. The funding of research in the NHS is changing, with a target that 1.5 per cent of NHS revenue should be dedicated to research and development, and a new national strategy for research in nursing, midwifery and health visiting has been developed which places the issues of evidence-based health care at the top of the research agenda, stating that 'the fundamental task is to evaluate the effectiveness of clinical procedures, practices and interventions' (Department of Health, 1993a).

Researching the effectiveness of community nursing, though it may deservedly receive more attention in the future, will remain an enterprise fraught with methodological and practical challenges (Barriball and Mackenzie, 1993). Nursing interventions are hard to define in terms which support the quantitative measurement of their impact on patients. Indeed, their impact can also be difficult to measure, and there is sometimes a risk that poor research designs will make them appear to have limited quantifiable benefits to patients. Also, the community is not an easy environment in which to research, because of the multi-disciplinary, fragmented service environment and the difficulties of controlling research conditions. These pressures make it difficult to carry out good, high-quality research of any kind, but particularly hard to design and execute quantitative, experimental studies such as randomised controlled trials.

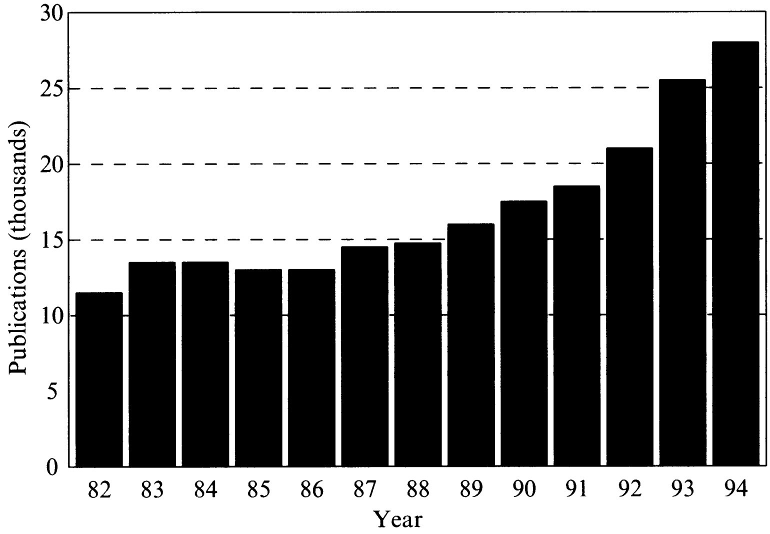
The debate about what constitutes good research evidence and what appropriate qualitative and quantitative methods should be used to obtain it is likely to continue. In other professions, notably medicine, quantitative methods including experimental designs are used much more widely than they are in nursing, where they sometimes inspire opposition because they are argued to be incapable of dealing with the ineffable nature of nursing practice (MacLeod, 1994). It is sensible to acknowledge that different research questions and contexts require different approaches or research designs, that complex and varied interactions may be less-suited to experimental methods, and that there are strengths in combining experimental and non-experimental methods within a study (Wilson-Barnett, 1991).

The aversion to experimental methods so evident in nursing research has left the profession without many researchers skilled in their use. Evaluating the effectiveness of nursing interventions is sure to make more use of such quantitative, experimental methods than other forms of nursing research, and so the need for nurse researchers with these skills is likely to grow.

HOW RESEARCH FINDINGS ARE DISSEMINATED

Even after all the caveats about the quality and nature of nursing research discussed above, there is still an enormous volume of existing research which nurses, including community nurses, can and should be using to inform their clinical practice. The main mechanism for disseminating research findings continues to be publication in an academic, refereed journal. The Cumulative Index to the Nursing and Allied Health Literature (CINAHL), the primary computerised index of nursing and allied health literature, indexed 27 898 papers published during 1994, approaching three-times the number indexed in 1982 as Figure 7.2 shows. But the act

Figure 7.2 Publications indexed on CINAHL by year of publication



of publication, seen as the end-point by many academics, is far from effective in disseminating the results of research. A small survey of 94 nurses showed that while popular nursing journals like *Nursing Times* and *Professional Nurse* were read regularly by about half the nurses surveyed, only a very small minority regularly read academic journals like the *Journal of Advanced Nursing* or the *International Journal of Nursing Studies* (Webb and MacKenzie, 1993).

There are three related sets of problems which act to constrain and prevent nurses accessing the results of research more readily. Firstly, and perhaps most importantly, there are attitudinal barriers to overcome, as Webb and Mackenzie's survey (1993) also demonstrated. Some nurses see research as irrelevant, over-academic, long-winded and foreign to their own ways of working. In part this reflects the fact that attempts to shift towards being a research-based profession are relatively recent in nursing. It may also demonstrate an understandable, common-sense reaction to some of the introspective, theorising research into nurses rather than nursing that was mentioned above. Either way, nurses who see little benefit in research are unlikely to make any effort to obtain research findings, let alone incorporate them into practice.

Secondly, many nurses lack the skills they need to find relevant research, to appraise its quality and relevance to their clinical situation, and to comprehend its implications for their clinical practice (Avis, 1994a, 1994b). Literature searching, the critical appraisal of research studies and the distillation of conclusions and recommendations for clinical practice are not skills which are taught extensively or practised widely (Pearcey, 1995). It does not help that, as Figure 7.2 shows, the volume of material which needs to be searched is growing steadily. Moreover, the language in which many research articles are written could almost be designed to deter clinicians and to hinder comprehension. The dense, long sentences, obfuscating terminology and over-referencing beloved of some academic journals mean that even once nurses have found reports of the research they need, they may find understanding and interpreting them difficult.

Thirdly, nurses face a host of practical and logistical problems in accessing research findings. Many nurses have poor or non-existent library facilities in their place of work. Community nurses, in particular, are likely to have to travel some distance to access books and journals, especially since changes in nurse education have meant that there are now fewer schools of nursing and so fewer libraries. Hospital and community trust libraries are often oriented towards the needs of medical staff, with limited resources and sometimes limited access for nurses. Even if access is possible, the pressures of work make it difficult to make time to use these facilities during the working day.

The inadequacies of journals as a mechanism for disseminating research findings have been recognised, and a number of alternative approaches are increasingly being used. Firstly, the review article, which provides a systematic and objective synthesis of the research evidence on a given topic, has become more common and more important. Of course review articles themselves are open to bias, and there is some evidence that different expert reviewers can reach quite different conclusions in review articles which draw on the same primary research. For these reasons, considerable effort and resources are being invested in undertaking systematic reviews, which follow a rigorous methodology focused largely on combining the quantitative evidence from multiple randomised controlled trials (Chalmers and Altman, 1995).

Secondly, the republishing of summaries of research articles in more digestible and structured forms is becoming common. In medicine, the value of carefully selected reports of research, quality-assured for their sound design and methods, is now the basis of two dedicated journals (Sackett and Haynes, 1995). In addition, the NHS research and development programme has invested heavily in producing and disseminating systematic reviews through a series of *Effective Health Care* bulletins (listed in Table 7.1) and through the creation of a Centre for Reviews and Dissemination based at the University of York.

Perhaps, however, the most exciting and potentially significant development of the last two years has been the development of the Cochrane Collaboration, an international partnership aimed at developing and maintaining systematic reviews of the literature on the effectiveness of health care interventions in a wide range of disciplines. Named after the epidemiologist who did so much to found the science of evaluating health care interventions (Cochrane, 1972), the Cochrane Collaboration consists of a number of coordinating centres in the UK, North America, Europe and Australia, which host a growing number of interest groups of clinicians and researchers. Each group takes responsibility for searching for and identifying all the available experimental evidence on a given topic or issue, producing a systematic review of that literature in a standardised format, and keeping it up to date by adding new evidence as it becomes available.

The Cochrane Collaboration has been founded on the work undertaken by Chalmers and others over the last two decades to develop and maintain *Effective Care in Pregnancy and Childbirth*, a comprehensive and structured collection of systematic review of the

Table 7.1 *Effective Health Care* bulletins

Screening for osteoporosis to prevent fractures
Stroke rehabilitation
The management of subfertility
The treatment of persistent glue ear
The treatment of depression in primary care
Cholesterol screening and treatment
Brief interventions and alcohol use
Implementing clinical practice guide-lines
Menorrhagia
Benign prostatic hypertrophy
Pressure sores
Cataracts
Hip replacement

literature on caring for women during pregnancy and childbirth (Chalmers, Enkin and Keirse, 1993). The work involved is time-consuming and laborious, and participants are not financially remunerated for their efforts. The output from the Cochrane Collaboration is published on CD-ROM as the Cochrane Database of Systematic Reviews, which is now widely available in the UK and elsewhere. The main criticism of the Cochrane Collaboration's work is that it focuses solely on randomised controlled trials, and takes little or no account of other quantitative and qualitative forms of evidence.

IMPLEMENTING CHANGE

Even when the research evidence is clear, and the information is made freely and easily available to clinicians, changes in clinical practice can be frustratingly slow to result. For example, the *Effective Health Care* bulletin on Selective Serotonin Reuptake Inhibitors or SSRIs (a new form of antidepressant drug) said that they should not be prescribed as they cost much more than traditional antidepressants and were not significantly more effective (Freemantle, 1994). The rate of SSRI prescribing, however, has since risen dramatically, driven by strong marketing by the pharmaceutical companies concerned, and apparently unaffected by the evidence presented in the *Effective Health Care* bulletin. More proactive and powerful mechanisms for ensuring that information on effectiveness is understood, accepted and adopted by clinicians are needed.

Although the process of changing practice is not well-understood, and may be the most complex and challenging stage in the evidence-based health care model set out in Figure 7.1, it has been the subject of relatively little attention from researchers. One model, which serves to highlight the complexity of the task of changing practice, suggests that there are four dimensions or attributes of any change which need to be considered (Department of Health, 1995). Firstly, there is the nature of the change itself – what is entailed in bringing it about, what benefits it will offer and for whom, how easy it is to implement and monitor, and so on. Secondly, there are the players or participants in the change process – those with an interest or involvement in the area of practice being changed. This may include clinicians, managers, purchasers, patients, researchers and policy-makers, and any strategy for bringing about change has to take account of their respective roles. Thirdly, there are the many different interventions which can be used to cause change. There is a huge variety of techniques or methods which can be used, and they can be difficult to categorise, but a selection of common approaches is listed in Table 7.2. Finally, there are the levers and barriers which are likely to promote or hinder change. These are the factors such as funding arrangements, financial incentives, organisational structures and other characteristics of the environment in which the change is to take place.

In researching the way in which clinicians change their practice in response to research findings, Oxman (1994) concluded that there were 'no magic bullets'. In other words, no simple approaches existed which could be used singly, applied widely and easily, and which would be effective in changing practice. Rather, the research suggests that approaches to changing practice are highly context-dependent, and it is difficult to generalise about their effectiveness. Approaches seem to be more successful when they are fitted to the organisational and social context in which they are to be used, and take account of the people and organisations they are trying to change. It also seems that multiple approaches, which are complementary or even overlapping, are more successful than single techniques used alone.

One development, however, which has taken place over the last five years may hold the key to the complex and challenging business of implementing change in the NHS and promoting the development of evidence-based health care. Since the introduction of clinical audit as part of the NHS reforms in 1989, about £220 million of special funding has been invested in creating an infrastructure for auditing the quality of clinical care in every health care

Table 7.2 Interventions to promote change

Academic detailing, or educational outreach visits
Audit and feedback of results
Attendance at conferences
The development and distribution of educational materials
The use of guide-lines and protocols
Marketing
The use of opinion leaders to influence others
Patient-mediated interventions
Reminder systems
Decision support systems

provider in England (Department of Health, 1993b). Every trust now has some form of clinical audit department, staffed with personnel whose primary remit is to help clinicians to examine the quality of care they deliver and to identify opportunities to make improvements. All trusts have some form of clinical audit committee, usually responsible to the trust board for clinical quality issues. These committees bring together senior clinicians from across the provider organisation to talk about the quality problems they face, often for the first time. Studies have shown that more clinical professionals than ever before in every discipline are now taking part in some form of regular clinical audit activities, with 95 per cent of departments holding some form of regular audit meetings (Buttery, Walshe, Coles *et al.*, 1994).

Of course, the content and effectiveness of these clinical audit activities varies tremendously. Current clinical audit activities in health care providers have many flaws, among them poor strategic direction, limited links to wider corporate goals and processes, inadequate planning and project management, little investment in training for audit staff and clinicians, few incentives or sanctions to promote participation, and an unhealthy medical dominance of the audit process. There are certainly many opportunities to improve the effectiveness of audit itself, and a growing body of research exists to inform the development of the clinical audit foundation (Walshe, 1995a,b). But the achievements of the last five years should not be underestimated. Firstly, an infrastructure for clinical audit has been established which, despite its weaknesses, is a formidable and available mechanism for implementing change and monitoring clinical practice. Secondly, attitudes of clinicians (particularly, but not only, doctors) towards the systematic assessment and improvement of clinical performance have changed. In the 1980s doctors were described as 'collectively allergic to rational examination of the case for medical audit in any form' (Maxwell, 1984). Yet, more recently, a *British Medical Journal* editorial urged doctors to 'claim ownership of audit, and see a constant search for improvement as a central part of being a doctor' (Moss and Smith, 1991). While clinicians who treasure their notions of clinical freedom and professional self-rule above all else can still be found, they no longer predominate. In most clinical professions, the need for quality management, accountability and performance measurement is increasingly accepted.

Provider audit programmes are a readily available and existing channel through which the growing volume of information on clinical effectiveness can be used. Clinical audit provides a natural mechanism both for implementing changes in clinical practice and for monitoring practice to ensure that lasting change has occurred. But without a sound basis of evidence, clinical audit activities can become muddled and confused, and are unlikely to be able to convince clinicians of the need for changes in clinical practice. For that reason, clinical audit and clinical effectiveness can be seen as natural partners, neither of which can really work without the other. Certainly, clinical audit seems to offer the most immediately available and apparently suitable mechanism for starting to implement evidence-based health care.

CONCLUSIONS

It seems certain that health care professionals will increasingly be asked by those who use their services and those who fund them to demonstrate the effectiveness of what they do. Those professionals who cannot or do not meet this challenge and address it put at risk the future of their own working lives, their profession, and the benefit they undoubtedly believe they are bringing to patients.

Up to now, as in too many other things, the medical profession has dominated the debate about clinical effectiveness, and has marked out the territory of evidence-based health care as its own. Perhaps understandably, since medical research has been established for longer, is better-funded and more quantitative in orientation than nursing research, the development of evidence-based health care and the NHS research and development programme has been biomedically-led. It is now essential that nurses stake their claim to an important role in this developing arena. Firstly, there is a pressing need for a more strategic and planned approach to research in nursing, focused on identifying priority areas for research and commissioning studies to meet those needs. Secondly, nurses need to learn from the example of the Cochrane Collaboration (though not necessarily to adopt their methods), and to start to organise their body of research knowledge in a systematic and orderly fashion which makes it accessible and usable. Thirdly, nurses working in clinical practice and their managers have to be persuaded to take research findings more seriously than they have done to date. The challenge of creating community nursing services which are clinically effective and can be shown to be so is a considerable one, but it is a challenge that nurses cannot afford to ignore.

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CHAPTER EIGHT

Palliative Care in the Community

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INTRODUCTION

This chapter is concerned with the provision of palliative care. Palliative derives from the Latin word pallium, meaning a cloak or cover. In this context it refers to the provision of active care for a person whose condition is not responsive to curative treatment. A more developed definition is that palliative care is

> 'The active total care offered to a patient with a progressive disease and their family when it is recognised that the illness is no longer curable, in order to concentrate on the quality of life and the alleviation of distressing symptoms within the framework of a coordinated service. Palliative care provides relief from pain and other distressing symptoms, it integrates the psychological and spiritual aspects of care and it offers a support system to help friends and relatives to cope during the patient's illness and in bereavement.'
> (SMAC/SNMAC, 1992)

Modern approaches to palliative care began in the UK after the Second World War and were concentrated in those first years in hospices. Dame Cicely Saunders, first at St Joseph's in Hackney and then St Christopher's Hospice in Sydenham, demonstrated a concern both to offer holistic care and to incorporate advances in symptom, and especially pain, control. In part, the development of the hospice movement was built on the observed deficiencies of the existing system, and in part it was a positive affirmation of a new way of approaching a need that crossed medical, social and spiritual boundaries.

Through the 1960s and 1970s in-patient hospices were the principal type of specialist palliative services developed. Some grew up within the NHS, others were run by voluntary organisations, charities and churches. Although the number of hospices grew, and in some places developed education and training functions, the great majority of patients who were eligible for palliative care were cared for in primary care settings or in ordinary hospital wards. The need, if the maximum benefit was to be gained from the progress in the hospices, was to disseminate practice into the community and the general hospital. Indeed the 1980 Wilkes Report argued that there was no reason why the hospices should continue to proliferate. It was preferable to 'encourage the dissemination of the principles of terminal care throughout the health service to develop an integrated system of care with the emphasis on co-ordination between the primary care sector, the hospital sector and the hospice movement' (Wilkes, 1980, p. 10).

The hospices did continue to grow in number, but in the 1980s there was also a growth of support teams. These consisted of specialist staff who would offer advice and support to health workers in the community or in hospitals. Trained nurses, often initially funded by the Cancer Relief Macmillan Fund, were at the centre of many of these teams. Medical social workers played a role as did doctors, physiotherapists and occupational therapists in the larger teams (Higginson, 1993a).

Subsequent developments have included the provision of day-care, either by an in-patient hospice or by a palliative-care team; the development of 'hospice at home' in which existing community services were augmented so that a twenty-four hour nursing or sitting service was provided (sometimes in collaboration with an existing Marie Curie provision); and specialist outpatient clinics which may concentrate on specific medical or social needs.

The resulting picture of services, summarised in Table 8.1, is a complex one. It is made more complex by the variation in funding arrangements, the local variation in service-provision, and the shortcomings of palliative care in any setting for people with an illness other than cancer.

Table 8.1 Hospice services in the UK and Republic of Ireland

In-patient hospices (3182 beds) 208

Type of in-patient unit	*Number of Units*	*Number of Beds*
Independent or Voluntary	142	2196
NHS Managed Units	46	533
Marie Curie Cancer Care Centres	11	290
Sue Ryder Homes	9	163

Community based palliative care teams +400 (260 freestanding and 150 attached to hospice in-patient units)
Day care hospices +200
Support nurse/teams in hospitals 250

Source: Adapted from Directory of Hospice Services, St Christopher's Hospice Information Service, 1994 and 1995.

THE NEED FOR PALLIATIVE CARE

The UK, in common with other advanced industrial countries, is characterised by an ageing population. Life expectancy has increased; in 1991 it was 73.2 years for men and 78.2 for women, and the survival of the very elderly has continued to improve, with 2.1 million people over 80 in 1991 (Central Statistical Office, 1992). Strongly related to these changes is a shift in the nature and pattern of disease. Diseases of the heart and circulatory system continue to be major killers but very many deaths are primarily caused by chronic degenerative diseases of the circulatory and respiratory systems and by cancers. These are predominantly diseases of the elderly. The number of people dying of cancer has not changed (although the primary sites of the cancer might have) throughout the life of the NHS. What has happened is that cancer deaths are occurring in older people. Often first manifestations of cancer can be responded to in such a way as to allow many more years of life. Table 8.2 provides a summary.

As well as there being a clear picture of considerable need, figures on where people with palliative-care needs die illustrate the importance of disseminating palliative care expertise to hospitals and the community, including to nursing and residential homes (see Table 8.3).

Table 8.2 Death rates per million population from common conditions in England

Age	*Sex*	*Neoplasms*	*Disease of the circulatory system*	*Disease of the respiratory system*
all ages	M	3017	4830	1174
	F	2648	5016	1175
65–74	M	12621	17517	3376
	F	7668	9034	1876
75–84	M	23532	43559	11575
	F	12404	29517	5492
85+	M	34529	88641	37272
	F	16868	76305	22709

Source: Adapted from OPCS, 1993.

Table 8.3 Place of death in 1991 of patients who were identified as having a terminal or palliative period in one health region.

Place of death	*Cancer deaths (N 2074)*	*Non-cancer deaths (N 1622)*
Home	29%	22%
Hospital	50%	57%
Hospice	13%	0%
Nursing/residential home	7%	16%
Ambulance/street	0%	5%

Source: Adapted from Addington-Hall, 1993.

'THE DYING TRIAD'

Consistent with the development of the hospice approach has been the recognition that there is a 'dying triad' – the patient, the professional and the informal carer (Gilley, 1988). In practice, informal care usually means care by family members, usually with one person carrying out the bulk of activities. That person is most often a spouse, is often of a similar age to the person being cared for, and is usually a woman. It may be that as a death approaches the network of carers expands, as compared with the pattern of care for a chronically sick person. But in the majority of cases the contribution of those other than the principal care-giver is in the area of emotional support (Seale, 1990).

Much recent health and social care policy has been predicated on the belief that there is a popular preference for informal care. It is a preference considered to be in the interests of a public policy that wishes to reduce the role and financial outlay of state services. In practice much informal care is not adequate, either emotionally or practically (Twigg, 1989). Further, 'Informal care is an uncommandable, unspecifiable resource that is unevenly distributed' (Neale, 1993). Even when informal care is available, there is a need to combat the often experienced social isolation of carers and to offer support to the carers in areas where they feel least able to meet the needs of the person they are caring for. In palliative care the emotional demands any caring entails can be compounded by the anxiety over impending death. In addition people in the last year of life often have particularly high levels of dependency, which results in severe restrictions on the carers' lives (Dand *et al.*, 1991).

Neale (1993) identified two trends in the last decade in palliative care which may impact on support for carers and influence the workings of the 'dying triad'. First is the development and changes evident within the hospice movement. Second is the trend in palliative care towards care in the community. A third can be added, the development of professional specialisms.

It may be that, although carers rate hospice care as better than mainstream provision (Seale, 1991), there is not as much attention given to carers' needs and views as the model would presume (see Dand *et al.*, 1991). This may be because of the pressures of responding to the 'new' NHS with its purchasers and providers (see Clark, 1993), or to a routinisation of the hospices as the approach expands and moves from being innovatory to established (James and Field, 1992).

As well as changes within hospices there has been the shift towards care in the community. This provides opportunities to disseminate the ideas of palliative care to that area where most care takes place; on average patients spend 90 per cent of their terminal year at home being cared for by informal carers with primary health care team back-up (Neale,1993). It also provides challenges, for example providing the appropriate level of support to lay carers and effecting a co-ordinating role over the complex array of potential sources of help available. Blyth (1992) identified up to 25 different professional and voluntary groups who could play a part. Although structurally in a crucial place, GPs, either through training, finance or time constraints, would find such co-ordination problematic.

As well as changes in hospices and in community care, a third development of importance is that of medical and nursing specialisms. Palliative medicine was established as a specialism by the Royal College of Physicians in 1987. It would appear that, so far, accreditation has concentrated on hospital doctors trained in internal medicine and in specialities like oncology. In nursing, the English National Board for Nursing has established two higher qualifications for nurses who wish to practise palliative care. One result of these developments has been to start a debate about the extent to which dying is being medicalised (see Ahmedzai, 1993; Biswas, 1993)

THE YORK PALLIATIVE CARE STUDY

To examine the dying triad in more detail we will continue with a consideration of data identifying the experience of palliative care in the UK today. The Centre for Health Economics at York University has been carrying out a Department of Health funded study designed to identify costs and impact on patients and carers of a range of palliative care services. Following a pilot study, the main period of data collection was between March and December 1994 in eight health districts in the north of England. The districts were selected according to the following criteria. First they had to have a hospice so that the study could look at the three key settings for the delivery of palliative care, hospice, hospital and community. Second, districts were selected with a high proportion of ethnic minority groups relative to the general population, but with a population that resembled England and Wales as a whole in regard to age and socio-economic factors. The result was that four districts were identified within Yorkshire Regional Health Authority and four in the North West Regional Health Authority.

Research nurses, with experience of working in palliative care, were appointed and began to recruit patients to the study. Inclusion criteria for patients were that they should be aged over 21 and that they should have an active progressive disease where the intention of treatment was not curative. Further, they should not show signs of cognitive impairment or psychotic disease. Patients were also excluded if they were considered too ill to complete the questionnaires which formed the basis of the research data.

In total 661 patients were recruited to the study of whom 280 were in hospices, 212 in the community and 169 in hospitals. In what follows we will concentrate on the 212 patients who were receiving palliative care in the community. Details of their socio-demographic and medical characteristics are presented in Tables 8.4 and 8.5. The majority of patients were female, did not live alone and had a carer. However these majorities were not overwhelming, 23 per cent of patients not having a carer, or 31 per cent aged under 59 represent a large proportion. Seventy per cent of patients had cancer as a main diagnosis. This is a lower percentage than in the total patient sample where the figure was 87 per cent. Those people identified as receiving palliative care in hospices and hospitals overwhelmingly are cancer patients, 97 per cent of hospice patients and 91 per cent of hospital patients. It can be noted that despite choosing areas of study with disproportionately high ethnic minority populations, we did not recruit people from any ethnic group other than white British. The problems of access to hospice and specialist palliative care services by members of black and ethnic minority populations are being increasingly recognised (Hill and Penso, 1995).

People receiving palliative care in the community in our study often had a prognosis of over 12 months, although 42 per cent were expected to live less than a year. The WHO score, completed by the patients' doctor at the point at which they were admitted to the study, is a measure of dependency, as identified by a five-point scale of ability or restriction, ranging from zero which is free from restriction to four which means incapable of self-care and completely confined to bed or a chair. We can see that 53 per cent of our study population had scores of three or four and, in consequence, can be seen as having very considerable restrictions on their everyday lives.

As already described, the role of lay carers is crucial to the nature and experience of care. In our study we recruited 99 lay carers, and their profiles are summarised in Table 8.6. Of those carers in the age group 21 to 59, 30 were not employed, nine did part-time work and 11 were employed full-time. None of the other carers in older age groups were employed. Twenty-five people being cared for in the community reported that they had nobody they could turn to for emotional support.

The majority of medical and nursing care was delivered at home. During the week before the completion of our baseline questionnaire only 13 patients had attended their GP's practice. Almost a third, 59, had been visited by their GP and 124 had received a visit from a district nurse. The majority of patients who received a visit from their GP were visited once, and half the patients having a visit from a district nurse were seen once. However some patients had much more frequent attention. Nineteen received two visits from district nurses, 14 had seven visits and six had 14 visits. Visits by both GPs and district nurses lasted an average of 25 minutes, with a maximum recorded as 90 minutes (excluding one exceptional visit by a district nurse which lasted over five hours) (Table 8.7). Apart from medical and nursing staff a considerable range of other professional groups were mentioned as visiting patients during the week: the vicar or priest (14 people) private carer (six), Crossroads sitter (five), home-care helper (five), private cleaner (five), physiotherapist (four).

Table 8.4 Socio-demographic characteristics of patients, recruited from the community (n = 212)

Sex		
Male	85	(40%)
Female	127	(60%)
Age Group		
21 to 59	66	(31%)
60 to 74	102	(48%)
75 and over	43	(20%)
Ethnic Group		
White	212	(100%)
Black Caribbean	–	–
Asian	–	–
Marital Status		
Married/cohabiting	121	(57%)
Widowed	60	(28%)
Divorced/separated	13	(6%)
Single	18	(8%)
Does patient live alone?		
Yes	56	(27%)
No[1]	152	(73%)
Does patient have a carer?		
Yes[1]	160	(77%)
No	47	(23%)

[1] Includes patients living in residential accommodation.

Table 8.5 Medical characteristics of recruited patients, community (n = 197)

Main Diagnosis		
Cancer	136	(70%)
COAD/Emphysema	5	(3%)
Motor Neurone Disease	5	(3%)
Multiple Sclerosis	34	(17%)
Other	17	(9%)
Prognosis		
Less than one month	1	(<1%)
One to six months	39	(21%)
Six to twelve months	37	(20%)
More than 12 months	105	(56%)
Unknown/refused to state	5	(3%)
WHO Score at Baseline completed by doctors		
Without restriction	8	(4%)
Restricted but ambulatory	36	(18%)
Ambulatory but unable to work	67	(34%)
Confined to bed or chair	39	(20%)
Completely disabled	45	(33%)
Number of Patients Reported by Doctor as Receiving:		
Pain control	125	(63%)
Respite care	26	(13%)
Assessment/investigations	66	(34%)
Emotional support	130	(64%)

NB: Medical details not provided for 15 community patients.

With this wide range of services on offer, the extent to which the services are getting to the patients that need them is crucial. In order to identify unmet need, at our first follow-up interview patients were asked if there was anyone they would have liked to have seen in the previous week but did not. Twenty-one patients said there was such a person, nine mentioned a doctor, seven a nurse and five a therapist.

At the baseline interview, lay carers were asked whether they would have liked any extra help during the previous week and 63 said yes. It was possible to specify more than one sort of help and, in order, the following were identified: give carer a break – 16; physical care of patient – 13; medical help – 12; help at night – 8; 'more help' – 6; housework – 5; other – 14.

Table 8.6 Profile of carers in the community

	Community	*(n = 99)*
Sex		
Male	39	(39%)
Female	61	(60%)
Age Group		
21 to 59	50	(50%)
60 to 74	41	(40%)
75 and over	9	(9%)
Relationship to Patient		
Spouse/Partner	77	(76%)
Child	11	(11%)
Parent	2	(2%)
Other Family	8	(8%)
Friend	2	(2%)
Does carer live alone?		
Yes	4	(4%)
No	96	(95%)
Does carer have paid employment?		
Yes, full-time	11	(11%)
Yes, part-time	9	(9%)
No	80	(79%)
Does carer have someone to turn to for emotional support?		
Yes	74	(74%)
No	25	(26%)
Quality of relationship between carer and patient		
Very good	87	(86%)
Good	10	(10%)
Fair	2	(2%)
Poor	1	(1%)
Carer's health		
Very good	18	(18%)
Good	49	(49%)
Fair	26	(25%)
Poor	7	(7%)
Contact with voluntary group		
Yes	32	(32%)
No	67	(68%)
Reason for contact with voluntary group		
Advice and information	16	
Practical help	13	
Financial help	7	
Emotional support	11	
Other	4	

Table 8.7 Number of patients receiving visits from GPs and nurses in the week before completion of baseline data (n = 212)

Visit from:	*No. of patients*	*(%)*
GP	59	(28)
Hospital/Hospice Doctor	3	(1)
District Nurse	124	(58)
Auxiliary Nurse	14	(7)
Macmillan Nurse	1	(21)
Marie Curie Nurse	6	(3)
Hospice Home Care Nurse	1	
Stoma Care Nurse	1	
Oncology Nurse	1	
Total	210	

Although receiving most of their care in the community, some of the community sample were using services provided in in-patient settings: eight patients had such a stay during the week before the completion of the baseline questionnaires and 40 had attended an out-patient clinic. In addition, 58 had attended a hospice day-centre, a day-hospital or other day-care centre during the previous week. Thirty-four patients had received treatment other than their regular medicines. These treatments included chemotherapy (five patients), radiotherapy (four) and oxygen therapy (four). Twenty-five patients had tests or investigations performed, of whom the majority (16) had blood tests.

When we move from a presentation of these figures to a consideration of what they might mean for service providers we can see that, at the very least, it is necessary to take into account the complex picture that palliative care in the community presents.

It is complex at the level of service provision. We have health and social care agencies involved in both statutory and voluntary sectors. Care primarily in the community does not mean that other care settings do not play a part in the day-to-day experience of the patient. The range of professions and the skill-mix involved in the care of patients varies greatly. We must note the considerable demands evident on community care providers; district nurses visiting in the previous week in two-thirds of cases, sometimes making multiple visits, and GPs visiting in over one-third. Specialist nursing is spread thinly: these nurses account for 11 per cent of visits reported in the previous week. One can argue that for most patients, in their day-to-day care, it is district nurse teams who are carrying out the bulk of the work. In some situations the tasks they perform will be within the generic remit of their usual role. But the specific circumstances of the palliative care population, its high level of need, the prevalence of pain (71 per cent of patients at baseline and 73 per cent at first follow-up reported they had experienced pain in the previous week), and the emotional and physical demands on carers mean, in effect, that the district nurse is providing a somewhat specialised service.

Palliative care is complex at the level of informal care. Carers' views express, in the high level of need they identify for some sort of respite, the extent of demands being made upon them by a group of patients who, in the majority of cases, are severely restricted in their ability to perform the basic activities of daily living.

It is also complex because of the variation within the patient group where there are a range of diagnoses, differing home circumstances and changing needs over time.

QUALITY OF LIFE AND PALLIATIVE CARE

It is of course not possible to identify outcome in relation to palliative care using commonly-held measures from other areas, for example mortality or morbidity. Rather one must devise a means of identifying, recording and analysing those things important to patients with progressive disease and, consistent with the holistic approach of palliative care, those things important to lay carers and family both during the illness and after bereavement.

There have been a number of attempts to create quality-of-life measures, both in relation to oncology patients in total, and to patients receiving palliative care in particular. In the main they seek to identify potential problem areas such as pain, anxiety and symptoms. Quality is equated with the extent to which these problems are absent. More ambitious is the attempt to do two things, first to identify the relative weight of each of these problem factors. For example is it the effective control over pain that really predetermines quality of life? Or, how can one balance pain control with side effects in terms of alertness or digestive problems? The second challenge is to identify positive, life-enhancing features occurring during the palliative care phase of a person's life. The possibility of these was certainly of central importance to Dame Cicely Saunders and colleagues in the thinking that underpinned the modern hospice movement (see Du Boulay, 1994).

Quality-of-life measures now generally include physical, emotional and social functioning. They also consider spirituality and sexuality (see Bowling, 1991; Doyle *et al.*, 1993). The York Study used a measure called the EORTC QLQ-C30 (Aaronson *et al.*, 1993) which has been developed out of an international collaboration for use with cancer patients, and is now being increasingly used for palliative care. The questionnaire, which takes about 11 minutes to complete, incorporates nine multi-item scales, five functioning scales (physical, role, cognitive, emotional and social); three symptom scales (fatigue, pain, and nausea and vomiting) and a global health and quality of life scale. Several single items are also included.

If, in palliative care, we take quality of life as a concept appropriate to assessing the outcome of any treatment, we have to ask which measure is the best way of gathering information on what quality consists of. But secondly we have to ask what this says about resource use. What structures and practices would maximise the achievable quality of life?

In the York study the overall mean quality of life increased from baseline to first follow-up (seven days later), and then decreased by the third follow-up (28 days later). In general this increase was associated with an improvement in functioning and a decrease in symptoms. We can hypothesise that the main impact of introducing palliative care occurs in the initial stages. This is a stage in which effective symptom control is achieved in most cases and underlines the value to the patient of a focus on palliative approaches. What we cannot do is be any more definite. Some patients in our study had been receiving palliative care for some time when we first recruited them. In addition, the point at which a patient is defined as entering a palliative phase is somewhat arbitrary. Further, it is not clear how far implementing palliative approaches necessitates the intervention of specialist workers. It is not surprising that, over time, quality of life deteriorates as even effective symptom control cannot overcome the progression of the disease being treated palliatively.

It does appear that, in medicine in general, there is an increasing recognition that biological end-points are not sufficient to define outcome, and measures of functional status, or health-related quality of life, are appearing with more frequency in the medical literature (Hopkins, 1992). In the USA, quality of life is being used increasingly as an outcome in clinical trials. In oncology, researchers are predicting that clinicians will begin to routinely evaluate quality of life in their patients and use these evaluations as part of the clinical decision-making process for individuals. It may be that, ultimately, policy decisions also may incorporate some form of quality-of-life assessment (Ganz, 1994).

This is not to say that the controversy that accompanies quality of life is abating in its detail. Which measures to use, as different instruments proliferate, how to include economic analyses including utility and cost-effectiveness, and how to reconcile potential conflict between the needs of individuals and societies are all areas still unresolved.

In the UK, although the main trends identified by Ganz are in place, the specific way the purchasing function has developed means that some of the questions as to the relationship between resource-use, cost and outcome are likely to be central, particularly in those local 'political' encounters between purchasers and providers of health and social care.

FUNDING PALLIATIVE CARE

We can see the patterns of historical development in palliative care and the fluctuating interactions within the 'dying triad'. But shaping the past, and crucial to the future of palliative care, is the extent and pattern of funding.

The voluntary sector was responsible for the development of many of the first palliative care services, particularly the in-patient hospices. Local groups in particular were heavily involved in raising funds. By 1995, 75 per cent of in-patient hospice care was provided by voluntary or independent units. Some of these were linked to national charities, Marie Curie Cancer Care and the Sue Ryder Foundation. In practice, links have developed with the NHS from which hospices receive varying amounts of funding to supplement that raised in local communities.

In 1988, the Department of Health began to allocate money to Regional Health Authorities, specifically for voluntary hospices and specialist palliative care services. The amounts so allocated rose rapidly: £8 million in 1989; £17 million in 1991 and £37 million in 1992. By 1994/5 the allocation was £35.7 million for specialist palliative care services plus £12 million for voluntary hospices, a figure which included an allocation of £6.3 million for drugs (NHS Executive, 1995). Beyond 1995/6 these allocations are to be built into general funding to health authorities and will not be separately identified for palliative care.

Because of the presence of special ring-fenced allocations we see a scenario in which the advent of the *Working for Patients* reforms (Department of Health, 1989), and the development of purchasing, was delayed for palliative care. In part this delay can be attributed to the wish to have in place a network of specialist palliative care as developed as possible, before exposing it to the health care market. In part it reflected the complexity of palliative care in itself. This is a service that crosses the divide between activities mostly under the jurisdiction of the *Working for Patients* changes and mostly under the NHS and Community Care Act (Department of Health, 1990). It also relies on a combination of statutory sector provision and voluntary, charitable and private sector input. It might be described as a working example of the mixed economy of care.

In a series of Department of Health circulars between 1987 and 1993 we can see the emergence of, first a role for District Health Authorities as lead bodies in planning and co-ordinating an integrated range of services for the terminally ill, and then the emergence of a funding partnership between the health authorities and the voluntary sector (for a summary see Neale, Clark and Heather, 1993). Specifically, in the area of home and hospital support teams, the NHS was encouraged to take on an active role in the development of services; to take over funding for Cancer Relief Macmillan Fund nurses after the initial three years in which they would be supported by the charity; and to maintain a commitment to Marie Curie Nursing Services. It was the intention of the government, expressed in documents like EL(94)14 (NHS Executive, 1995), to maintain existing levels of financial support and to continue the partnership with the charities.

The financial year 1995/6 is the first year during which palliative care enters the purchasing cycle. Current guidance identifies the nature of responsibilities within that cycle. Purchasing authorities are responsible for ensuring a comprehensive and integrated range of palliative care services for patients and their informal carers, across a range of individual diagnoses and care settings; these include hospital, in-patient hospice, day and home-care services and respite care. They are encouraged to make strategic plans based on aggregate needs assessment, operational research data and consumer feedback; to identify the range of existing provision available and gaps in provision which are to be filled consistent with consumer choice; to produce joint purchasing strategies through joint and multi-disciplinary planning groups; to negotiate contracts with both NHS and independent-sector providers, and to promote a partnership between them; and to monitor provision through audit processes based on agreed quality standards and outcome measures.

It was envisaged that it would be through the contracting process that authorities should aim to increase understanding between service providers across all care settings and sectors, and raise standards of care through staff development programmes (see Neale *et al.*, 1993, pp. 16–17). In practice, the process of purchasing palliative care is little-developed. It is an area that requires close collaboration across sectors and involves a careful examination of what standards and outcome might be. There has been development of audit measures for palliative care in the UK and abroad and some progress which links audit procedures with improvements in care for patients (see Higginson, 1993b). Indeed, in a recent publication from the National Council for Hospice and Specialist Palliative Care Services (1992) it was possible to list eight different examples of audit being developed in palliative care.

Provider units and teams are also becoming clearer as to how they should negotiate with purchasers. Those units that are part of a larger national organisation, Marie Curie Cancer Care for example, have help from their headquarters about adapting to the new scenario. But for many the different demands it makes, for example in drawing up business plans, require a considerable change in the ethos of the establishment. It is, in short, a time of flux and uncertainty on the part of both providers and purchasers of palliative care. It is an uncertainty likely to continue for some time. With the piloting of total fund holding by general practitioners, which would involve GPs purchasing palliative care, we have further possibilities of continuing change.

FUTURE SCENARIOS

Some features of the coming years are relatively predictable. The changing demographic profile of the population, allied to the long-term shift in patterns of mortality in which more people die from chronic conditions late in life, will continue. These shifts will ensure that the demand for palliative care will increase. It is likely also that most patients with a progressive illness that is no longer curable will receive much of their care outside a hospital or hospice, in the community. Secondary care settings will tend to concentrate on those patients with the most severe symptoms or for whom lay-carer distress is greatest (see Higginson, 1993a).

Less easy to predict is the likely development of patterns of service. It appears that the general public places care for people who are dying high on lists of priorities (Heginbotham, 1992), and so there is likely to be both public support and increasing demand encouraging the growth of palliative care. Health districts will seek to identify levels of need but will then have to decide on what mix of services should be developed locally. The balance they strike between cost and quality will be the important variable in patterns of future service development. There is some concern amongst hospice providers that care will shift to nursing homes and will be pursued by non-specialist trained personnel.

The 1992 SMAC/SNMAC report recommended that all patients needing palliative care services should have access to them. As yet there is a disparity between services for people with cancer and those needing palliative care but with non-cancer diagnoses. Discussing motor neurone disease as recently as 1992, a *British Medical Journal* article could say with confidence that:

> 'Many doctors and especially neurologists (ninety per cent in our experience) continue to offer no care to patients suffering from this fatal paralysis, as though the lack of cure is somehow equated with the absence of any treatment. This is curious because patients with many other fatal diseases receive supportive care or palliation from their doctors (including neurologists). Yet a paralysed patient with motor neurone disease is often neglected despite the availability of many symptomatic treatments.'
> (Norris, 1992; see also Norris *et al.*, 1985)

One possible future would be for more concern with non-cancer diagnoses to be evident in planning and delivering palliative care. Another, allied, possibility is for the original message of the Wilkes Report to be more systematically pursued, that is the dissemination of the principles of terminal care across all sectors with an emphasis on the need for coordination between sectors. Certainly the York study underlined the complexity of delivering palliative care. It also reinforced the already widely recognised importance of the role of lay carers. For all the discussion about the development of specialisms and the advance of palliative medicine, indeed of the medicalisation of dying, most people for most of the time during illness are cared for by their family at home. When they do see health service staff it is usually those who are local and generic.

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CHAPTER NINE

How to Deliver Effective Community Health Care

Lucy Hadfield

INTRODUCTION

This chapter examines the traditional community health services and considers how they might move forward in tandem with the many other drivers for change in the NHS. It starts by defining community health services and then considers what is the nature of an organisation delivering community health care by looking at its function, culture and environment. From this, five criteria are derived that are used to appraise the effectiveness of current provider organisations in delivering community health care, that is NHS trusts, general practice and independent sector organisations. Finally, the strengths and weaknesses of the current organisations are taken forward into implications for the future of community health organisations and their staff.

DEFINITION OF COMMUNITY HEALTH SERVICES

When we consider how community health services can be provided, we need to know what we mean by the term, community health services. There is no universally accepted simple definition and they are often defined by what they are not:

- health care not in hospital or in an institution;
- not GP services;
- not social services.[1]

For a future health professional in pre-registration training, they are rather a nebulous concept, a tangle of spaghetti around a clear central point, the patient. For hospital staff, they lack the clarity and boundedness of services in a hospital, which a patient clearly enters and leaves. For the general public, it is just one of a number of virtually meaningless terms that the modern confusing NHS seems so keen on. For a politician and/or social idealist, it is inherently good, like motherhood and apple pie and it is one answer to containing health care costs (because buildings do not have to be paid for) and improving responsiveness to consumers (and voters) because of their localness. For a practitioner and a patient engaged together in an episode of community health care, they are just a straightforward, no-nonsense way of tackling whatever is the health need or problem. For an NHS manager, they are a collection of services that evolved separately from hospital and GPs. They either originated in the public health arm of local authorities (for example, community nursing and child health), or grew out of transferred resources when long-stay hospitals closed down (for example mental health and learning disability services), or were deliberately moved from district general hospitals' management to change the ethos of 'complex health care automatically equals hospitalisation' (for example therapy services).

In the world of the NHS market and contracting, community services are currently purchased on the basis of patient contacts with a health professional (face-to-face contact) or on the basis of whole-time-equivalent (WTE) staff, whereas hospital services are mainly purchased on the basis of a 'finished consultant episode' of care. Both community and hospital services are purchased from the Department of Health's financial allocation for hospital and community services, which is kept rigidly separate from funding for family practitioners' services or general medical services (GMS).

In the spectrum of health care, community health services cover health promotion, prevention, surveillance, diagnosis, treatment, rehabilitation and palliative care. The focus of most of community health care is on the prevention of disease and disability in children, and managing the impact and consequences of chronic disease or disability in all age groups. The largest numbers, however, are amongst elderly people. Most diagnosis and treatment is undertaken by doctors, and most doctors work either in general practice or are specialists in hospitals. The main providers of community health services are nurses and professionals allied to medicine. Often, there is direct access by the patient to community services, and assessment and interventions are undertaken without the involvement and intervention of a doctor, for example speech and language therapy, or chiropody. The few doctors that do work in community health services are not generally body system or organ specialists, but specialists in the pathology associated with particular client groups (for example paediatricians, geriatricians, psychiatrists, family planning specialists) or in the stage of disease (for example, rehabilitation or palliative care). The dominant paradigm in doctors' training is diagnose – treat – cure. Doctors who choose to work in community health services (other than general practice) are often still regarded by the medical profession as either heroic, or of lesser calibre (and status) than a traditional organ/system specialist.

Another notion to consider in trying to define community health services is the degree to which they can honour values such as patient choice and equity of access, better than institutionally-based care. The patient is in a more powerful position *vis-à-vis* the health practitioner when they are in their own home or in a known environment.

Community health services have been distinguished from social care by separate public sector funding streams. But every district nurse will be familiar with the conundrum of, when is a bath a medical one or a social one? The difficulties of this separation for clients is now becoming highlighted politically following the Community Care Act 1991, and, more recently, guidance from the NHS Executive on the responsibilities of the NHS for continuing health care (DoH, 1995). The separation of purchasing and providing in health and social care opens up the potential for more imaginative ways of bridging the divide for so-called seamless care.

A major problem, and therefore a major challenge, for community health services is the lack of evidence for their effectiveness (see for example the National Association of Health Authorities and Trusts, 1995). Research is difficult and expensive to undertake in such an uncontrolled environment and, therefore, has traditionally been neglected. Outcome measures associated with quality of life are far less accessible than those that show presence or absence of a disease.

I will finish this section with a list of the main services you would expect to see in a description of community health services. It is not intended to be comprehensive:

- Community nursing:
  - district nursing
  - health visiting
  - community psychiatric nurses
  - community mental handicap nurses
  - school nursing
  - midwifery
  - nurse practitioners
- Therapists:
  - occupational therapy
  - physiotherapy
  - dietetics
  - speech and language therapy
- Other professionals allied to medicine:
  - psychology
  - chiropody
  - podiatry
- Medicine:
  - geriatrics
  - paediatrics
  - psychiatry
  - rehabilitation
  - obstetrics and gynaecology
  - population prevention, screening and multi-disciplinary teams for surveillance programmes, for example immunisation, child health, breast, cervical cytology
  - family planning
  - mental health
  - adults with learning disabilities
  - children with disabilities
  - drug and substance abuse
  - people with physical disabilities
  - people with terminal illness

DO COMMUNITY HEALTH SERVICES NEED TO BE ORGANISED?

Few would seriously argue that there should be no organisation of community health care. Without organisation, there would be a totally free market with health care from individual practitioners available only to those who could pay on demand. The question for now is how should they be organised and where should choices be made on the trade-offs amongst cost, quality and amount of health care?

The NHS, since the reforms of the early 1990s, now has a complex system to balance supply and demand in health care, using a mixture of market and collectivist principles. Community health services must be organised in the context of the macro-perspective of the new NHS, which is no longer a closed system as it was from 1948 to 1990. Figure 9.1 gives an overview of the key stakeholders in the NHS and their roles, showing how they interact to create a balance between demand and supply for health care.

CRITERIA TO DETERMINE AN ORGANISATION'S FITNESS TO DELIVER EFFECTIVE COMMUNITY HEALTH CARE

Before proposing criteria to judge whether an organisation is fit to deliver effective community health care, it is useful to explore the context for community health services, looking at:

- Current management theories of organisational structure and design, for example Mintzberg (1979);
- The forces in the environment around community health services;
- The nature of the services themselves.

Some questions are posed (see also Johnson and Scholes, 1993, chapter 10) and addressed in order to describe the context, as follows.

How answerable is the organisation to external stakeholders?

Most community health services are currently provided by NHS trusts, which are run by a trust board appointed by and accountable to the Secretary of State for Health. A minority of community health services are provided by not-for-profit organisations, for example charities, and accountability is to the board of independent trustees. The managers of community health services are open to quite a high degree of public scrutiny and have many stakeholders to please, not least the local community and the patients they serve.

Figure 9.1 NHS key stakeholders and their roles

	DEMAND	BOTH	SUPPLY
Individual ↑	Patient – needs or demands NHS health care to prevent, treat or manage disease	← **Voting Citizen** →	Tax Payer – pays a fair share indirectly to ensure universal health care when needed
	Helps assess need for health care	← **Health Practitioner (and patient's carers)** →	Direct supplier of health care
	Health Authority or GPFH – decides what health care to purchase on behalf of the population they serve to maximise the health benefit for each £ spent	← **Service Contracts** →	Health care providing organisations – general practice, NHS Trusts and independent organisations assemble the delivery of health care services and contract with purchasers
Local			
	Consumer groups – advocate the needs on behalf of sections of the population	← **Lobbying Interests** →	Health professional bodies – set standards and support the interests of members of the profession
	Promotes awareness and debate	← **The Media** →	Promotes awareness and debate
	Sets policies which shape demand	← **NHSE/Department of Health** →	Sets policies which shape supply
↓ **National**	←	**Government** determines the health care system and the amount of GNP spent on public health care	→

What about reliance on simple or complex technologies?

Community health service providers are traditionally the least technical part of health care. Most procedures dependent on technological support have been confined to hospitals, for reasons of cost, scarcity and immobility. Community services are dependent mainly on human skills, supported by simple, often portable technology. Their benefits are either taken for granted or viewed by some with scepticism or agnosticism. However, the nature of health technology to assist diagnosis and the treatment is changing rapidly – in many areas it is becoming more sophisticated and more flexible, both in where it can be used and the level of skill needed to use it – and becoming cheaper. This is changing the boundaries of community health services – they are no longer just the low-technology services. Technological developments in intravenous infusion therapy mean that complex and high-dosage drug therapies can be administered to heavily-dependent patients by community staff, enabling such patients to lead more normal life-styles in the community, and often administered even by the patients themselves as in the case of cystic fibrosis.

Developments in information technology are also having a major impact on community services. Not only do they enable professional staff to plan, manage and evaluate packages of care to chronically-ill patients over long periods of time, they enable information to be easily shared by the many professionals involved in the cases of patients with complex problems. They also enable the clear identification of resource inputs and the ability to relate these to clinical outcomes.

How diverse is the organisation?

The diversity of community health services can be seen from the list on p. 201. Diversity is in terms of the number of different types of client groups served, the different elements in the services themselves, the different locations from which services are provided and so on. Most community health services are currently provided by NHS trusts that supply at least 15 or so of the services listed to a population of usually over 200 000. An increasing minority of community services are provided by small independent organisations serving a smaller number of patients with a special problem or set of problems, for example HIV services.

Is the environment complex and changing or stable?

Other chapters in this book explain at some length the historical context for the enormous changes that are happening within and around the NHS in the 1990s. Some of the major factors at work around the NHS are as follows:

- *Economic* The UK economy (and those of other European states) are not growing as fast as Far East economies, and there are major changes taking place in the balance of world economies. Increased taxation to enable the NHS to grow is unlikely to be acceptable to the electorate (see for example Healthcare 2000, 1995). Any growth in health care would have to be from individuals choosing to spend more of their disposable income on health care, which erodes the principles of the NHS.
- *Sociological* The population is ageing, placing an increased burden on the NHS. At the same time, the numbers of people of working age to support the growth in demand for care of elderly and other dependent people is decreasing. One of the consequences of an ageing population is an increasing reliance on close family and friends for informal caring. Carers have become recognised in the 1990s as a distinct client group with rights and needs independent from the person being cared for. Caring for the carer has become a vital component of our health and social system and is of great significance to the provision of community health care.
- *Technological* Developments in information technology are a major force behind the increased power of world markets and the relative decline in the power of individual state governments. There are, and will continue to be, quantum leaps in medical and scientific technology particularly in the areas of pharmaceuticals, biological sciences and genetics.
- *Political* The results of the changes in the economic, sociological and technological environments are increasing difficulties with predictability in politics. Despite government of the UK by one party for the past 16 years, instability is increasing and this has a major impact on a major public sector organisation such as the NHS.

  Because of the need to remain competitive in world markets, political parties in western countries are tending to move further to the right of the political spectrum and a result is an increasing polarisation between 'haves' and 'have-nots'. Health status is closely associated with economic and social status. Amongst the 'haves', consumerism is a significant sociological phenomenon.

Within the NHS, we are also working through major structural reforms put in place in the early 1990s (DoH, 1989a, 1989b). These include:

- separation of purchasing from providing;
- changes to the GP's contract;
- the development of NHS trusts as semi-independent organisations;
- the emergence of general practice fundholding (GPFH) as a new form of purchasing;
- reforms to the funding and organisation of community (social) care and its relationship to the NHS;
- mergers between District Health Authorities and Family Health Services Authorities;
- a framework of *Health of the Nation* targets;
- the *Patient's Charter*;
- an increased emphasis on evidence-based medicine.

These policy initiatives or changes are described in more detail elsewhere in this book, but it is important to emphasise the collective intended impact of these reforms to overhaul the provision of primary and continuing health care as part of an evolution to 'a primary care-led NHS'. The aim is for decisions about purchasing and providing health care to be taken as close to the patient as possible by GPs working closely with patients through primary health care teams. This requires major shifts in the roles of both GPs and community health providers, and exploration of how the concept of a primary health care team can be turned into a robust organisational reality offering an equitable primary health care service in both inner city and rural area alike.

What are the types of problems facing the community health organisation?

The types of problems facing community health service providing organisations reflect the many factors discussed above. These can be summarised as problems around:

- political accountability;
- diversity;
- complex and rapidly-changing external environment;
- changing technologies.

In addition, there are two further specific problems deriving from the dependence of community health service provision on a controlled supply of human resources in the form of health professionals trained to apply their competence in a community setting:

1. *Alignment of the purpose of the organisation with attitudes of health professional staff and their professional bodies.* The pressures that a rapidly changing environment place on health professional bodies are considerable. Their traditional role of ensuring and monitoring standards to protect individual patients largely through control of skills, works on long timescales. Legitimising changes in standards and implementing changes are very slow, delicate processes. There is a fine line between taking on board pressures for change very slowly and carefully, and actually trying to resist the pressures. The tensions and pressures of the interface between the changes described above and the actions of health professional staff lie within the culture of the organisation. An example of this type of pressure is around the UKCC's classification of specialist community nursing (UKCC, 1994). Whilst the reforms to the classification were long-awaited and welcomed when they came, are they over-specialised for the needs of the primary care team as we see it emerging?
2. *Nature of the physical working environment for health staff.* Organisations providing community health services need to understand the factors that motivate their health professional and support staff. We assume that health staff in whichever sector are motivated by feelings of intrinsic value that derive from promoting good health and helping to make the lives of sick people better. Other motivational factors such as pay, job security, sense of identity, relationships, intellectual stimulation, and so on are also very important. However, there are particular problems of staff motivation in community services which come from the nature of the physical working environment:

- *Locus of care*

Care is provided in patients' homes (or other locations which are part of their daily lives, for example schools, day-centres and so forth), or in local health clinics, GP surgeries or health centres. Staff either work in small-scale health clinics or are peripatetic and spend a proportion of their time travelling from place to place. Although individuals vary in their preferences to be 'roamers' or 'homers', most health staff would regard excessive travelling time as dead time and demotivating. The quality of the physical environment that staff work in is important and has an impact on the quality of their work. Working in people's homes is particularly challenging because health staff have no control over the environment which can be perceived as ranging from luxurious to ghastly. The ability of staff to overcome the negative effects of unpredictable and poor physical environments, or excessive travelling time, is aided by the knowledge that they are providing health interventions in situations where access is critical and where people would not otherwise benefit from help.

A sense of isolation is another feature of the community health worker's environment, and a clear sense of identity is often an issue for community staff. Peripatetic working can make staff invisible and they have a hazy image with the public. Do community staff get their sense of identity from being a member of a profession, an employee of a particular organisation, a member of a team or as a person serving a local community? Contact with other health staff can be infrequent and communication is often a logistical challenge. The problems of a peripatetic working environment are most extreme in inner cities or remote rural areas and in providing 'out-of-working-hours' services. Fears for personal safety and security of largely female staff is a major problem, particularly in areas of high crime.

- *Locus of training and education*

The problems of delivering health care in community settings also apply to training and education of health professional staff. The traditional pattern of health education has been to train staff in an environment designed for group learning (that is in a college etc.) and to get practical experience of patients in a convenient setting for group learning (for example a teaching hospital). Learning how to apply core health skills in an uncontrolled environment such as a person's own home and in a peripatetic mode of working is currently a post-basic set of competences to acquire.

- *Hospitals – large-scale health centres of convenience?*

It can be seen that hospitals as large-scale 'centres of health care' are very convenient places for health staff to train in and to work in. They offer an environment that can be controlled for health staff, removing risk and unpredictability in their working lives and offering benefits such as easily accessible catering, social and sports facilities. This, of course, has to be balanced with considering the needs of the patients they exist to serve. We know that hospitals are, at worst, risky or dysfunctional places for ill people (risk of cross-infection, risk of loss of self-caring skills) as well as, at best, curative or life-saving centres. A major problem for community health organisations is to wean the mainstream of health professionals away from the immediate comfort and security of the hospital institution and to inspire their confidence that large-scale improvements in quality for people with common, chronic disease would be achieved if far more services and training were community-based.

Are traditional centralised and top-down methods of direction and control still appropriate for the NHS?

Community health services, as part of the NHS since 1974, have been part of a bureaucratic organisation where strategy has been formed at the top (Department of Health/NHS Executive/Regions) and health authorities, and NHS trusts are means of implementation. In Mintzberg's (1979) categorisation of organisations, the NHS is most similar to a 'professional bureaucracy' where the skills of health professionals are standardised by statutory and professional bodies' accrediting mechanisms. Power has rested with the professionals; the hospital-based medical profession being the most dominant.

Community health service organisations have also had elements of a 'machine bureaucracy', where work has been standardised (for example immunisation protocols), and a 'missionary' organisation where the organisation is brought together by shared core beliefs (for example that the inexorable pull towards hospital-based and specialist care should be resisted). The nature of the direct accountability of the Secretary of State for Health to Parliament for the

NHS, also gives the NHS the characteristics of a centrally-controlled organisation.

The purpose of the NHS reforms has been to open the NHS to new forces such as those of competition and the market, to achieve the government's aim of a publicly-funded and accountable NHS that is more cost-effective. We are now living through the consequences of a massive organisational experiment – seeing whether we can retain a universal public health service whilst increasing the forces that also have a risk of fragmenting the NHS. We cannot put the genie back in the bottle, so we have to find new ways of managing the conflicting forces in the NHS (which many would argue were always there), including creating new forms of organisations and new ways of running them. Traditional methods of direction and control are no longer appropriate. The NHS, and community health service providers, need to become far more decentralised and able to work across several horizontal dimensions (that is with different purchasers – GPFHs and health authorities – and with partners such as social services and GPs etc.), in the drive to become more responsive to the consumer.

Through addressing the above questions, I have derived five criteria to judge an organisation's fitness for delivering effective community health care.

ORGANISATIONAL FITNESS CRITERIA

These criteria will be used to appraise the effectiveness of current organisations in delivering community health care.

Current provider organisations

Most community health services are currently provided by NHS trusts. However, as purchasing becomes more creative either through health authorities or GP fundholders, an increasing number of services are being provided by the independent sector or by staff employed by GP practices.

The configuration of NHS trusts varies across the country and most are made up of the collection of services put together when district health authorities were formed (on the abolition of area health authorities, when their new units of service were identified in 1982 (DHSS, 1981). Units of management were strengthened when general management was introduced in 1985 (DHSS, 1985) and unit general managers were appointed, accountable to the district general managers. Most units have changed little in their configurations over the 1980s and passed into their current quasi-independent status as NHS trusts over a five-year period in the early 1990s (DoH, 1989a, 1989b).

Some NHS trusts provide a combination of acute hospital services, mental health and learning disability and other community health services. Such a combined NHS trust occurs most frequently in rural areas. Other, more frequent, permutations include 'priority' services trusts, that is community, mental health and learning disability services, or acute services and community services (without mental health), or mental health services alone, (with or without learning disabilities), community services alone or acute services alone. Across the country, most community services are provided separately from acute hospital services. The policy underpinning the creation of NHS trusts did not prescribe the precise configuration of services, except in the case of inner London, where the recommendation of the Tomlinson report (Tomlinson, 1992) that community health services should not be combined with London teaching hospitals in the same trusts, was adopted by the Secretary of State. This was because it was believed their interests would be subsumed in the interests of survival of secondary and tertiary services in an intensely competitive market.

GP practices are currently heavily restricted by the terms of GPs' national contract, in the range of staff the practice can employ to support the core work of the GP. They can employ administrative staff and practice nurses and the practice must pay 30 per cent of the salary of the employee. Practice staff do not have the same framework for their terms and conditions as NHS trust staff, that is based on the Whitley Council's system (Whitley Council, 1973) and a significant difference is they do not benefit from public sector pensions. However, the number of practice nurses employed by GPs has grown rapidly and studies show that they are largely satisfied by the role, in particular the close identity with a defined population and the responsibility/flexibility of working in a small organisation. GP fundholding gives a practice considerable freedom to determine how a wide range of community services will operate in respect of its practice population by having the budget to purchase those services. This includes the freedom to directly employ community health staff, with the exception of community nurses whom they must purchase currently from NHS trusts. Many GP fundholders would like greater freedom to employ community health professionals and provide the services themselves.

Certain community services, usually those serving a clearly definable client group, are provided by independent providers, either not-for-profit organisations or private sector organisations. Some have been provided in this way for some time, for example the Family Planning Association or Macmillan Nurses for Cancer, and are purchased by NHS trusts, health authorities and GPFHs. Others are being stimulated to come into the NHS and community care market for the first time, for example nursing home providers.

The five criteria for organisational fitness will now be applied in turn to NHS trusts, to general practice, and to the independent sector.

Criterion 1

Capable of development of professional standards both in line with evidence of effective outcomes and with the needs and preferences of individuals?

NHS community trusts

The identification of professional or clinical standards of practice is vital for the effective management of health services. We know that identification alone is not sufficient, they must be constantly subject to review in the light of any new evidence about the outcomes of application of the standard, and sensitive to the diversity of individual need and preference of any given population. Most community trusts operate through a multi-dimensional matrix structure of professional group, locality, and client group to try to ensure clinical standards are relevant, for example a health visitor in general practice delivering child health services. It requires considerable managerial skill to get these forces in an optimal balance and to demonstrate accountability.

However, most mature community trusts would regard this as very close to their approach to ensuring quality, using techniques such as clinical audit or service reviews. Accountability to the trust board is clear in the case of the medical and nursing professions, that is through the medical director and director of nursing, but less clear for other professional groups. Weaknesses include the paucity of scientific evidence of effectiveness of clinical outcomes in many aspects of community health services (see for example the National

Association of Health Authorities and Trusts, 1995), and the difficulty in monitoring the practice of semi-autonomous professionals who are peripatetic. The structural divide from GPs dilutes the feedback loop of information from service users that both clinical staff and their managers badly need. There are many examples, however, of community trust staff changing clinical standards and influencing the wider clinical bodies as a result of taking on board the views and needs of their individual clients, for example HIV services. Community trusts can enable a critical mass of professionals to come together and learn from each other.

NHS combined NHS trusts

Many points made in respect of community trusts apply, but combined trusts have a further dimension or dimensions in their structure which tend to dominate the rest, that is disease or medical speciality. The disease dimension should be a very useful addition as it offers good potential for evidence-based outcome information, but only if it is in balance with, rather than dominant of, the other dimensions.

General practice

Progressive general practices are strongly committed to medical audit and, increasingly, multi-professional audit supported by health authority-led initiatives. A strength of general practice is its closeness to its practice population, and its patients theoretically can vote with their feet if standards of practice do not meet their needs or preferences. Patients do not have that option for community services provided by NHS trusts. However, there is a wide spectrum in different parts of the country between practices that inspire the full confidence of their practice populations and other primary care workers, and those that do not. Concerns are greatest where the practice population is deprived (socially or economically) and/or vulnerable, for example the disabled or chronically sick, or where English is not the first language. Patients in this situation find it hard to change GPs and the apparent choice many not be real.

GPs have considerable freedom to determine the development of clinical practice standards themselves through their national contract, with 'light' accountability to their local health authority. This leads to a wide range between excellent and poor practice. The partnership structure of general practice does not appear a very robust organisational form on which to build greater responsibility for the development of a wider range of clinical standards of practice of other community health professionals, if equity of access is an important policy aim.

Independent sector

Independent community providers tend to operate in niche areas, where needs are highly specific. Their strengths lie in the development of clinical standards of practice tending to be very sensitive to the views of the user. However, they may be less strong on basing standards on evidence of successful outcome. Audit methods to ensure consistent applications of standards are likely to be unregulated and therefore subject to wide variations between good and bad.

Criterion 2

Capable of being an effective part of a wider health care network?

NHS community and combined trusts

Most senior community health staff understand that their contribution to health care is part of a wider system and they are part of a complex network of potential and actual interventions in the life of an individual patient with health or other associated needs. This perspective is inherent in the training that health care staff have to operate in the community (for example for community nursing and health visiting). The effectiveness of any individual professional's input to a particular case or package of care for a patient (particularly one with complex needs) is limited if it is not integrated and connected with the total experience of the patient, for example, prescribing a complicated hearing aid for a confused elderly person. Often it is as important for a health professional to manage how their unique contribution will impact and connect with other aspects of the patient's life as it is to provide their discrete service, item of equipment or drug.

The concept of being part of a network starts with the way services are delivered, keeping the patient in the centre of the process. It is well illustrated by the Department of Health's care management approach for social care (DoH, 1989a, 1989b). This approach then needs to pervade the whole culture of an organisation providing community health care – the organisation is no more than a node in the care network, it is not an end in itself or the centre of the universe. Trusts' cultures vary as to how internally or how externally they are focused. Large hospitals find it harder to operate within the concept of a network; they are more used to being fixed points in the centre of a local health care system. In combined trusts this culture can constrain the flexible provision of community services, where sensitivity to diversity of need is vital.

General practice

General practitioners vary considerably in their ability and inclination to operate within the context of a wider network of health care provision for their patients. Medical training concentrates on diagnosis and treatment, which demand skills of convergence rather than divergence. Many doctors find that putting large amounts of effort into communication and managing their role in the network, with inconclusive outcomes, is frustrating. Also, the demands on GPs' time are very heavy – most problems presented to them are in fact trivial and self-limiting, but every so often there is the serious case to be spotted amongst the trivia. The numbers of patients they see in a day are large – 50 would be a typical number. It is a dilemma for GPs – do they have fewer patients on their list so they can personally manage their care holistically, as part of a network, and have less financial reward for doing so, or do they maximise their income and manage less of a slice of the care for a larger number of patients, who may then have to depend on a wider range of other health professionals or to take more responsibility for managing their own network of care? Most GPs are dependent on the network around them, but cannot give priority to actively maintaining it. Size of practice is less of an indicator of how well the practice performs as a node in the network of care than the culture and attitudes of the GP and their staff.

GP fundholding offers a development opportunity for GPs to become less isolated and to work more collaboratively with other parts of the care network. The power that fundholding gives to GPs can be used positively to enhance the connectedness of the network for patients, or negatively to fragment the network even further. The total-purchasing pilots for GP fundholding give great scope for developing networking around the needs of patients.

GPs' training has developed enormously in the last couple of decades and great emphasis is placed on communication and team-working skills. This is a good foundation for the potential development of general practice into an organisation providing community health services.

Independent sector

Independent organisations are often more effective than statutory organisations at networking with other key players. However, they are not always seen as critical to the network, their survival depends on their sensitivity to their users' and sponsors' needs and to their environment. Successful organisations place emphasis on provision of information and communication.

Criterion 3

Capable of planning and implementing strategies for key resources – that is human, financial, buildings, equipment/supplies and information technology?

NHS community and combined trusts

NHS trusts have been set up to have the capability to undertake strategic planning and to manage the above key resource inputs strategically, that is with a view to where the trust might be in the future, beyond the next couple of years. Trust boards are monitored by the NHS Executive on their management performance through adherence to financial targets, evidence of robust business planning and strategic planning processes, and through the submission of proposals for any major development requiring a significant amount of capital investment. Accountability for strategic management of resources is tight – executive managers are accountable to trust boards with equal numbers of non-executive directors, many appointed for their expertise in these fields.

It is rather early to tell how successful trusts are in strategic management, and the situation is complicated by the complexity of measuring their performance in terms of health outcomes. The jury is still out, particularly on human resources where the two major issues for all trusts are the devolution of the national machinery (the Whitley Council system) for negotiating pay, terms and conditions to the local control of trusts and their staff (Langlands, 1994), and also the introduction of NHS contracting with higher education for the education of most non-medical health professional staff (NHSME, 1995) and the continuation of tight controls on the numbers of training places for all other health professional staff, including doctors.

The use of information technology is not an area in which NHS trusts have excelled themselves to date. The technical solutions are there to revolutionise the way all types of health care information are collected, communicated, analysed and stored, but many complex factors hold NHS providers back in exploiting information technology as much as other industries such as banking, insurance, airlines and so forth.

An NHS trust's ability to manage its resources strategically has a cost, and would be identifiable as a significant element of its management costs (which are typically around 3–6 cent of total income, using Audit Commission (1995) definitions. Community trusts and combined trusts would not be significantly different in this criteria, though community only trusts would be more focused. They also would tend to be smaller, which may have disadvantages for attracting and retaining managers of appropriate calibre. An NHS trust providing a significant range of community services (that is at least 15 different services) with an income of less than around £14 million would find it difficult to sustain a strategic management performance without disproportionately high management costs.

General practice

Most general practices are much simpler organisations than NHS trusts, and most GPs and their staff have little experience of strategic management of the key resources for community health services. GPs do, however, have the intellectual capacity to learn how to undertake strategic management and many are demonstrating their enthusiasm and commitment in their purchasing role as GP fundholders, particularly in the total-purchasing pilots. Many also have some experience of developing their own premises with examples of large, complex schemes; for example a GP fundholder in Epsom, Surrey, entering a joint venture with developers to create a combined GP surgery and surgery day-care centre, again stimulated by the wider freedoms of fundholding. Many GPs have been able to harness the benefits of information technology for their practices more quickly than many NHS trusts, and there are examples of several practices close to achieving systems of paperless medical notes. GP fundholding is dependent on information technology.

The organisation model of partnership is one that best suits a stable environment. Rapid and unpredictable change can challenge relationships built on simple joint aims and assumptions. The incidence of break-ups of GP partnerships is increasing and is not conducive to effective strategic management.

Independent sector

The independent sector is finding it difficult to enter into the community health market by providing a diverse range of services to compete directly with NHS trusts. In economic terms this would be described as due to the high barriers to market entry.

Generally, they are not sophisticated organisations able to make large-scale investments in any of the key resource areas. The strength of independent sector organisations in these areas depends in part on their size and the strength of their financial viability. They can display innovation on a small scale in any of these areas.

Criterion 4

Capable of maintaining motivation of the work-force of key health professional staff?

NHS community trusts

Most community health professional staff (nurses, therapists and other professionals allied to medicine and doctors) are conservative by nature and prefer continuity of employment to offer continuity of service to the population they are serving. Many staff live in the locality they are serving and work autonomously. They generally prefer not to take risks, but are willing to innovate to improve care because they feel that care can be improved, mainly through additional funding. They do not like innovation imposed from outside. Traditionally, employment in an NHS organisation has offered security, both in employment and as a base to develop or maintain professional practice in a safe environment. Some community trusts have had command-and-control management cultures, where field staff have been constrained in their autonomous decision-making and development, and discouraged from working collaboratively with GPs. Community trusts will vary in their ability to maintain the motivation of their staff. They mostly have the loyalty of their staff and if they are able to continue to offer competitive reward packages that are not just monetary but include imaginative use of benefits such as flexible working and training opportunities, they will be in a good position to retain loyalty.

NHS combined trusts

Much of the above can apply to combined trusts, and they have the advantage of being able to develop more effective ways of managing the hospital/community interface, for example on admission and discharge. But they also have the risk of being less sensitive to the characteristics and needs of community staff that distinguish them from hospital staff, and the prevailing culture within some combined trusts is still one where community services are 'Cinderella' services in relation to hospital specialist services.

General practice

The advantages of general practice are that it is small and highly focused; communication amongst staff and patients can be on a personal scale. Most GPs employ administrative staff and practice nurses who are mainly loyal, long-serving employees. However, there are wide variations in employment practices – for example between single-handed and large practices – and stress levels can be high. Expanding into direct provision of community health services, and employment of community health professionals, is a new experience for general practice. Focusing on the holistic needs of individuals and the practice population, and working in well-ordered multi-disciplinary teams where goals, methods of communication and performance review are mutually agreed, will be motivating factors for most health professional staff. However, to sustain the motivation and development of staff, general practice needs to become a more sophisticated organisation, capable of offering personal benefits at least as good as or superior to those of an NHS trust. These would include pay, hours of working, a sense of value and belonging, a good working environment, training and development opportunities, and minimising non-productive time (for example travel time, duplicate data entry or attending inappropriate meetings).

Independent sector providers

The independent sector, like GPs, has to entice health professional staff away from perceivedly more secure employment in NHS trusts. Without GPs, the independent sector cannot offer holistic, multi-disciplinary services to a large population. However, by focusing on particular, niche areas of the market usually associated with a defined client group, the independent sector can attract health professional staff who prefer a focused, specialist commitment to particular client need, for example dentistry or chiropody.

Criterion 5

Capable of offering value for public money by minimising expenditure on overhead cost or transaction costs?

Any organisation should strive to add value to those who have invested their money in it. A private sector company aims to give profits to its shareholders, and a public sector organisation to give special benefits that outweigh its costs, borne to some degree by the tax-payer. Pressure comes from both customers and funders to minimise any non-essential costs, and overhead costs will always be an element that needs to be justified in terms of the extent to which they improve the quality, efficiency or effectiveness of the product or service provided.

Overheads are made up of management costs, costs of running buildings, administrative support, and anything else that cannot be identified as a direct cost associated with a particular service or product.

Definitions of many elements of services and their costs are undeveloped in the NHS and comparisons are very difficult, particularly across totally different organisations.

Community trusts and combined trusts

NHS trusts are viewed by their purchasers, particularly GPs, as having a natural tendency to inefficiency. Annual requirements for a percentage across-the-board cost-improvement programme by health authorities are a response to this belief. An organisation which has for so long been part of a monolithic bureaucracy which was not always cost-conscious, is suspect.

There is quite a large range of management costs in different trusts across the country, as shown by the Audit Commission's (1995) work. There is often a relationship to size – most larger trusts have lower management costs proportionate to income than most smaller trusts. However, whether larger trusts give better value for their management costs depends on their performance under other criteria. Although there is public perception that management costs are excessive, when compared with the private sector NHS management costs do not seem excessive and there may even be under-investment in management. Costs of administration are probably high though, due to under-investment in information technology. Investment, say in fully automated patient records, would have a high impact on overhead costs. Trusts differ in the amount of capital assets they own. If they have inefficient buildings to run (for example buildings that are not fully occupied or are inefficient in their use of energy, such as an old mental illness hospital in the process of being closed), their overhead costs may appear inefficient and uncompetitive in the short term.

General practice

GPs regard themselves, and are regarded by the public, as the least bureaucratic part of the NHS, offering excellent value for money in their gate-keeper role for the whole population. Their overhead costs are transparent because they are small organisations – in terms of the cost of premises, support staff and so forth. However, there are also the costs of administering their elaborate contracts to consider, which lie in health authorities. This is another area that has been slow to reduce costs through use of information and communication technology. As GP fundholders move into purchasing other aspects of health care on behalf of their patients, overhead costs go up to pay for the transaction process of contracting for services. These transactions are on behalf of individual patients, and when added together, represent a significant increase in overhead costs for the NHS as a whole. Again, their value depends on whether patients receive better care as a result. There is likely to be an optimum size for GP practices as efficient purchasing entities which is well above the single-handed practitioner level.

As the market for health care becomes more and more sophisticated and more fragmented, the costs of contracting are bound to increase and will be present in all organisations, purchasing and providing. The question is, can the costs be justified in terms of improved performance from the NHS as a whole and can information and communications technology be used more extensively to reduce administration costs?

Independent sector

Independent sector organisations can be very effective in minimising overhead costs. They are less-regulated than NHS trusts and can be far more flexible in the way they manage the business. Their survival depends on tight control over the quality, volume and costs of their service.

FUTURE IMPLICATIONS FOR COMMUNITY HEALTH ORGANISATIONS AND THEIR STAFF

Dr Paul Lambden was a first-wave GP fundholder in Hertfordshire who became a chief executive of an NHS combined trust and has now returned to general practice. When asked in 1995 about his views on the future he said:

> 'It is quite clear that health provision still has to undergo some very fundamental changes and they will probably happen irrespective of which political party is in power. I think there has to be a continuing move from secondary to primary care. There has to be rationalisation of GP and community services and rationalisation of hospital management to ensure cost-effective service provision. The number of hospitals will decline dramatically over the next 10–15 years and one of the biggest challenges will be persuading the public that they no longer need them.'
> (Hadfield, 1995)

Providers of community health services are involved in a massive sea-change, starting in the 1990s, in the way health care is perceived, organised and delivered. It can best be summed up as moving *Towards a Primary Care Led NHS* (NHS Executive, 1994). This chapter has been written particularly about community health services as they have been traditionally defined and understood, in order to illuminate their essence, character and strengths and weaknesses, to be considered alongside the futures of health service purchasing, general practice, social care and hospital provision. Perhaps least has been written about community health services, which appear at times invisible behind the limelight placed on GPs. Yet over a third of all face-to-face contacts patients have with health professionals in primary care are with community health staff. The reality of primary care in its many forms today is a highly complex web of services that are not well integrated, and of which general practice is a significant, but incomplete, part.

The greatest strengths of the traditional community health services are in promotion of health and prevention of ill-health and in care of chronically-ill people. These lie alongside the traditional strengths of the medical profession, which are in the ability to diagnose, treat and cure illness. Community health services deal mainly with the politically unpopular parts of the NHS, patients whose stories are undramatic and do not make the story line of 'Casualty', but who suffer silently day-in and day-out from the effects on their lives of the pain, functional immobility and psychological distress that derives from chronic disease. The term 'Cinderella services' still applies.

The future for community health services lies in their taking their place alongside general practice in a reformed and truly integrated primary care service, which is funded through a simplified, unified weighted capitation formula to ensure equity. The challenge is to build on the strengths of primary care as we know it today, and to enable health and social care professionals to work together as part of flexible teams that can adapt themselves to meet the diverse needs of the population served.

The vision of truly integrated primary care services with the combined strengths of their traditional separate branches will require new forms of primary care organisations by the end of the 1990s. Both general practice and NHS trusts, as we know them today, will be too rigid to allow the degree of integration that is required to best meet the fitness criteria.

Reform of primary care is dependent on an informed public engaging in the debate. Very few people have a clear overview of primary care and there is a lack of appreciation of its potential to improve the quality of health care and to tackle the negative effects of over-specialisation of health care, that is iatrogenesis and excessive costs. We need to gain greater clarity about what are the core inputs for a primary care centre or team serving an optimum size of population in terms of skills, buildings and technological support. Then there will be legitimacy in allocating a budget for the primary care organisation to use to provide primary care, buying in any elements it chooses from other providers; and to be used in referring to, or purchasing, secondary care when necessary. This process has already started through GP fundholding or through alternative approaches of locality purchasing.

Community health staff need to be involved as key players in the reform of primary care. They will respond well to the prospect of improving patient care, providing the process is not handled in an autocratic manner and that the reforms are not based on the assumption that the GP's clinical expertise is universally superior to that of other community health professionals. In turn, community health staff need to accept greater personal responsibility for the development of their clinical practice, informed by the diverse and changing needs of the population, and for determining their terms and conditions of work as responsible members of new primary care organisations.

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CHAPTER TEN

The Effects of Changes in Hospital Care on Community Health Care

Sandra Legg and Helena Ellerington

INTRODUCTION

> 'With a lever long enough . . . single-handed I can move the world.'
> (Archimedes)

Health care is being affected by a number of trends, all of which will impact upon the delivery of services within the NHS and beyond. Fundamental changes in the delivery of services within acute and primary care, together with the changing shape of nursing, have created opportunities for the profession to influence the alternative patterns of health and social care delivery. These issues will be addressed in this chapter, together with the opportunities that exist for building bridges between the plethora of health and social care, and voluntary organisations. Lessons learnt from the challenges and opportunities that hospital nurses face will be applied to community nurses as they develop the government agenda of a more primary care led service.

The policy debate around the future of acute services and the role that hospitals will play in the future is gaining momentum. The move towards replacing existing provision in the UK with fewer accident and emergency departments and separating more locally-based, elective facilities from tertiary care services, faces health professionals and managers with difficulties in achieving change on the ground. Recent attempts, therefore, to re-configure acute services around the country seem timely but, by tracking the process, Turner (1994) shows the difficulty that health authorities are facing in trying to deliver change.

Recent changes have introduced many uncertainties, and for most parts of the service the future seems unclear. It is with this background that nursing moves forward into the millennium, assessing where its future contribution lies and identifying ways and means of moving the service forward. Nurses working within acute and community care must identify the forces for change, and in so doing learn how to accommodate these by protecting what is good from what is not, and having open minds for future development. Nurses must therefore be in the forefront of change; purchasers of health care and patients look to them for continuing guidance and direction.

Early in the 1990s, health planners began to discuss how health and social care might be delivered in the early part of the twenty-first century. Similarly, the Chief Nursing Officers of the United Kingdom met to discuss health care in the twenty-first century and beyond (DoH, 1994, the Heathrow Debate). It was evident in these debates that the current patterns of service would change in response to various social, technical, economic and political pressures. Government policy-makers wanted to ensure that there remain sound, clear and logical patterns of service because of the cost of health care and its importance to the public. Politicians must therefore find a balance, framing a policy that trades-off the public's expectations, their own philosophy and vision of the future, and the economic realities. Three areas have recently received particular attention and are likely to have a long-term impact:

- A focus on the individual, with consumer-empowerment, citizen-involvement and health promotion, sharpening the focus on individual needs and demands.
- A shifting of the balance between care in institutions and in the community.
- The use of resources must be efficient as the pressures of an ageing population, new technology, restructuring the medical workforce, and a new emphasis on quality and choice take effect (Warner and Riley, 1994).

The reforms, with the formation of trusts and trust boards, have sent shock waves throughout the service, having a marked effect on nursing and medical services. Overnight, new organisational structures, new information, and the requirement of new management skills have been required. These challenges have excited many nurses and doctors, though some observers have been concerned at the scale of change and the lack of evaluation as the reforms progress. There is little slack in the system, with the services facing tight financial limits and the reluctance of many professionals to take on further work. There are also pressures to reorganise care away from institutions to the community, and a further complication is the mounting evidence from the World Health Organisation's *Health For All Targets* (WHO, 1991) of the limited role of health care services in influencing health and well-being.

Nursing's response to these changes can best be described in terms of shifts in thinking and practice. Key areas of change are new technologies, new locations for care, new skills and manpower substitution, and new ways of working across structures through inter-agency collaboration. Nurses within the acute care setting have demonstrated new and innovative ways of handling some of the complexities within acute health care today. Innovations such as reinventing Florence Nightingale's insight into nursing leadership and management, developing a transformational leadership style, identifying the nurse executive's contribution to the board agenda, working within a clinical empowerment environment, developing clinical supervision for the practitioner, contributing to technological assessment, working with more flexible work patterns, and introducing case-management systems of service delivery, are all structures and systems which community nurses will need to think about as the primary care led service is developed. All these issues will be highlighted in this chapter, together with the effects that such changes and innovations will have on nurses working within the community services.

THE CHANGING SHAPE OF HOSPITALS

It is not possible to consider the changing shape of hospitals without first considering how they have emerged in history, and what have been the catalysts producing the changes.

At the end of the Second World War, the formation of the National Health Service in the UK was the cornerstone of the Labour government's welfare state. For the first time in Britain health care was free, and for many the 'promised land' had arrived. Freedom from the fear of illness, injury or disability, together with the ensuing poverty which always accompanied ill-health, became a reality. Initially it was thought that the cost of the health service would be high, but as the population became healthier, so would the costs decrease. The health service, therefore, became a 'sacred cow', and it is easy to see why the vast majority of people were prepared to campaign to keep their local hospitals open, and were happy to wait for hours in out-patient departments, or to spend years on waiting lists for surgery.

The separation of the purchaser and provider roles is the biggest change in the NHS since its inception. This has brought about significant changes in many parts of the United Kingdom, particularly in large conurbations, but most extensively in and around London. This, and the contribution of capitation funding, has highlighted the vulnerability of London's major teaching hospitals, which were already facing reductions in their relatively well-funded positions as a result of the move towards Resource Allocation Working Party targets. It is patently clear that a number of London's teaching hospitals will not be viable in their present form when purchasers plan services on the basis of their assessment of the needs of the resident population.

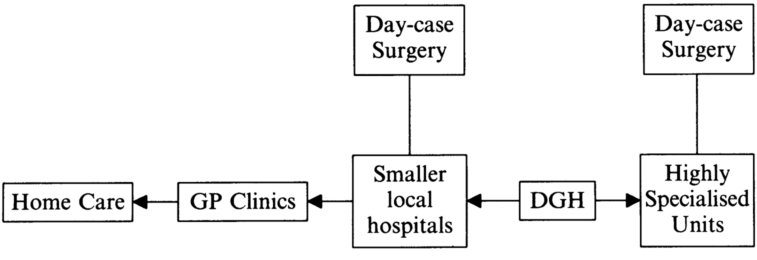
Debate on the future of hospital services within London, following the publication of the inquiry by Sir Bernard Tomlinson (1992), has been extensive and time-consuming. This situation mirrors the thinking about acute care across the country. Expenditure of £17.7 billion was spent on hospital and community health services in England in 1989 to 1990 of which approximately £3.3 billion was devoted to London, although only 15 per cent of the population live in the area covered by the London health authorities (King's Fund, 1992). It is perceived that in the twenty-first century only diagnoses, investigations and treatment which require the use of expensive equipment and a range of highly skilled personnel will take place in acute-care hospitals. Accident and emergency facilities will be linked to acute tertiary hospitals. Special trauma units will serve patients with major and multiple injuries, using skilled teams of clinicians expert in this type of emergency work.

Outside London there will be a fundamental reassessment of the district general hospital, both in size and role. The hospitals will become more highly specialised units treating only acutely ill in-patients and day-cases. Beds will be reduced to approximately 250 per hospital, and the less-acute care will be provided by local community hospitals serviced by general practitioners and peripatetic hospital consultants. Maternity care will be provided on both sites but only high-risk cases will go to the specialised obstetric units. More births may occur at home, and since the publication of *Changing Childbirth* (DoH, 1993), the government appears to be willing to provide more support for home deliveries.

The Heathrow Debate (DoH, 1994) outlined a scenario for hospitals in the year 2010, not only supporting the overall direction of the above new paradigm in health care, but also providing a useful template for discussion and thought about the possible configuration of services. The report describes the pattern of care in terms of a circle, with *general care teams* on the periphery and *specialised care services* in the centre. The *specialised care services* will remain centralised services for the severely-ill and for major surgery, offering high-technology and very specialised services. Other services currently provided by larger hospitals, including laboratory, diagnostic and surgical facilities, will move to the community along with 40 per cent of out-patient consultations. By the year 2002, it is also predicted that the current distinction between health services and social services will have blurred, everyone over 85 will have a key worker, 15 per cent of births will take place outside hospital, and acute beds in district general hospitals will be reduced by at least 40 per cent. Without doubt if these proposals are adopted the greater amount of care will be offered in the community by the *general care teams*, and the changes will dwarf the very radical and 'painful' fallout of the Tomlinson Report (Tomlinson, 1992) in London. Figure 10.1 illustrates the complexity of organisational change resulting from the impact of the new technologies.

Since the health reforms the population has begun to think increasingly of health care as a service industry rather than part of the welfare state, and has undoubtedly become more demanding.

Figure 10.1 Organisational change resulting from new technologies



Source: Warner and Riley (1994). *Closer to Home, Health Care in the 21st Century*. Research Paper 13. London: NAHAT.

The publication of league tables and *The Patient's Charter* initiative by the NHS Executive (DoH, 1991), have all raised awareness and expectations of the services, and the rights of the individual to demand quality. This has ultimately received the persistent attention of the press on all matters related to health. The unremitting demands for high-quality service and treatment, together with the shift towards a more primary care led service, have therefore led health planners to think more strategically across the great organisational divide. Some of the trends affecting changes in the area of acute care are shown in Figure 10.2.

Figure 10.2 The political, social, economic and technical trends which have influenced changes in acute care

Political	*Economic*
• Spiralling health expenditure • Keeping patients in their local community – a cheaper option than hospitalisation • Concept of health moving from welfare to a service industry • Future issues (Warner and Riley, 1994) • A focus on the individual rights vs responsibility • Efficiency and effectiveness	• Postwar UK economy characterised by 'boom' – 'bust', but also periods of substantial growth • UK economy affected by the global economy • Recession in the 1970s, the late 1980s, and the 1990s, have made many western countries target health spending • Control of inflation – driving force in the UK
Social	*Technical*
• Demographic problems not only in the UK, but also in western Europe • Birth-rate does not match the replacement rate – in the UK • Growth in higher education in the UK influences attitudes and produces a healthier population • Education raised expectations and demand as people become more aware of factors influencing their own health • More divorce and family breakdown, mobile families, nuclear families and working women reduced the number of 'traditional' carers	• Escalating advances in technology • Developments in the information 'superhighway' and 'superjanet'. • The NHS information network strategy launched in 1993 • More access for customers and consumers of health to information on services, waiting lists and performance indicators • Medical advances in miniaturisation, imaging, ultrasound and keyhole surgery having a radical effect on the service, its delivery and patient length of stay

The business environment and health care

With the introduction of key business ideas into the health service the internal market has developed and taken shape. Marketing, a key idea, has become essential for the efficient and effective delivery of services. 'Branding' of services and organisations has become a must, and the corporate 'logo' and mission statement are visible examples of this process.

Branding is not a new concept, in fact, it started in the middle ages when craft and merchant guilds required that each purchaser should mark goods, so that the output could be restricted and inferior goods traced to the producer. Today, a brand name, design or symbol identifies the products or services of a seller or group of sellers. Evans and Berman (1985) emphasise that by establishing well-known brands, companies are usually able to obtain acceptance, extensive distribution and higher prices.

Another key business idea, adapted for a health environment, is the concept of Business Process Re-engineering. Developed by Hammer and Champy (1993) re-engineering has become the radical re-design of a company's processes, organisation and culture. Hammer and Champy show how some of the world's premier organisations use the principles of re-engineering to save millions of pounds in resources, to achieve unprecedented levels of customer satisfaction, and to speed up and make more flexible all aspects of their operations.

The concept is considered to be one way of revolutionising health care organisations today, and has been tested at the Leicester Royal Infirmary. The initial results of this pilot project were so promising that a project has been funded by the NHS Executive at King's Health Care Trust, a London teaching hospital. The project is summed up as a 'root and branch' look at services and their delivery. The process involves all grades of staff, who pool their ideas and skills and 'map' the processes of service delivery. Staff belong to what are called 'laboratories' which decide on the redesign of processes. Leicester took the 'patient visit' as one of the first processes to be mapped. The processes were mapped from the patient's referral by the GP, through the hospital out-patient department, day-case or ambulatory service, and back to the patient's home. Following this mapping process the trust's neurology clinic was revolutionised.

Precision marketing such as branding and business process re-engineering are considered to be two key business elements in the new health environment. Nurses have therefore had to readjust their ways of working within this new environment, and have ultimately become more flexible and more collaborative in their approaches. As yet, planners have not considered the benefits of re-engineering in community services, though work is already established across the interface of care. This concept, nevertheless, is worthy of note.

THE CHANGING SHAPE OF NURSING

Health sector reform has had a huge impact on nurses and nursing within the acute and community care settings, and in particular on nursing leadership. In the United Kingdom, and elsewhere, there has been a gradual demise of nursing leadership with a political agenda entirely focused on general management issues such as efficiency and effectiveness, which has continually pushed nurses to the periphery of decision-making. It is also evident that since the reforms the reconfiguration of management structures within organisations, is at great odds with the *centrality of caring*, and with the role that nursing leadership plays in the management of nurses and patient care. It is not before time, therefore, that organisations should be redesigned, so that nurses may hold strategic leadership positions which ensure that the *core values* of health care become central, once again, to these organisations.

The nursing profession has to ask fundamental questions about its future direction if services polarise, as suggested by The Heathrow Debate (DoH, 1994), between the new-style acute hospital offering a high-technology centre and the community-based services. The acute hospitals will need highly-skilled technicians but will they need nurses? With boundaries blurring and many more agencies and voluntary bodies providing care, what role will nurses have? Traditionally, nursing has focused on the patient as an individual, not on a specific clinical problem. This co-ordinating role will become more important as care diversifies, and will be enhanced by the continued development of the specialist-nurse role across all the new divides. This will be an important thread in the new tapestry of care.

Nurse executives have a major responsibility in leading organisations through the management of change agenda and into the *new reality* of health care, and perhaps lessons should be drawn from American colleagues who are at the forefront of some of these changes. Time and resources in the USA are committed to preparing leaders for the future, and a total *shift of mind* enables organisations to flourish in a *learning environment.*

Nightingale onwards

One of the key lessons learnt from America is a more in-depth understanding of Nightingale's work in preparing leaders for the future. Professor Beverly Henry, from the University of Illinois, is running a joint masters programme on nursing and business administration, and within this curriculum, she places a major emphasis on Nightingale's thinking and writing (Henry, Woods and Nagelkerk, 1990). Nightingale stipulated that nurse leaders should be:

- Educated leaders;
- Clear-thinking and decisive;
- Collaborative and capable of managing complexity;
- Imaginative and have the ability to grasp technical details of a vast range of subjects;
- Capable of organisational design and governance;
- Capable of personnel management;
- Capable of financial management and patient classification.

Henry *et al.* (1990) maintain that the administration of nursing services is done best by educated and experienced nurses who understand the nursing processes required for patients, and their twenty-four hour nursing and health care requirements.

Transformational leadership

Encompassing Nightingale's criteria for effective leadership is the style and form of leadership. Transformational leadership is a style of leadership which stems from the creative work of Benis and Nanus (1985), who hold the view that 'a leader who transforms, is one who commits people to action, who converts followers into leaders, and who may convert leaders into agents of change'. It is evident that this style of leadership fits very well with nursing ideology, which is based on *concern for others*, and on *interaction* with patients.

Throughout the USA this style of leadership is practised widely and is very effective in bringing together the whole multidisciplinary team. In these times of change and the re-configuring of services, leadership which empowers and enables practitioners to make decisions at the point of delivery can only be enhancing.

Senge's (1990) ground-breaking work in *The Fifth Discipline* further develops our thinking around styles of leadership, suggesting that participative management is not merely a new form of entitlement, but a basis for learning. Senge's *learning organisations* are organisations where people continually 'expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together' (ibid., p. 4). Organisations such as these, therefore, offer a marvellously empowering approach to work.

The board

By statute, nurse executives in both acute and community care act as representatives of the nursing profession on trust boards. Their roles have never been completely clear to themselves or to others, and some would argue as to their effectiveness and their contributions to the board agenda.

The Department of Health's *One Year On* (NHSME, 1992) study of trust nurse executives found that many of them were prepared to sacrifice their nursing role and to declare that they were executives and not nurses. Similarly, a recent survey by the NHS/Newchurch and Company (1995), reported that chief executives believe nurse executives lack strategic skills, and nurses down the hierarchy think that nurse executives are far removed from hands-on care. Clearly there is a role crisis here which may never be resolved.

Most worrying of all, however, is the finding from the Newchurch survey that nearly 30 per cent of nurse executives in acute and community trusts manage no nursing services whatsoever. This highlights grave concerns which Porter-O'Grady in Naish (1995) warns is 'slow suicide', in that having someone on the trust board with whom you have no real relationship widens the policy/practice gap even further. The nurse executive is the person with the information that other nurses need, but the further that person is removed from practice, the less relationship he or she is going to have with the staff whom he or she is supposed to be leading.

Clearly, the report also identified the problems that chief executives have in pigeonholing nurse executives into their idea of what nurse executives can contribute to the board agenda. Most chief executives seem ambivalent, and suggest that on the one hand nurses are good at and should be seen to be leading in traditional nursing areas such as quality and clinical-practice development, while at the same time believing that nurse executives should be making a corporate contribution.

If chief executives have the wrong idea about nursing's contribution to the board, then nurses, themselves, must surely put the record straight and take ultimate responsibility for shifting this thinking and clarifying the nurse executive's *raison d'être*. Naish (1995) goes further to suggest that 'nursing is in danger of having to declare itself *clinically bankrupt* as trusts demand, in response to ministerial dictates, that health care professionals establish the worth of their work' (ibid., p. 6). If nurse executives are to survive, Naish is adamant that they 'must reassert their professional leadership by *linking* strongly with their hands-on nurses, and with researchers, to develop the new effectiveness agenda and nail it to the heart of their corporate trusts' agenda' (ibid., p. 6). In response to the nurse executive's question, then, 'what do I bring to the board?', surely the answer must lie in the 'clinical effectiveness' debate. Nurse executives, in both acute and community care, *must* therefore prove that their interventions benefit patients, at all costs.

Clinical empowerment

Since the 1960s, many hospital nurses in America have been making changes in the clinical setting which directly improve the delivery of patient care. The introduction of primary nursing has enhanced the nurse–patient relationship and placed higher accountability for patient care with the primary nurse. Similar needs have sparked the development of shared governance structures in nursing. Whilst traditionally implemented within hospital services, shared governance is now being considered as a valued systems model within community services. Its main focus is that of developing leaders and bridging the great policy/practice divide between clinical practitioners and nurse executives.

What then is shared governance? It is a decentralised approach which allows nurses to retain their influence about decisions that affect practice, the work environment, professional development and personal fulfilment. As an organisational structure, it also requires practitioners to assume higher levels of accountability for patient care, clinical practice and professional activities. By building peer relations, governance can enhance the staff's ability to take more responsibility and accountability for themselves and their peers. Its committee structure fosters teamwork, thus allowing staff nurses a more active role in developing and implementing systems designed to achieve patient care outcomes and develop nursing practice.

In 1994 a shared governance structure was implemented in St George's Health Care Trust (Legg and Hennessy, 1996), a London teaching hospital, following a two-year preparation for implementation. Following a year's implementation phase, a survey was carried out throughout the trust to gain the views of professional and administrative staff. It was apparent from the survey findings that all staff interviewed were in favour of empowering nurses. Some, however, questioned the readiness of nurses to take on such accountabilities. For example:

- All nurses were in favour of shared governance, but questioned whether this was the *right* time.
- Staff nurses generally did not feel confident about making autonomous decisions, whereas staff nurses in specialist areas were more confident and had more equitable relationships with their medical colleagues.
- Some middle-level nursing managers were uncertain about the feasibility of a staff nurse taking the *chair* of the nursing practice committee.
- General managers were in favour of nurse empowerment, yet at the same time felt that nurses would find the chance of moving beyond the boundaries somewhat daunting. Perceptions such as these, however, may be influenced by the unwillingness of general managers to relinquish their own status and territory.

Findings from the St George's experience, however, suggest that when culture change occurs in an organisation, which requires a *paradigm shift*, the leader should be *totally* involved and committed to the change process. Research findings also suggest that the implementation of shared governance requires a *champion*, who will envision, lead, facilitate, support and *drive* when necessary. Shifting the balance in thinking, behaviour and attitudes can also be translated across service and professional boundaries, and ultimately has the potential for assisting professionals in moving towards new areas such as primary care led services.

Clinical supervision

The concept of clinical supervision has both excited and bewildered the profession in a manner reminiscent of other nursing innovations in the past. Whilst new in its implementation, this innovation, however, like shared governance, is such a good idea because of its potential to produce change and assist nurses through a period of paced change. Described as a professional relationship between practitioner and supervisor, and aimed at encouraging self-assessment, reflection on practice, therapeutic proficiency and the promotion of innovation, its potential for guiding nurses through periods of great change, and in particular crossing the boundaries of care, is enormous. Clinical supervision supports nurses in meeting the changing circumstances in acute services, and in developing a more strategic approach to their own development.

Clinical supervision therefore provides nurses with an effective 'tool' for monitoring, supporting and developing the profession, and also has the potential to become an important factor in the development of improved services to patients and clients. Potential benefits, nevertheless, are not limited to the patient, client or practitioner. A more skilled, informed, aware and articulate profession will contribute strongly to the ability of an organisation to meet its objectives.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) is clear that 'clinical supervision will play an increasingly important part in ensuring safe and effective practice' (UKCC, 1996). This is supported by Butterworth and Faugier (1994), who postulate that the 'exchange' or 'relationship' existent in clinical supervision, has a range of benefits which include:

- Improved patient and client care;
- Improved staff performance;
- Improved managerial performance;
- Reduced risks.

However, the UKCC stresses that clinical supervision is *not* the exercise of overt managerial responsibility, a system of formal individual performance review, or intended to be hierarchical in nature.

Various trusts and health care organisations in acute and community care are developing models of supervision, and it is timely that nurse managers throughout the health service should coordinate evaluation of clinical supervision to demonstrate effectiveness and service benefits. As the balance in health care shifts from the hospital to the community, it is essential that a better mutual understanding exists between all professionals, and that a common method of monitoring and support exists for all concerned. The United Kingdom is clearly at the forefront of these innovations, and should publicise its findings as soon as possible in order to influence global trends elsewhere.

Nurse development units

Demonstrating the worth and value of nursing is becoming increasingly important. Why should the commissioner of services in the new century employ registered nurses? With a cost-effective agenda cheaper staff substitution will become the order of the day. If nurses and nursing skills are perceived as more expensive and less effective than alternatives, the alternatives will be purchased.

The work undertaken at Burford Community Hospital in Oxford by Pearson (1983) has been the catalyst and has inspired the development of nurse-led services. The philosophy at Burford aimed to maximise the therapeutic potential of nursing for patients who were admitted to the unit. The prime objective of nurse development units (NDUs) is the provision of client-centred care by nurses who are *questioning* and *autonomous practitioners* within the health care team, and the implementation of processes of nursing care based on *research* (Redfern and Norman *et al.*, 1994).

Looking at the theory supporting the development of NDUs, the work of Pearson (1983) and Ersser (1988) is of particular interest. Ersser looked at the individual needs of hospital patients and argues that health needs were not synonymous with *medical* needs. This fact becomes increasingly significant when patients in hospital are reviewed and found to have become *medically* stable, but still require some form of therapy.

This therapy could take the form of adjustment to a disability, or regaining independence. Estimates of the number of patients in hospital who do not require acute medical care range from 15 per cent to 48 per cent of acute medical patients and absorb, therefore, a significant chunk of the health service budget (Audit Commission, 1992).

Pearson believes that therapeutic nursing care is the major factor in patient recovery, and the presence of such care is a major determinant of recovery. Pearson also postulates that the therapeutic aspects of nursing are impeded by the contrasting demands made on nurses' time in an *acute* area. The rationale for placing patients in a clinical nursing unit was to 'create a unit where an ideology of therapeutic nursing could prevail' (Pearson, 1983).

Looking towards the future polarisation of hospital services, it becomes apparent from Pearson's work that the concept of only technicians in acute areas may become a reality as the value and importance of nursing evolves, and the majority of care and services move into the community.

The development of the 30 Department of Health-funded nursing development units (NDUs) has gone further to tease out the true value of nursing in its own right. The King's Fund has also been instrumental in evaluating four of these units over the first two years, namely, Brighton – a 22-bedded rehabilitation unit for elderly patients; King's College Hospital – an 18-bed acute general medical ward for female patients; Stockport – a 27-bed rehabilitation ward for care of the elderly; and West Dorset – a 24-bed acute general medical ward for female patients (Shaw and Bosanquet, 1993). The King's Fund NDU programme now encompasses specialities as diverse as forensic psychiatry, intensive care, accident and emergency, and occupational health (Griffiths and Evans, 1995).

The development of NDUs is dependent upon the commitment of staff and leaders. The leaders are important as key agents of change. In the King's Fund study of 1993, all units identified leaders, job descriptions of the ward sisters were reviewed, and development posts were created (Shaw and Bosanquet, 1993). The development posts were slightly different in each unit, but all had the overall aim of assisting the development of nurses' skills in enquiry and research, enabling practitioners to use the findings to adapt their clinical practice.

One of the units in the King's Fund study created the post of lecturer/practitioner. This was a joint appointment between the NDU and a university Department of Nursing Studies (ibid.). The lecturer/practitioner post was reviewed during the study and considered to have been useful especially at an early stage of development, but it was felt that the resource implications restricted the development or replication of other similar posts. The lecturer/practitioner was replaced for the final year by a full-time researcher with the emphasis on 'outcomes of nursing care' (ibid.).

It is recognised that not all nurses would wish to pursue the intense educational and research activities which are the hallmarks of a nurse development unit. Some of the negative attributes of NDUs include feelings of professional isolation and alienation. The continued questioning and high pressure of expectation from outside can also be overwhelming. However, despite the difficulties, the contribution of the NDUs to the nursing profession and its development cannot be underestimated.

Developments in technology and technology assessment

Probably the most profound development of the latter half of this century has been the increasing place technology plays in our everyday lives. Nowhere have these changes been felt more acutely than in the health care arena. The developments in medical technology have been staggering, and will be one of the issues that determine how services develop into the next century. Alongside, and in addition to the advances in medical technology, are the developments in information technology which have revolutionised many traditional services such as banking, as well as industry.

One of the driving forces behind the NHS reforms of the 1990s was the need to optimise the quality of patient care and outcomes within the constraints of affordable resources. The greatest problem was that although the health service was awash with paper, there was little information easily accessible to assist with the development of the services and the internal market. It was against this background that Stephen Dorrell opened the NHS Centre for Coding and Classification in Loughborough, Leicestershire in 1990, with Dr James Read as its first Director. The function of this centre was to assist the health service to join the information technology revolution by developing codes which convert medical *terms* into numbers for computers (Read codes).

The codes are owned by the Secretary of State for Health and are crown copyright. The Secretary of State also licensed Computer Aided Medical Systems Limited (CAMS) to market and make available the Read codes to all users both inside and outside the NHS (CAMS, 1991). Although Read codes were originally developed only for *terms* used by general practitioners, they are now widely used throughout the NHS in both primary and secondary care settings.

The crucial difference between this system and other coding systems, is that Read codes were developed for use by clinicians with direct responsibility for patient care, and not just for research. Therefore, it was envisaged that with the appropriate technology and software, Read codes could be used to support the management of patient care, as well as clinical audit and resource management.

In addition to the work undertaken by the medical profession, work has also been completed on the 'terms project' to be described in the following section. This project looked at the needs of nurses, chiropodists, speech therapists, occupational therapists, physiotherapists and dieticians. The value of this work is that it assembles agreed comprehensive *terms* for patients' records enabling the records from doctors, nurses and all other professions allied to medicine to be incorporated into Read codes in a format suitable for the NHS information systems.

The nursing terms project

The objective of this group was to look specifically at the needs of nurses, the terminology used by nurses in their practice, and to identify all codes and terms. It was accepted that the terms nurses use may be different from those used by doctors. The nursing profession was represented by the Strategic Advisory Group for Nursing Information Systems (SAGNIS). The task of identifying all the terms required for nursing was assessed so that the resources needed to develop nursing terms into Read codes would be suitable across the whole NHS (NHS Centre for Coding and Classification, 1993).

Although this work is now complete, the whole Read Code project appears to be in question. The cost thus far is £3.7 million and has involved 55 working groups and over 2000 clinicians. The present edition, version 3, which the NHS Executive describe as 'a national thesaurus of clinical terms' has had some fairly major teething problems (Cross, 1996a). It was envisaged that this version would enable the creation of an individual's clinical record. The resolution of the current problems will be essential if the original vision of the NHS IT strategy is to be realised.

Technology assessment

Working across the whole spectrum of services, nurses have major responsibilities in disease prevention, health maintenance, care of the sick, health education and management. Improvement of health depends, in part, on the selection and use of appropriate technology to prevent disease, to care for patients, to educate patients and staff, and to manage data.

Attainment of these goals is essential for nurse executives in acute care, and increasingly in community care, and depends in part on their selecting and using appropriate technology. Similarly, matching the highest quality of health care to available resources requires the involvement of nurses in the assessment of technology. Within community services there is now a greater emphasis on more technical and advanced care following earlier discharge home, and the development of more acute care within the home or local community setting.

The US Office of Technology Assessment (1982), describes technology assessment as 'a pragmatic, dynamic, interactive process with many applications. Used when a technology is introduced, extended, or modified, technology assessment is a comprehensive form of policy research that explores short and long-term consequences of technologic applications.' McConnell (1992) suggests five steps of assessment – need, safety, effectiveness and efficiency, economic appraisal, and social impact – which can be applied individually or comprehensively.

Health care technology is challenging because it generates questions from patients, providers and purchasers of health care, educators, lawyers, policy-makers and judges. Representing various perspectives, interests and philosophies, all have a stake in technological decisions. Nurses encounter these stakeholders in a variety of ways, and can promote intelligent deliberation and facilitate the selection of appropriate technology by using the framework of technology assessment.

There is no one better able than nurses to be at the forefront of technology assessment in diverse settings, but involvement does demand, however, that nurses be proactive and knowledgeable. Nurses can select technologies to be used with individual patients by being aware of suitable alternatives, and by collaborating with the patient, the patient's family and other health care providers. Suggesting the trial of certain technologies and participating in the evaluation of 'new' technologies are other ways in which nurses can be involved. By networking and collaborating with a multiplicity of agencies at local, national and international level, nurses increase their opportunities to have input into design, selection and use. Joining and participating in international organisations have many advantages as well.

Technology abounds in the acute services, and continues to escalate in the community setting. Nurses, therefore, taking a lead in technology assessment are well-positioned to improve the health of all people by promoting the efficient and effective allocation of health resources. Similarly, as advocates for patients, nurses as part of the multidisciplinary team are well-placed to guide and monitor the myriad of ethical issues surrounding the use of technology and, in particular, to assess the impact of technology on the quality of life of patients.

The flexible firm and the twenty-three-hour patient

The devolution of management responsibility and the creation of NHS trusts has, in theory, enabled managers to become far more flexible in determining priorities and achieving strategic goals. Greater flexibility in developing staff has also been cited as giving more freedom to trusts.

Flexibility issues have been particularly prominent in the context of the health service's employment of nurses over recent years, yet nurses remain somewhat sceptical about the underlying reasons for flexibility, such as cost-cutting, and the casualisation of their employment conditions.

However, the Institute of Manpower Studies (Atkinson and Meager, 1986) has carried out a series of influential studies and has developed the concept of the 'flexible firm'. Similarly, Handy (1989) has developed the idea of a 'shamrock' organisation. These models suggest that there is a core group of permanent employees, supplemented by one or more groups of peripheral workers, who may or may not be employees of the 'firm'. More recent research by MacGregor and Sproull (1991) has confirmed that UK employers have rarely shown a strategic approach to changing working patterns.

Armstrong (1992) has developed a typology of different forms of flexibility which highlight the variety of flexible approaches to managing a work-force. These include contract-based, time-based, job-based, skills-based, organisation-based and pay-based approaches. This typology is relevant to all nurses across the spectrum of care, since most of its elements are being actively applied by NHS managers. Short contracts and temporary staff are therefore becoming more common within the acute services as a way of improving deployment. Buchan (1995) suggests that some are now arguing strongly that NHS trusts will have to 'flex' their staffing levels in order to survive in competitive markets. This argument, therefore, needs to be applied to all trusts as a matter of some urgency, and in particular to community trusts. However, there is growing concern within the nursing profession that flexibility of staffing and short-term contracts affect the quality and continuity of care. A recent report by the Health Service Ombudsmen (NHS Executive, 1995) has highlighted the problems of communication amongst health care staff themselves, and between patients and staff. This clearly demonstrates that good communications have to be a major priority for the 'flexible firm'.

Further work-force issues gaining momentum within acute care are the drives to re-profile the nursing work-force, and to engage in skill-mix exercises. This has been a major political agenda, with the driving force of motivation, undoubtedly, being cost-containment.

Decreasing length of in-patient stay and increasing the number of out-patient procedures within the acute services has led to what is often called the twenty-three/twenty-four hour observation patient. This patient spends a few hours in acute care, followed, ideally, by an overnight stay in a patient hotel facility. However, the reality is that there are very few patient hotel facilities in existence, and so the twenty-three/twenty-four-hour patient spends his or her total in-patient stay in an acute-care facility. Kumarich, Biordi and Milazzo-Chornick's (1990) study demonstrated that the addition of day-case patients to the aggregate workload data on an acute-care ward created a definite staffing deficit in 60–90 per cent of clinical areas. In other words, patients who are admitted to in-patient facilities for a day-case period of 23 hours do, contrary to general opinion, require more than observation, and therefore generate a higher workload on those units.

Findings such as these dispel generally-held beliefs that day-case patients of 23–24 hours duration reduce staffing levels and workload, and are therefore more cost-effective. In order to smooth variations in workload for these patients, a more flexible approach to staffing levels is required. Kumarich *et al.* suggest several strategies which include:

1. flexibility around shift patterns;
2. the opportunities for cross-training of staff to cover fluctuating census and the associated workload;
3. limit the admission of day-care patients to one specified unit;

4. maximise the more efficient use of staff skilled in specialist treatments, such as chemotherapy.

Studies such as these clearly highlight the flexible use of skills and staffing patterns, and also provide opportunities for a more creative and flexible approach to them across a whole range of services, especially when working across a more seamless service of care. Community nurses will therefore need to think creatively around these issues, as more and more acute care is transferred to community facilities.

Case-mix and nursing management

Nurse managers are now accountable for an increasingly complex matrix of health care planning, organisation, delivery and management. The efficient management, however, of these services is often severely hampered by crude resourcing formulae and management information systems. With few exceptions, it is still difficult to determine accurately the cost of a patient's episode of care, or what is the most effective treatment known, or what quality indicators should be used, and what outcomes should be expected from health care interventions. Given that nursing costs generate the largest component of the budget, it is essential that the accuracy of related nursing costs is verified and models developed to determine how these costs will behave over a period of time.

Across the whole spectrum of care, nurses are now faced with the responsibility of managing resources within budget constraints in business units. The development of case-mix information systems provides nurses with the opportunity to manage both their services and their patients with the benefit of good management information. When case-mix information is combined with patient dependency or nursing intensity measures, the resulting data are powerful sources of information for planning, cost-measurement and control, and for assessing the quality and outcome of care provided.

The Australian Commonwealth Department of Human Services and Health Care (1994) has undertaken a major national programme on case-mix, and senior nurse leaders have been involved in the development of this programme at the highest levels. Nurses in Australia are determined that rather than have the agenda set for them, they are instead going to make case-mix 'work for them', and to their own advantage. Several projects in acute and community care are now underway in Australia, and some are in the process of being evaluated. The impact that case-mix methodologies may have on nursing care is still not clearly defined, but Australian nurses are working hard to find solutions from evaluations already undertaken. The first challenge, however, for nurses over the next decade will be to set the standards of clinical practice, for it is only through the setting of such standards that problems can be identified, such as over-use or under-use of services, the wrong location or the improper use of services. Setting standards in respect of outcome measures is therefore critical to the future development of quality care.

Closely associated with and allied to case-mix is *case management*, a multidisciplinary problem-solving system designed to ensure continuity of services through a restructuring of the clinical processes. Nursing expertise is essential to a patient's episode of care, whilst acknowledging the rest of the team's contribution. It is noted that in Australia, nurses have been very proactive in leading this initiative together with the development of critical paths.

Critical paths form a dynamic management tool which organises, monitors, and sequences the delivery of patient care by a multidisciplinary team. Such a tool has great potential for linking an episode of care across the spectrum of care, thus ensuring continuity and quality of care for the patient. According to Ferguson and Picone (1994) the benefits of managed care with critical paths being a major component are enormous; such an approach:

- Leads to common language between care givers and patients;
- Reduces workload pressure because it sets realistic outcomes;
- Aligns all staff working with a case type into a collaborative practice;
- Ensures predictability and control over the processes of care which establishes optimal delivery of care;
- Decreases isolation of clinicians and thereby each profession has an understanding of the other's role in care delivery;
- Provides expertise in forming a set of problems into meaningful outcomes. (Ferguson and Picone, 1994)

Within the United Kingdom, hospital and community nurses must therefore ensure that, together, they are at the leading edge of developing managed care systems.

BUILDING BRIDGES AND THE IMPACT ON SERVICES

The transferring of health care from acute services to primary health care will only be made if everyone with an involvement in, or an influence on, health care, thinks in terms, first, of the needs of patients, clients and communities; next, of the skills required to meet those needs; and, then, of the ways of harnessing skills in order to fulfil the primary care objectives. Collaborative working and team-building across the primary/secondary interface is probably one of the most difficult for many nurses to come to terms with, but it is essential if the range of skills, and the resources to deploy them, are to be channelled to the maximum benefit of people in the most cost-effective way.

Community nurses have been challenged by the social services' 'army' of care workers, and by 'outreach' workers from the acute hospitals. Nurses in the community have a unique opportunity to lead the way by challenging some very well-established principles, such as for example the community nurse as the 'primary' nurse following the patient's progress from home to hospital, and back home again. This requires that hospital and community nursing staff work closely together to ensure a seamless continuum of care. Such a model would have enormous benefits for patients, reducing the amount of time currently spent on discharge planning, and assisting in the breakdown of professional tribalism.

Within hospitals, working with social services and the voluntary sector does not create as many problems as it does across the interface, and in primary care where it is a real challenge. Community nurses have real conflict with issues such as confidentiality, accountability and shared records. However, the UKCC offers the registered practitioner guidance and direction in the *Code of Professional Conduct* (UKCC, 1992). Paragraph 6 of the Code states that registered practitioners should 'work in a collaborative and co-operative manner with health care professionals and *others involved in providing care* and recognise and respect their particular contribution within the care team' (our emphasis).

Practical progress will depend on the development of collaboration between different sectors. The training of all staff across the interface will help the transition. A beginning has been made with Project 2000 (UKCC, 1987), but continuing attention to post-registration education strategies will be important in order to transfer knowledge of developments of nursing in acute services to the community, and vice versa.

CONCLUSION

Health care has always been, and will continue to be, a political 'animal', and nurses working within the acute care environment since the reforms are only too mindful of this ethos. In this respect community nurses have a unique opportunity to learn from their colleagues, and as the concepts of a primary care led service develop they are ideally placed not only to lead change, but also to place nursing firmly on the map. It is recognised that this process will not be easy.

Perhaps, faced with this political environment, nurses should therefore follow the lead of the first Duke of Wellington. This wise statesman, like many nurses today, felt totally exasperated with the demands of his political masters, but he made absolutely sure that they were aware of his main priorities, by insisting that the officers in his command maintain independence from all political administration.

Contributions made by nurses working within acute care cover a broad range, from policy formation to direct patient care. These suggest how progress can be made – authoritative leadership, political acumen, strategies, practice development, bridging the policy/practice divide, work-force planning and technology assessment.

A checklist of progress for all nurses, whether on the board or in clinical practice, is offered below:

1. *Lead the nursing agenda with authority and conviction, ensuring they have a 'locus of control' in all matters related to strategy, patient care, nursing resources and professional development.*
2. *Bridge the policy/practice divide, ensuring direct links between nurse executives and clinical practitioners, for example the use of models such as shared governance and clinical supervision.*
3. *Be at the leading edge of change, by managing the process.*
4. *Be radical and innovative in strategic thinking and organisational behaviour, ensuring effective paradigm shifts.*
5. *Make in-roads into the competitive environment, ensuring that competition does not decimate care.*
6. *Adapt and develop business ideas and techniques from industry, such as re-engineering processes, branding, marketing-mix and information 'networks'.*
7. *Develop new skills and be abreast of technological advances and their assessment.*

8. *Become more flexible in work-force patterns and planning,*
9. *Build bridges in a collaborative way with all other stakeholders.*
10. *Be cognisant of the value of nursing and communicate this effectively.*

It is envisaged that this checklist may assist all nurses working across the divide of care, as they demonstrate their ability to be in the forefront of *leading edge change* and development.

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CHAPTER ELEVEN

Epilogue

Deborah Hennessy and Geraldine Swain

> 'We have seen a massive increase in the numbers of young people forced on to the streets, more mentally ill people in the streets, more people dying, often literally of the cold. The change has been horrifying and yet what has been far worse has been the way in which so many of us have become acclimatised to the situation, inoculated against it. There has been a loss of passion, a loss of anger, and of the impetus of change.'
> (Garth Hewitt (1995) *Pilgrims and Peacemakers*. Sutherland, Australia: Albatross Books)

At the beginning of this resource book we looked at the values which are at the core of the work of the community nurse engaged in community health care development. An essential value is the belief in individual human worth and potential, a valuing too of our humanity, as a prerequisite for valuing others. We emphasised that whatever changes may lie ahead, and change is inevitable, the values that we hold at the core of our work essential to community health care development do not change. They form the backbone of our work together with a commitment to social justice.

Whatever changes take place, and there will be many more – resources for health care are very unlikely to increase – the demand for nurses to continue to develop compassionate and knowledgeable care will always be there. The need will continue also, to work alongside individuals, families, groups, communities and colleagues, constructively and energetically, recognising that challenges can provide opportunities for creative imaginative response rather than despair.

We stressed the importance of nurses being fully involved in the policy processes, that is in influencing the development of policies in health and all other areas of community-living that impinge on health, such as education, housing, child care services, employment and income distribution. There is no area which it is inappropriate for nurses to attempt to influence. The role of advocate requires a certain fearlessness even when fearful.

This book is an example of multidisciplinary endeavour. Working in concert with all colleagues is essential. It is destructive to maintain inter and intra-professional and disciplinary barriers where professional rivalries and jealousies invade the work. There is not time for this, and anyway it is so exhausting and the work demands sufficient of our energies. Interprofessional barriers are so unhelpful to our client groups as is the supposing that one group of workers has the monopoly of compassion, and another of science.

> 'As all . . . patients know intuitively, after all their needs include both humanity and expertise; it requires little additional thought to realise that fragmentation of these qualities between different medical personnel, with the doctor providing only science and the nurse only sympathy, is. . .neither humane nor scientific. . . We are all of us . . . in need not of alternately science and tenderness but of a humane expertise from every sort of [health care] worker we encounter.'
> (Marks, S., 1994 *Divided Sisterhood*, London: Macmillan, p. 213)

Contributing to the shaping of a more 'appropriate model of human encounter' in community health care development is within the gift of every community nurse.

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