Middle Articles

GENERAL PRACTICE OBSERVED

Attachment of Community Nurses to General Practices. A Follow-up Study

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Summary: A follow-up survey has shown that in a two-year period the number of community nurses working in general practice attachment schemes rose from 11 to 24% (32% in counties, 13% in county boroughs, and 12% in London boroughs). The proportion of health visitors and home nurses rose from 15 to 29% and from 9 to 25% respectively. Reasons given for the 23 attachment schemes which were discontinued included administrative and personality problems. Careful preparation and continuing support, for both the general practitioners and the community nurses, are stressed for the success of these schemes.

Introduction

In a general practice attachment scheme for a community nurse,[1] the nursing responsibilities are for the patients of a practice rather than for a population which is defined geographically. Reports of previous surveys (Anderson and Draper, 1967; Anderson *et al.*, 1967) of all local health authorities in England and Wales indicated a steady growth of attachment schemes during 1960-7. The enthusiasm with which a few authorities have committed all or nearly all their community nurses to this method of working can be contrasted with the many where relatively few staff or none at all are attached. The report of the Chief Medical Officer of the Department of Health and Social Security (1969), like those of many previous years, strongly recommended attachments. It was therefore decided that a further survey should be undertaken to investigate the position on 1 January 1969.

Method

Postal questionaries were sent to the medical officers of health of all local health authorities—that is, counties, county boroughs, and London boroughs—in England and Wales. Boroughs with delegated powers to appoint their own nursing staffs were also included in the study. Questions about attachment and liaison schemes, the numbers of community nurses employed, vacant posts, and whether State-enrolled nurses, nursing aides, or others were employed to help with nursing duties were asked.

The definitions used in the survey were as follows:

Attachment Scheme.—A formal arrangement in which a community nurse is responsible for the patients on the lists of specified general practitioners (at least the patients within the local authority boundary) and has given up a traditional geographical district.

Liaison Scheme.—A community nurse is responsible for a traditional geographical district. At the same time there is a formal arrangement for contact between the community nurse and specified general practitioners. If the patients referred by the general practitioners are not within her district she refers them to the appropriate community nurse.

When collecting information about the proportion of staff working in attachment or liaison schemes, consideration was given to counting community nurses in terms of whole-time equivalents. It is, however, difficult to obtain accurate information either for community nurses who combine duties, such as home nursing and midwifery, or for the many health visitors who work for part of their time as school nurses. Furthermore, attachment is intended to improve working relationships between individuals. For these reasons, and also for comparability with our earlier surveys, we asked for information about the numbers of individual community nurses working in attachments rather than their whole-time equivalents.

Results

Questionaries were returned during 1969, and by mid-December completed forms had been received from all the authorities approached. Detailed checks of the questionaries were carried out, not only for self-consistency but also in relation¶ to the information provided for the two previous surveys. Apparent errors were referred back to the authorities concerned and eventually resolved. The results indicated that attachments in England and Wales had more than doubled in number since 1967, and the proportion of all community nurses working in arrangements of this kind had increased from 11 to 24% (Table I).

The counties, which tend to be more rural, and their delegated authorities had proportionately more staff attached (32%) than the county boroughs (13%) or the London boroughs (12%). Overall more health visitors than home nurses were attached to general practices; nevertheless, the proportion of health visitors had increased from 15 to 29% in the previous two years, contrasting with the increase in attachments among home nurses, from 9 to 25%, during the same period. When home nurses who were State enrolled were added to those who were State registered the total number attached rose from 1,742 to 1,967, though the proportion in relation to the total number of nurses employed (7,901 State-registered and State-enrolled nurses) remained at 25%. In addition, 138 out of 658 nursing auxiliaries (21%) were working in attachments at that time.

Of the major authorities 27 (6 counties, 13 county boroughs, and 8 London boroughs) had had no attachments in January 1967 but had started them two years later. Furthermore, 21 major authorities (12% of the 173 in England and Wales) had more than half their complement of community nurses attached, which contrasts with only seven (4%) two years previously. In 19 counties (33%) and 11 delegated authorities (39%) more than half the health visitors were

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[1]Community nurse in this paper includes home nurses, health visitors, domiciliary midwives, and those who combine these duties.

¶One county borough (population 100,680), which was established since our previous survey, has been excluded from this report.

TABLE I.—*Community Nurses Working in Attachments on 1 January, 1969. Figures in Parentheses Show the Attached Staff as a Percentage of Employed Staff Whether Employed Full or Part-time—i.e., Reduced Hours*

	County Councils	Delegated Authorities	County Boroughs	London Boroughs	All Authorities	Total No. of Employed Staff
Home Nurses (S.R.N.s.)	1,111 (37·5)	97 (25·9)	352 (15·3)	182 (14·4)	1,742 (25·2)	6,900
Health Visitors	1,562 (41·2)	144 (39·7)	297 (14·4)	102 (8·6)	2,105 (28·5)	7,394
Midwives	320 (19·9)	62 (29·7)	120 (7·7)	53 (12·4)	555 (14·6)	3,801
Combined Duties	696 (22·7)	7 (31·8)	0 (0)	4 (17·4)	707 (22·6)	3,122
All Nurses	3,689 (32·3)	310 (32·0)	769 (13·0)	341 (11·8)	5,109 (24·1)	21,217
Total No. of Employed Staff	11,431	969	5,924	2,893	21,217	

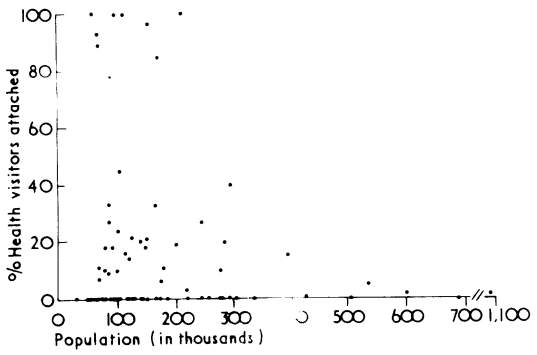
attached (Table II), while eight county boroughs (10%), and only one of the 33 London boroughs had involved health visitors to this degree. Thus not only have the counties continued to have, on average, a higher proportion of community nurses in attachments but the extent of involvement by many counties adopting this method of working is greater than in

TABLE II.—*Involvement of Local Health Authorities in Attachment of Health Visitors. (Combined Duties Nurses with Health Visiting Responsibilities have been Excluded)*

Proportion of Health Visitors in Attachments on 1 January 1969	County Councils	Delegated Authorities	County Boroughs	London Boroughs	All Authorities
None	13 (22%)	7 (25%)	44 (54%)	15 (45%)	79 (39%)
Less than a quarter	14 (24%)	8 (29%)	24 (29%)	16 (48%)	62 (31%)
A quarter to half	12 (21%)	2 (7%)	6 (7%)	1 (3%)	21 (10%)
More than half	19 (33%)	11 (39%)	8 (10%)	1 (3%)	39 (19%)
Total No. of Authorities	58	28	82	33	201

the London or county boroughs. With home nurses the contrast is less pronounced; there were 12 counties (21%), 6 delegated authorities (21%), 10 county boroughs (12%), and 3 London boroughs (9%) which had committed themselves to attachment schemes beyond the "halfway point."

Extensive attachment in county boroughs is inversely related to population size. No county borough with more than 250,000 inhabitants has attached more than half of its health visitors (see Chart). In addition, the importance of the halfway point in the introduction of attachment schemes is to be noted. The eight county boroughs with attachment schemes involving more than half of their health visitors had at least



Proportion of attachments by population (health visitors in county boroughs).

85% in attachments. Once an authority has a substantial proportion of its health visitors working on a practice or attachment basis it becomes much more difficult to run a district service at the same time. Thus all or nearly all the staff are attached at least nominally. (It does not follow, however, that all the remaining general practitioners or health visitors will participate enthusiastically in the new arrangements.)

The picture for home nurses is similar, though the critical point is less easy to show graphically, as five county boroughs had between 40 and 60% of home nurses in attachments. Three of these five county boroughs, however, had definite plans for additional attachments, while the other two had already committed several of their remaining home nurses to liaison schemes.

Ending Attachment Schemes

As in previous surveys there was no evidence that local health authorities were having to revert to district organization for appreciable numbers of staff once attachments had been introduced.

During the two years covered by this survey 23 attachments were discontinued and 25 reasons were given. The stated reasons for this were due to administrative problems in 14 cases, half of which were geographical in character and half concerned with shortages of staff. Personality, relationship, or similar factors were mentioned in eight cases, including the subsequent appointment of private nurses by two general practice teams; no reasons were given in either of these latter two cases. (Possibly the practitioners concerned thought that a nurse employed privately would fulfil the needs of the practice better than one who was attached and retained her links with the town hall.) In two instances the attachment of domiciliary midwives was discontinued because of insufficient case-loads and one (involving a health visitor) because "there was no room for her on the premises."

Furthermore, in one instance, a health visitor originally selected for attachment, was subsequently replaced by a home nurse and, in another, a nurse engaged on combined duties (home nurse/midwife) by a State-enrolled nurse.

Liaison Schemes

Some authorities favour liaison schemes rather than attachments, and a further 2,380 community nurses (11%) were deployed in this way on 1 January 1969. This proportion was also an increase on the figure for two years previously (1,449 out of 21,287, or 7%), but the increase was not nearly so great as in the case of attachment schemes. The lowest proportion of liaison schemes was found among home nurses (629 out of 6,900, or 9%) and was highest among midwives (666 out of 3,801, or 18%). Liaison was less common than attachment in the counties, where 1,209 community nursing staff out of a total of 11,431 (11%) were reported to be working in liaison schemes (as opposed to 32% in attachments). The difference was less pronounced in London and the county boroughs, and indeed in these areas there were more health visitors employed in liaison than in attachment schemes—London 10% compared with 9%, county boroughs 15% compared with 14%.

Discussion

The present study indicates that attachments more than doubled in the two years ending 1 January 1969. This is encouraging to those of us who believe that attachments tend to improve working relationships and patient care. Only two counties, five London boroughs, and 15 county boroughs had no attachment or liaison schemes for community nursing staff on 1 January 1969. Nevertheless, participation was fairly limited, particularly in London and the county boroughs, since only a quarter of community nurses employed in England and Wales were in attachments. Even with the 11% working in liaison schemes fewer than four out of every 10 community nurses were using one of the two main methods of formal collaboration with general practices.

We believe that the figures for attachments are fairly accurate, since administrative practices within local health authorities

have to be changed to create such schemes. Attachment involves more than a change of name. The same cannot be said for liaison schemes even though these were fairly rigidly defined. Liaison does not require the same amount of reorganization as does attachment, and subjective differences in interpreting the definition are more likely. Thus the figures for liaison schemes obtained from this or similar studies should be interpreted with greater caution than those for attachments.

One of the findings of an earlier study (Anderson and Warren, 1966) based on structured interviews with general practitioners was that many were uncertain about the role of health visitors, while some admitted that they had never discussed a patient with a health visitor. In the same survey nearly all the doctors believed that they knew what home nurses did, though a different study showed that home nurses thought that the inappropriate tasks were not infrequently referred for home nursing care (Hockey, 1966). Moreover, Hockey's study showed that communication about patients from doctors left much to be desired. Under such circumstances potential misunderstandings could jeopardize an attachment scheme unless a lot of care was taken to ensure that everybody knew what to expect. Thus both careful preparation and continuing support for general practitioners and for community nurses during the early stages of attachments are necessary, a point also stressed in another report (Abel, 1969). That such misunderstandings appear to have been comparatively rare may well be due to the improved communication between general practitioner and community nurse when working in attachments, for high levels of communication between doctor and health visitor in attachment schemes have been shown to exist (Ambler *et al.*, 1968).

Though it is difficult to determine the sort of initial help and continuing support which may be desirable for any particular attachment scheme, some deductions can be drawn from the reasons given by authorities in the present study and the two previous ones (Anderson and Draper, 1967; Anderson *et al.*, 1967) for discontinuing schemes. These answers tended to stress difficulties of administration and personality, but from personal discussions and more detailed reports from those involved we have found that inadequate preparation or subsequent lack of support are probably the paramount factors leading to failure.

Many attachment schemes blossom from the start, particularly where a carefully selected community nurse has been allocated to an equally carefully selected practice. Even so some support is usually required; under less favourable circumstances judicious support is required for a long time, occasionally indefinitely. This is particularly likely in those areas where a high proportion of the community nursing staff work in attachments, since "matching" them with practices becomes increasingly difficult. Continuing education is one of the important elements of support needed by community nurses.

Support by the medical officer of health or his nursing advisers has to be given tactfully, as motives may be misconstrued. We believe, however, that the failures we know about resulted from too little rather than too much preparation or from withdrawing support too soon after the attachment had been started rather than from continuing it for too long. Even in specific attachments which have been generally successful, some staff have felt insufficiently supported by the local health authority. The relatively few schemes which have been abandoned, however, is strong evidence of their administrative viability.

Further important points are preparing the practice secretary for proposed changes and educating the patients about health teams to prevent misunderstandings. Patients tend to be satisfied with what they have in terms of a family doctoring service (Cartwright, 1968), but little is known about how far patients will accept changes in primary care in Britain or about the effect of any non-acceptance on the success of attachment schemes. In a detailed study in the U.S.A., however, nurses were acceptable to patients even when acting as agents of primary medical care (Lewis, and Resnik, 1967).

One of the problems about the widespread attachment schemes for the community nursing services is that arrangements suitable for a few or even most cases may not be satisfactory for all. In a study of three towns based on opinion and work studies of the individual health visitors, one had 100% attachment (at the time it was the only county borough which had committed itself to this extent); one traditional district services; and the third some liaison schemes (Ambler *et al.*, 1968). These and further studies, involving home nurses and general practitioners from the same towns, indicated that many of the arguments against attachment (such as increased travelling time, etc.) had less foundation than many feared.

The present study shows that there are still some authorities which have reservations about pursuing a whole-hearted policy of attachment, particularly in the larger county boroughs and in most parts of London. Those seeking to introduce or extend attachments may have problems which are not related to the results presented in this paper; some of these will be considered in future reports. There are, however, encouraging signs of both a growing number of practitioners working in groups and also a developing interest in practice organization, including the limitation of catchment areas and the use of purpose-built premises. Furthermore, a few authorities responsible for quite large urban populations have several attachment schemes which suggests that the problems may not be so great as they appear or that they are not insuperable. At present it is impossible to say whether the relatively few attachments in the larger urban areas are linked with real differences in patterns of general practice or community nursing and how far with administrative problems or inertia.

Further increases in the number of attached staff can be expected, but if the rate of increase is to be maintained until "saturation" is approached more authorities in London and the county boroughs will have to become more deeply involved than at present. Local health authorities, the employers of community nursing staff at the present time, are influenced by the views of their professional advisers, and extensive change is unlikely to occur if the medical officer of health and his senior colleagues responsible for community nurses are unconvinced that attachments are desirable. It is therefore to be hoped that staff with continuing doubts, including community nurses engaged in field work, will take every opportunity to visit and talk to colleagues in areas where attachments are working successfully. In addition, it would be useful if general practitioners with similar reservations would do likewise and if those who are already convinced would continue to press for attachments.

Once again we thank the medical officers of health and their staffs for completing our questionary and for providing helpful supplementary information.

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