The Green Paper

The Government's Green Paper on primary health care was eventually published — with a blue cover. *Primary health care: an agenda for discussion* is a discussion paper and opinions are being canvassed by the Government, not only from general practitioners but also from hospital staff, non-medical community care professionals, community health councils, family practitioner committees and from the consumers of health care directly. The proposals will be sharpened and influenced by evidence from all of these people and bodies. It is important that faculties meet with all members in their area to discuss the paper and come to some consensus on its proposals. As well as considering whether the proposals are good or bad, any omissions of aspects of good practice which should have been mentioned should also be noted. In this process it is worth noting that a proportion of the proposals closely mirror those in *Quality in general practice, Policy statement 2,* published by the College. When a consensus has been reached, it is important that meetings are held with local medical committees, local MPs, nursing and health visiting associations, community health councils, family practitioner committees and district health authorities to exchange views and perhaps come to a joint conclusion about the document. The faculties are also asked to inform Dr Bill Styles, the Honorary Secretary of the College, of the outcome of their discussions by 31 July, and the whole matter will be discussed at the September meeting of Council.

This Green Paper presents the first major review of the structure of the primary health care services since their beginning 40 years ago. It is important that we consider and comment on these proposals in a way that will promote the high quality of general practice that we as a College strive for.

E.J.M.

Evidence of the RCGP (Welsh Council) do the Committee of Enquiry into Community Nursing Services in Wales

All fellows, members and associates of the College resident in Wales were invited to contribute to this evidence. Information was gathered by means of a questionnaire which set out to invite replies on the following topics:

1. The range of services provided at present by the various nursing disciplines within the community.
2. Aspects of community nursing that are deficient at present.
3. Developments that are regarded as desirable during the next 20 years.
4. General comments on primary health care relevant to this enquiry.

The most obvious factor that emerged was the wide variation in the range of services offered by all groups in the nursing profession, which included district nurses, health visitors, community midwives and practice employed nurses.

The present position

Services provided by local authority employed nurses were often seen as restricted by administrative constraints. This varied from area to area, but in many districts there appeared to be little scope for the individual professional to develop her role to the full capabilities of her training.

We would wish to encourage a more progressive attitude by nursing administrators to the evolution of an expanding role for community nurses, health visitors and midwives.

It is recognized that some of the problems arise as a result of insufficient resources being allocated to community nursing care; the present level of service often being maintained by the goodwill of nurses who are prepared to increase their workload and/or compromise their standards of care to cover for colleagues absent as a result of holidays or illness.

Many practices employ nurses directly so that, with appropriate training, they may undertake tasks which attached nurses are prevented from performing, for example ear syringing, immunization, anticipatory preventive care procedures, cervical cytology and the follow-up of chronic diseases.

Other practices have directly employed nurses because there may be undue delay in making contact with attached nurses, and particularly at times of staffing deficiencies there is little continuity of care as a succession of different nurses cover for absent colleagues. This problem is increased in practices which cover more than one administrative area.

Future development of community nursing services

Several factors are seen as essential:

1. The concept of the primary health care team should be firmly established. A small number of identifiable doctors, nurses and social workers, assisted by receptionists, secretarial staff and others, should offer total primary care services to a specific group of people.

The advantages of this organizational framework are described in the College publication *Quality in general practice, Policy statement 2.* Although, of necessity, the catchment area of this client group will have certain definable boundaries, it should not be restricted by geographical administrative boundaries but should depend on demographic boundaries applicable to that community.

Patients must retain their right to seek medical care from the primary care unit of their choice. In making such a choice individual patients may wish to take into consideration members of the primary care team other than the general medical practitioner. This arrangement will allow patients direct access to nursing services without necessarily directing such requests through the general practitioner. Doctors should be encouraged to participate in the functional operation of effective primary health care teams.

2. Communication between the members of the primary health care team must be easy, frequent and beneficial to the care of the patient. Potential for such communication will be enhanced by the administrative arrangements described above.

Regular meetings of the team members should occur and there should be agreed arrangements by which each professional can consult with any other in appropriate circumstances.

Additionally it is considered that patient care will be improved if there is integration of medical records. There may be occasional instances where access to certain information is restricted to the originator of the data, but this would be an infrequent occurrence. In most instances the advantages of a unified medical record held centrally on the practice premises would enhance patient care.

The use of computers to achieve integration of records with protection of confidential information should be encouraged.

3. Nurses should assume more individual responsibility for the evolution of their role. Tasks which they undertake should be related to their personal ability, skills, knowledge and training, and not restricted by statutory controls exercised in a blanket manner by administrative authorities.

All members of the primary health care team should be involved in setting targets of care for the practice population and assess the success of such policies by clinical audit in the practice.

Professional indemnifying bodies should recognize the developing and extending role of nurses and provide appropriate amendments to the cover offered.

4. The primary health care team should devolve to appropriately trained nurses aspects of practice that are within their capabilities. For example normal antenatal, intrapartum and postnatal care; chronic disease surveillance with agreed protocols (the development of practice protocols should be the result of discussions between all members of the primary care team); and immunization programmes.

5. Nursing services must be flexible, and adaptable to the varying needs of patients. It is present policy to maintain the care of the chronic sick within the community; as a result of population changes many of these patients will be elderly and isolated. Studies have shown that this group of patients do not respond well to a change of environment during an acute illness, But they are also at risk if left alone at home. There is therefore the need for the provision of intensive home care, including nursing, at short notice (a few hours) in such circumstances.

6. Primary care has the central role in preventive health care. All members of the primary care team should contribute to anticipatory care. This will include the development of age–sex registers, screening and recall programmes for such conditions as obesity, hypertension and diabetes and for cervical cytology. Nurses have a fundamental role in the development of such systems.

Apportioning of duties

Practices should be encouraged to compile registers of patients with specific health care problems and, by mutual discussion between the members of the primary care team, each should assume responsibility for particular aspects of the care of those patients. This may involve individual team members undertaking duties normally seen as being the province of another team member. This will avoid the twin dangers of *ad hoc* arrangements, which may result in waste of resources by duplication of effort with some patients, while others fail to receive the care they need.

The primary health care team

The aims of care should be to provide comprehensive medical, nursing and social services to patients who are in contract with an integrated group of professionals who have undertaken to provide such care.

This will be achieved by the functional association of doctors, nurses and social workers, aided by necessary clerical staff, acting as health professionals of first contact, and accepting responsibility for the continuing care of their client group over long periods. This will best be achieved by having a list of patients drawn from an area with boundaries sufficiently flexible to allow for local mobility of the population without necessitating a change of health care personnel.

In the main the professionals involved should be generalists, capable of making decisions, and taking action, on all health care problems presented to them by their client group. They will require the support of other personnel with specific skills to whom certain tasks, such as bathing, may be delegated. The importance of family, friends and voluntary agencies, acting as carers, is recognized in this context.

There will also be a need for access to specialist advice for medical, nursing and other disciplines. These agencies should channel their activities through the primary care team, and not supplant it in its continuing care role. Specialist nurses, who may be hospital based, should liaise with community nurses as well as with hospital consultants and general practitioners.

The special position of the community psychiatric nurse is recognized as being distinct from other hospital based specialist nurses. By virtue of their training they are an integral part of the primary care team, but would relate to more than one primary care unit, except in larger practices.

The services provided by the primary care team will normally be available within practice premises and at patients' homes. Medical practitioners should be encouraged to make facilities available within their premises to enable the other professionals to develop their role, including screening clinics, counselling, chronic disease surveillance and administrative duties. This will require the provision of adequate consulting and treatment rooms and necessary clerical staff.

In many areas there are strong arguments in favour of developing community hospitals. These will reduce the need for removing patients to distant district general hospitals, and will retain continuity of care within the community. Community hospitals might provide such facilities as physiotherapy, day units for the elderly and handicapped, holiday relief beds and 'minor' medical beds.

Administration

It is envisaged that the primary care team will function as an integrated unit with direct accountability of members to one another, and both individually and corporately to their patients. The efficiency of these arrangements should be monitored by regular meetings and adequate assessment of the services provided. Basic minimum standards of care may be established by compiling the findings of such audit activity.

Facilities must exist for administration of the primary health care team, but the administrative body should not have restrictive regulatory controls over clinical aspects of care, provided this is conducted within the terms and conditions of service of the professionals involved. The development of the integrated team concept is feasible with separate administrative units for the different professional groups, including social workers, but it is possible that a single professional administrative unit — 'primary care committee' — might be a better way of providing this. Should such a development be considered appropriate, then it is seen as desirable that it should be introduced on a limited pilot scale before general application.

Training

All professionals within the primary care team should receive some common core training at undergraduate level and joint postgraduate courses should be encouraged. This would develop a sense of unity between various groups and make each more aware of the potential of others.

The development of primary care courses should be based on general practice with the use of innovative practices as examples for training. General training practices which are capable of providing training to undergraduates in all disciplines, and postgraduate training by appropriate attachments should be developed. A general practice component to training should occur in all primary care training even when the fundamental course is based on a college of further education.

Continuing education should be central to the normal activities of all members of the primary health care team. The special training needs of practice employed nurses should be particularly recognized and appropriate training courses should be developed.

MRCGP examination

The written papers of the next examination will be held on Tuesday, 28 October 1986 in London, Birmingham, Bristol, Exeter, Leeds, Manchester, Edinburgh, Newcastle, Cardiff, Belfast and Dublin. The closing date for applications is Thursday 4 September, and candidates are advised to apply well in advance of the closing date to ensure a place for sitting the examination. Applications may be obtained from the Examination Administrator, RCGP, 14 Princes Gate, London SW7 1PU, telephone 01-581 3232.

Around the faculties

Quality

Many of the reports from faculties mention activities relating to quality maintenance. The East Anglia Faculty newsletter lists the projects carried out by the faculty board in response to the quality initiative and Dr Berrington discusses *Quality in general*

practice, and argues that the College document does not go far enough. He claims that more specific priorities should be identified, and suggests that doctors in East Anglia should concentrate on performance review and audit; quality of clinical care and patient management; management of priority groups, especially the elderly, mentally ill, children and patients with chronic disease; consultation skills; management skills; preventive care; continuing care, after care and rehabilitiation after hospital discharge; continuing education; NHS planning and resources; and general practitioner research.

North West England Spring Meeting on 18 April consisted of the presentation of eight audit projects looking at subjects such as diabetic care, patients' expectations of antenatal care, and practice visiting.

Small groups

Many newsletters contain reports from sub-faculty groups within the faculty. The reports are from area representatives responsible for coordinating activities in these areas. The South-West Wales Faculty are setting up new principals groups to support young doctors on entry into general practice. The Bedfordshire and Hertfordshire Faculty now has 15 small groups meeting in the two counties.

Trainees and training

Many faculties are concerned that they lack contact with trainees in the vocational training schemes. Essex Faculty Board has one member responsible for contacting trainees and encouraging participation in College activities. Trainees are being identified and a trainee project is to be started in August 1986.

The 10th national general practice trainee conference is being held in Swansea on 16–18 July 1986. This will be the first time that the conference will have been held away from a city with a medical school. The title of the conference will be 'The changing face of general practice'. The conference has been organized by local trainees with a little help from Sir Clive Sinclair. Among the speakers are Dr John Fry, Dr Marshall Marinker and Dr Julian Tudor Hart.

Dr Tudor Hart, the Provost of South-West Wales Faculty, writes about training and the MRCGP examination in a letter in the faculty news. He argues that working for the MRCGP examination during the trainee year helps to provide some sort of structure, some sort of objectives and some measure of attainment, whereas at present there is little or none of any of these. He writes, 'as examinations go, the MRCGP is a good one: well-designed, honestly and self-critically administered and with a definite aim in mind; an evaluation of how candidates seem likely to behave in the real conditions of practice they are likely to encounter.' He claims that many of the opponents of the MRCGP examination are against any objective measure of performance. Dr Tudor Hart also encourages all trainers to sit the examination. It is the willingness to prepare for the examination, rather than the final result, which is of value to a trainer.

Medical history

Perhaps the most unusual report comes from the Cumbria Faculty. A rare document dating from 1835 informing people of compulsory vaccination of children against smallpox turned up in a local shop but the Copeland County Council could not afford £35 to buy it. The Cumbria Faculty bought the document and presented it to the Whitehaven Museum, thus preserving a historical document and carrying out a valuable public relations exercise at the same time.

Quality assurance

At the end of May the King Edward's Hospital Fund for London launched a project to promote quality in the health services in Britain. The aims of this project are to catalogue existing activities relevant to the assessment and promotion of quality, to collect information and make it available to others, to identify needs for training, research and development and to encourage quality assurance nationally among individuals and statutory, voluntary and private organizations.

To pursue these aims the Quality Assurance Project has established the following: the Quality Assurance Information Service which collects any type of published information relating to all aspects of quality assurance in the health services; *Quality Assurance Abstracts,* a bimonthly abstract bulletin produced jointly by the Information Service and the DHSS Library; an information exchange which aims primarily to put enquirers in touch with other people already working in relevant areas of quality assurance; an enquiry service aimed at health workers and others with a professional or occupational interest in quality assurance in health care; and a survey of colleges, a recently completed catalogue of current initiatives directly related to quality assurance among national professional bodies.

The Project is currently concerned with a survey of quality assurance activities among regional health authorities and community health councils and the preparation of a handbook entitled *Introducing quality assurance.*

Further details may be obtained from Dr Charles D. Shaw, Coordinator, Quality Assurance Project, King's Fund Centre, 126 Albert Street, London NW1 7NF. Telephone 01-267 6111.

Assessment of elderly patients moving into part III accommodation

The British Geriatric Society has produced a draft protocol for the assessment of elderly patients moving into part III accommodation (part IV in Scotland) or nursing homes. They suggest that these patients should all be examined by a geriatrician before they are admitted into these sheltered institutions. The College disagrees with this protocol. The following facts are of relevance: 90% of elderly patients are fully cared for by general practitioners. Elderly patients consult their general practitioner on average in excess of six times a year. In any one year 75% of elderly patients will consult their doctor. These patients have often been registered with their doctors for many years, so that the general practitioner is able to make a wider assessment of the patient's physical, psychological and social health than other doctors. It seems evident that the general practitioner is the key person to help an elderly patient to make a judgement about when it is right for them to move into a protected environment. If the general practitioner does not carry out this task well, the need is for an improvement in quality of the service, not for a transfer to another doctor less suited to carry out the task. If a bed is not available, rationing of resources is not a medical task.

Quality assessment in general practice in Europe

The New Leeuwenhorst Group is a working party of general practitioners from 22 European countries which is carrying on the work of the original Leeuwenhorst Group whose definition of the work of a general practitioner and statements on education and general practice influenced the developments in learning and teaching in general practice which have taken place in Europe in the last decade. The new Group has now produced two booklets. The first described the present state of learning and teaching in general practice in Europe. A new publication looks at quality assessment as a way of improving the quality of care provided by general practitioners.

The booklet contains many of the ideas which were put forward in the College's policy statement *Quality in general practice.* Doctors in the United Kingdom may be interested to see the way in which these ideas are formulated in a European con-

text. Copies of the booklet are available from Dr Chris Watkins, Senior Lecturer, Department of General Practice, St Thomas's Hospital Medical School, 80 Kennington Road, London SE11.

Personal doctor programme — Finland

In the 1970s the aim of health policy in Finland was to increase health care resources and to redistribute primary health care to cover the whole population evenly. One of the main aims in the 1980s is to improve the adequacy and the quality of the services. The improvement of the continuity of care given by primary health care physicians is regarded as one of the main elements underpinning the delivery of high quality care in the community. The personal doctor must also be supported by nurses, auxiliary staff and social services working as a team.

A research project is evaluating models for developing the physician's responsibility for a defined population, the teamwork between physicians and other health workers, and the physician's ability to manage his practice. The project is being carried out by the Health Service Research Unit, which is involved in monitoring and planning various systems for the delivery of primary health care in Finland.

The CASE programme: continuing education for general practitioners

This educational series has now been requested by 9500 practitioners throughout the United Kingdom and Eire.

Comments were invited and the response has been favourable. General practitioners welcome a method of learning based on real case histories and containing up-to-date factual information on a wide range of topics relevant to current practice. The series has been found stimulating and convenient, and can be used in ways best suited to each doctor's learning style.

The booklets in the series have been produced in close consultation with groups of practitioners working in 18 faculty areas including the Cork Faculty of the Irish College of General Practitioners. The group members have found their involvement enjoyable and have often gone on to tackle further educational projects after completing their booklet.

Booklets are used by individual doctors, small groups and trainers in discussion with their trainees. Multiple copies have also been requested for use at meetings where a clinical topic is reviewed.

A list of topics covered in this first CASE series may be obtained from the Project Coordinator, Dr Karen Adam. She will also welcome requests for enrolment and back issues. The address is: CASE Programme, The Centre for Medical Education, The University, 2 Roseangle, Dundee DD1 4LR.

1987 Smith and Nephew Foundation Fellowships

Application forms are now available for the 1987 Smith and Nephew Foundation Fellowships. There are two awards, each worth £18 000 plus travel costs, for British physicians wishing to undertake a year's postgraduate research overseas. Applicants must be aged between 25 and 35 years and live in the United Kingdom. They should have received their training and qualifications within the UK and now be embarking on higher training. Applicants are expected to have had at least two years' clinical experience since qualification, and probably have held residential hospital appointments.

Proposed research projects can be in any branch of medicine or surgery, but must be undertaken outside the UK. The closing date, application forms and further details may be obtained from The Secretary to the Trustees, Smith and Nephew Foundation, Temple Place, London WC2R 3BP.

DIARY DATES

13th Annual Congress of the Association of Professions for Mentally Handicapped People

'Our lives: your jobs' is the title of the 13th Annual Congress of the APMH. It will take place at Bowland College, the University of Lancaster on 16–19 July 1986, and will look at aspects of staff development for living in the community. The APMH Congress is recognized as the main annual event for those working, living and learning together with people with mental handicap and their families.

Applications should be made to Mrs Irene White, Administrative Secretary, APMH, Greytree Lodge, Second Avenue, Greytree, Ross-on-Wye, Herefordshire HR9 7EG.

La Leche League Annual Conference

La Leche League (breastfeeding help and information) is holding its Annual National Conference and Health Professionals Seminar at the University of Warwick (Coventry) on 20–21 September 1986.

Speakers include: Drs Penny and Andrew Stanway (authors of *Breast is best* and *The Baby and child book),* Professor Peter Howie (obstetrician), Barbara M. Pickard (nutritionist) and Mrs Peter Barnes ('Foresight').

There will be discussion groups for mothers, fathers and health workers on all aspects of breastfeeding, parenting, allergy and so on.

Children are welcome and a play area is provided. Registration fees are £8 before 15 July and £10 after 15 July. Overnight accommodation is available.

For more details send a large stamped addressed envelope to Shirley Waplington, 18 Cymbeline Way, Rugby CV22 6JY.

Leukaemia Research Fund

Annual guest lecture 'Leukaemia and the regulation of haematopoiesis' will be given by Dr David Nathan on Monday 17 November 1986 at 17.30 hours at the Jarvis Lecture Theatre, 66 Portland Place, London W1. Dr Nathan is Professor of Paediatrics at the Harvard Medical School and Physician in Chief of Boston Children's Hospital, USA. Admission is by ticket obtainable from: The Leukaemia Research Fund, 43 Great Ormond St, London WC1N 3JJ.

In pursuit of quality: continuing education and health care

A conference arranged by the Centre for Professional Development of the Department of Community Medicine of Manchester University will take place on 17–19 December 1986 in the Sorby Hall of the University of Sheffield. The conference will be exploring the issues of:

a) What is quality and how to assess it?
b) The role of continuing education in the achievement of quality
c) Motivation for continuing education
d) Matching continuing education approaches to the provision of quality health care.

Participants are invited from all health care professions, from members of adult education departments and from organizations and institutions concerned with the professional and managerial development of health care personnel. Further information can be obtained from: Dr Frada Eskin, Centre for Professional Development, Department of Community Medicine, The Medical School, Oxford Road, Manchester M13 9PT.