Middle Articles

GENERAL PRACTICE OBSERVED

Total Attachment of Community Nurses to General Practices

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Summary: The impossibility of increasing the number of experimental attachment schemes between general practitioners and the community nursing services led to the proposal and implementation of a complete, simultaneous unification scheme. Despite major administrative difficulties, this has proved both acceptable and workable.

Introduction

The problem of whether, when, and how to attach the community nurses—midwives, health visitors, and home nurses—to general practices on a list basis instead of continuing the traditional work pattern by area has been disturbing the relationships between medical officers of health and general practitioners for over 10 years. Some have gone a long way in this field, some have done nothing, and all of us have talked about it. One practicable but rather drastic solution has been tried in Southampton.

Problem

Experiments in attachment of one sort or another have been going on in Southampton for some years. By Easter 1968 a situation had been reached in which midwives were attached on a list basis to four of the practices in the city, home nurses to five other practices, and formal liaison arrangements existed —not amounting to attachment—between health visitors and 13 practices. Apart from the formally attached midwives and home nurses all the other community nurses continued to work on an area basis.

Further extension of the arrangements seemed very desirable but presented serious difficulties. Every time a nurse was transferred from a geographical area to a general practice on a list basis her colleagues had to enlarge their areas to cover the one she had left. In theory no one worked any harder, but in fact everyone began to feel that they were doing more than their fair share to make the experiment work. The arrangements for night, weekend, holiday, and sickness cover also became extraordinarily complicated.

Solution

After much discussion the proposal of changing all the nurses' pattern of work simultaneously appeared the most practicable solution and was one that would entirely overcome all the innumerable transitional problems which result from providing services both on an area and on a list basis at the same time.

One of the problems with the evolutionary system of change is that it cannot move any faster than at the rate at which individual general practitioners and nurses can be persuaded to agree to the change. Furthermore, the new proposals could be considered not as an exercise in co-operation between community nurses and general practitioners but simply as a purely administrative rearrangement, with all its benefits. This emphasis did much to make the scheme more acceptable to both general practitioners and nurses, and hence the scheme became known as one of unification rather than "attachment." Moreover, the nurses also had the assurance that their pattern of work would still be controlled by the health department, even though individually they were allocated to general practitioners on a list basis.

Because the three nursing services had problems of differing severity the acceptable solution was to phase the change, aiming at total unification of the home nurses within one month, the midwives within two months, and the health visitors within three months.

Home Nursing Service

It was decided to organize the district nurses into three teams—east, central, and west—each under a senior nurse. Thus each team of about eight nurses could cover its own sickness and holiday absences and ancillary staff could be allocated on a team basis.

Another important decision was that daily contact should be made with the general practitioners in their surgeries only by the nurses attached to group practices, as any commitment to visit every single-handed practitioner's surgery daily would simply cause breakdown.

The superintendent nursing officer then allocated home nurses to practices, using as a basis the known volume of work coming from each practice rather than the number of patients. Three factors were also considered: the mobility of individual nurses—for example, whether they had cars—the geographical extent of individual practices, and whether doctor and nurse were likely to get on together. By the middle of July every general practitioner on the Southampton Executive Council list was notified of the details of the scheme, which emphasized the need for flexibility if the demands of leave, sickness, and staff changes were to be met. Moreover, it was also pointed out that under existing economic restrictions it was unlikely that the number of district nurses would be increased, and hence any increase in demand for the service would have to be met by using the nurse's time more efficiently. Complete unification of the home nursing service took effect on 1 August 1968.

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Midwifery and Health Visiting Services

Following the pattern successfully applied to the home nurses, the midwifery service was planned as three teams, each with its own senior midwife and responsible for its own leave, sickness, and rota cover. Though the proposed building of a 20-bedded general-practitioner maternity unit threatened to complicate implementation in the midwifery service, the change was completed successfully within four months.

On the other hand, the unification of the health visiting service with general practice presented many problems. While the home nurses' and midwives' duties revolve round individual patients—with whom individual general practitioners are closely concerned—this is not so for health visitors. The health visitors not only routinely visit healthy children, including all new infants, to give advice but may make repeated visits to particular children over a period of years without ever making close contact with a general practitioner. The health visitor also has responsibilities to the community at large which are quite unrelated to individual patients. Any unification scheme therefore had to ensure that the health visitors' work in such areas as the school health service, health education, and liaison work with hospital services could continue.

Because it was impossible to keep the numbers of health visitors at much more than half the establishment laid down for the local community services, and because unification would mean time lost in covering the extra mileage due to the wide scatter of general practitioners' lists, it therefore seemed essential to review all the health visitors' existing commitments to identify those which could be abandoned or substantially diminished while the new arrangements settled down. The final plan adopted made time for travelling by reducing activities such as hospital liaison visits, but retaining routine home visiting of young infants, and by increasing the school health service work, including home visiting, done by State-registered nurses. The health visitors were also grouped into three teams under senior health visitors.

Health Service Records System

The next major task was to assess the volume, extent, and nature of work for the administrative staff resulting from unification. For example, change to a general-practitioner list basis meant not only reallocating all the records held by individual health visitors but also completely reorganizing the general distributive and circulation arrangements.

Every week, for example, the housing department and the children's department sent in lists of changes of names and addresses, which involved some 40 households. Furthermore, there was a steady flow of changes coming to the knowledge of health visitors from a variety of other sources, including transfers from and to other local authorities. Consequently every week about 100 changes had to be made in the records.

The possibility of using the computer to make the necessary link between a given address and a health visitor or general practitioner was found not to be feasible, because the records of children older than 3 were far from complete, and there were no records at all for those over 5.

To solve this problem a complete cross-reference card index of every health visitor record was set up. Each reference card had to give at least surname, Christian names, date of birth, health visitor's name, name of general practitioner, and computer number. A check indicated that there were about 15,000 records, and it was clear that unification of the health visiting service could not proceed any faster than this central cross index could be completed. This would be at best at about a rate of one card per minute, so that the whole job was going to take 250 hours' work, say, by one typist working full-time for seven weeks.

In addition, each record had to be checked to ensure that the most recent information showing was in fact correct and any errors were amended. None of this could be started until health visitors had been provisionally allocated to general practitioners. Because the records would not be available to the health visitors during the period in which they were being processed, the processing time had to be kept to a minimum. Similarly, any changes of, for example, address that came in during the processing exercise would have to accumulate until the exercise was complete, as it would not be possible to find any individual card or record until it was all over.

Because some of the health visitors would shortly be leaving the service of the local authority, and a group of newly qualified health visitors would be joining the staff on completing their training in the middle of September, it was decided to make the changes in two stages. Firstly, a de facto unification which was to be introduced in time for the new health visitors was to be regarded as a provisional allocation, and therefore no notification was sent to general practitioners. Secondly, a review and finalization of the allocations and formal notification by letter to general practitioners would take place about three months later.

Once the central card index was completed it has only been necessary to keep it up to date, which is done by referring daily to the notifications of births, transfers, etc. The index, which has grown steadily in size and now approaches 20,000 cards, will probably have to be maintained indefinitely. While the computer-handling of data has been most successful it has the major drawback that retrieval of information about a particular child is entirely dependent on the knowledge of that child's computer number. The notification-of-birth form has now been redesigned as a perforated card, so that the upper half may be retained without further work as the index card.

At the end of the year the allocations of health visitors to general practitioners were reviewed in the light of the volume of work and of the staff changes. Some of the health visitors had to be allocated to different teams to get a better balance of more or less experienced members. In total, extensive modifications were found necessary before general practitioners could be sent formal notice of their attached health visitors.

Results of Total Unification

Even though the amount of travelling was doubled the improved understanding and closer contact between nurses and general practitioners more than compensated. A sharp rise in the volume of work occurred in the home nursing service, and during the first three months the number of patients increased by more than 300 and the number of visits by 3,000, even though there was no staff increase.

Despite the difficulties, which most severely affected the health visitors, it must be emphasized that all concerned gave of their utmost to facilitate the change and that morale has now recovered completely. All the work that was abandoned to ensure that the scheme would be a success has been taken on again and everything is running remarkably smoothly.

Clearly in all three nursing services the change has been well worth while, and the area pattern of work would no longer be considered acceptable by any of the nurses. Most of the general practitioners were extremely enthusiastic about the changes and have continued to be so. They have welcomed the enormous simplification of having to know the name of only one midwife, one home nurse, and one health visitor, and have gone out of their way to get to know their own particular nurse.

After a short time many general practitioners asked for more help because they had found the community nursing services so valuable. Unfortunately, it has been repeatedly necessary to emphasize the impossibility of increasing the number of

staff and the need for direct discussion between the general practitioner and his nurse to determine the work to be done.

Though it has been clearly established policy that home nurses were not to undertake surgery-nurse work, some disagreement did arise regarding where exactly this work started and finished. As a result the home nurses have been advised that they will personally have to answer to the superintendent for what they do, and in fact with time solutions have been found possible.

Similarly, the difficulty of determining the extent to which midwives and health visitors should do their own work in general practitioners' surgeries caused some disagreement. Very few general practitioners run well-baby clinics, but health visitors do attend those that are held. On the other hand, more than half the general practitioners now organize their antenatal work into sessions, and midwives attend where this is done. Problems have arisen in relation to what is or is not a reasonable grouping of work, though in every case these have been settled in direct discussion between the general practitioners, nurses, and nursing superintendents concerned.

Discussion

Since it is inconceivable that the public would ever agree to their choice of general practitioner being limited, only the pressure of ever-increasing traffic densities—and therefore longer travelling time—is likely to gradually encourage a de facto return to general practitioners restricting their practices to a localized area. Continuing adherence to the traditional area pattern of community nursing organization has no influence on public opinion and can no longer be justified.

On the other hand, some practical limits have to be set. While it may seem reasonable to some general practitioners based in Southampton to continue to attend patients who have moved out of the city to places as far as 30 miles (48 km.) away, because the patient's demands for service are very rare, sending a health visitor out of the city for two hours to give advice on infant feeding and development is impossible to justify. Accordingly in Southampton the nurses have been restricted to working within the city boundary.

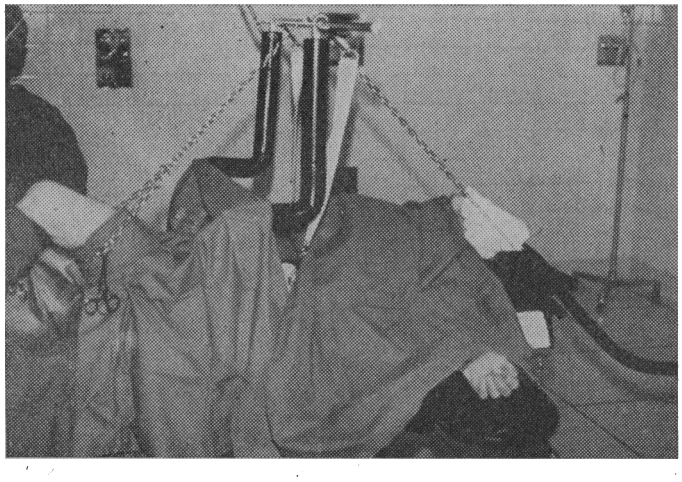
Though it is to be hoped that the appearance of health centres and group practices will enable this problem to be solved in a rational manner, the consumer's freedom of choice of doctor must obviously be recognized as a basic factor. The confusion caused by equating the term "attachment" with visits by the community nurses to doctors' surgeries has caused quite unnecessary delay in the past. The essence of establishing real and effective doctor-nurse teams lies in each doctor knowing the names of the community nurses who will work with him in caring for the patients on his list, and not in argument about where records are to be kept or communications passed.

Thanks are due to the nursing officers and administrative staff who made the changes possible, and to the nurses for their forbearance during all the difficulties.

NEW APPLIANCES

An Aid to Leg Amputation

Professor LAURENCE TINCKLER, Royal Gwent Hospital, Newport, Mon., writes: During amputation of a leg it is necessary for the limb to be held steady and at an angle convenient for the surgeon. This duty inevitably falls to the lot of an assistant, who is thus presented with a tedious and perhaps exhausting task. To lighten the assistant's load, or if necessary to enable the surgeon to amputate without help, an aid has been devised which has advantages over the commonly used sandbag support and is simple and effective. It consists of a length of stainless-steel chain and two stainless-steel hooks, which are sterilized before use. The patient is placed on the operating-table with lithotomy posts in position at about the level of the iliac crests. A crossbar is then placed athwart the table through the rings of the lithotomy posts (I have found the extension piece of a drip stand convenient to use).



When the limb has been prepared and towelled-up one end of the chain is slung under the thigh, with a towel interposed between thigh and chain, and made fast to itself by means of a hook; the other end of the chain is then passed over the crossbar to the anaesthetist, who fastens it to the edge of the head-piece of the table with the other hook after pulling the chain sufficiently taut to support the limb at the appropriate angle (see Fig.). Minor adjustments of the angle of the limb can be made during the operation by raising or lowering the head end of the table.

The device can be supplied by Chas. F. Thackray Ltd., of Leeds.