

Health care units: an extended alternative to the Cumberlege proposals

E.I. WILLIAMS, MD, FRCGP

Professor of General Practice, University of Nottingham

A.D. WILSON, MRCGP

Lecturer in General Practice, University of Nottingham

SUMMARY. *The proposals of the Cumberlege report are reviewed as they relate to general practitioners and the effectiveness of the primary health care team. An alternative proposal is described which uses combined general practitioner lists rather than a neighbourhood boundary to define the population served by a 'health care unit'. This would be the basis for both general practitioner and nursing care, and would allow effective multidisciplinary teamwork, as well as encouraging cooperation between general practices and the development of community general practice.*

Introduction

THE report of the community nursing review, *Neighbourhood nursing: a focus for care*,¹ has provoked mixed responses from general practitioners and their representative bodies. The report's statement that 'nurses are at their most effective when they and general practitioners work together in an active primary health care team' received widespread affirmation from general practice, but the proposal for a neighbourhood nursing service was less well received. In this paper we discuss the report's proposals as they might affect general practice and describe an alternative model which, we believe, could benefit not only community nursing but also primary health care as a whole.

The Cumberlege report describes three main problems in the current provision of community nursing services. The first and most important is that the structure and scale of management is not conducive to good practice. This contributes to the second and third problems — lack of teamwork with general practitioners and the low morale and lack of professional autonomy of some community nurses.

Problems discussed in the Cumberlege report

Poor management structure

The report describes the functions of management as setting aims and objectives, planning, action and monitoring and controlling. It notes that action is a strength of the community nursing service but that in the other areas there are weaknesses: little evaluation of need takes place at a local level, informal networks of support are not utilized, roles are too strictly defined, and there is too much duplication of effort. The lack of an appropriate organization at the local level is seen to contribute to these problems. The attachment of nurses to general practitioners with dispersed lists is considered to militate against coordinating effective services at a local level, as well as wasting time and money in travelling.

The report recommends a single management for health visitors and nurses at district health authority level. The argu-

ment for this is compelling and should lead to more flexible working patterns and an ability to merge roles where necessary.

The proposed neighbourhood nursing unit, however, imposes a further tier of management at community level. Experience with reorganizations of hospital nursing and social services has shown that extending the chain of command can result in inefficiency and poorly defined responsibilities. Policy formulation and monitoring are roles of senior management which would remain unchanged under the Cumberlege proposals. It is doubtful whether this will be devolved to community level, even though operational freedom could be developed. Thus decisions will continue to be made remotely from the day to day experience of the nurses and those, particularly in general practice, with whom they work.

The main difficulty with the establishment of neighbourhood nursing units is that they would not be coterminous with general practices. Except in rural areas, a neighbourhood nursing area would probably contain many practices, and equally any one practice would overlap with several neighbourhood units. Despite statements that geography and practice location would be taken into account when drawing neighbourhood boundaries, the report underestimates the complexity of this task.

Management problems also emerge when considering the proposed agreement or contract between neighbourhood units and practices. The number of agreements necessary with overlapping units and practices would be a bureaucratic nightmare.

Lack of teamwork

The failure of the primary health care team concept to become a reality in most localities is discussed in the Cumberlege report. Although this failure is largely attributed to poor communication and lack of mutual understanding of roles within the team, there are other important reasons. Some team members experience conflicting loyalties owing to different chains of accountability, and there may be a lack of shared objectives within the team. An important emphasis missing from the report however, is, a general appreciation of how the primary health care team can function.

As Reedy points out,² a team will only succeed if the members agree prior objectives, and in the context of primary health care these must include responding to patient demand as well as service-initiated care. He notes that in many cases of attachment, no such objectives have been agreed, indeed in one study the members of the team did not even agree about whether they were attached or not. He and others³ have also emphasized that the team should be small enough to provide frequent and informal contact.

In British primary health care, the core members of the team are health visitor, district nurse, general practitioner, practice nurse, midwife and sometimes social worker. Beyond these are a wider network of workers both within and outside the health service, for example counsellors, physiotherapists, chiropodists, pharmacists, teachers, and priests. Usually one team member identifies a need or problem and forms a small team, which dissolves when the need is met, leaving only the key member to continue care. For the small team to be successful, the main team must fulfil the criteria described by Reedy and therefore consist of members who are well known to each other.

Cumberlege reminds us that some general practitioners have a negative attitude towards team care. This is illustrated in practices where there is lack of communication between general practitioners and nurses, no regular meetings, no formulation of shared objectives, and no involvement of nurse colleagues in planning within the practice, especially in such areas as prevention, health promotion and care of the chronic sick. Demarcation disputes are often reported, for instance about immunizations, and the question of who eventually carries responsibility has sometimes soured relationships. The financial arrangements allowing general practitioners to claim item for service fees for tasks that could be performed by an attached nurse has created further resentments and contributed to the employment of practice nurses.

The management difficulties outlined above have significant bearing upon how the team functions. If nursing units are to work with several practices, doctors and nurses will have difficulty getting to know their co-professionals sufficiently well for teamwork to develop.

This problem arises again in the Cumberlege report's proposal to establish contracts between general practitioners and each team. These are likely to have little legal force and their main value would be in the discussion engendered between team members in drawing up and working to protocols for various preventive and therapeutic programmes. Such a process requires a degree of trust which is unlikely in colleagues who do not work closely together. Another major problem with a contractual approach to working together is that some practices may not agree to sign. Given the present independent contractor status of general practitioners no pressure could be brought to bear on them, and their patients might end up with a second class nursing service.

Lack of professional autonomy of nurses

The Cumberlege report describes how community nurses find their present role confining, trapped by tradition and an unwieldy management, while practice nurses illustrate the problem of one professional having an employee relationship to another.

The report suggests common training for all community nurses as well as an extension of traditional roles to include, for example, limited prescribing and a nurse practitioner grade. These trends would be welcomed by most general practitioners but, as the boundary between nursing and medicine becomes blurred, the arguments for a strong team at practice level become more compelling. Again, the question must be whether neighbourhood management would inhibit this process or militate against nurses developing their professional autonomy with clients.

Alternatives to the Cumberlege proposals

Despite the criticisms we can only agree about the need for major improvements to nursing in the community as outlined in the report: ensuring needs are identified, enabling the team members to respond effectively, strengthening management of nursing services, increasing the status of nurses within the community, and finally offering opportunities for consumers to be directly involved. However, it is doubtful whether the neighbourhood nursing schemes could solve the current problems in the community or provide a framework which would result in the major nursing task being successfully undertaken. Although there are practical arguments against plans being too radical, it may be useful to take a closer look at some of the alternatives.

One suggestion would be to preserve schemes which already exist in some districts where a form of neighbourhood unit exists with looser administrative arrangements than envisaged by Cumberlege. Many of these schemes are working effectively and

districts with this type of service should obviously be studied more carefully.

A second possibility results from the government's decision to retain the practice nurse direct reimbursement scheme. General practitioners have the power to extend the practice nurse system and employ their own district nurse or health visitor to work outside the health centre or surgery. It is likely that 'practice district nurse' or 'practice health visitor' posts would not be difficult to fill. These would attract reimbursement, and many large practices are currently well within their allowance of two ancillary staff per doctor. A restructuring of community nursing which did not gain the confidence of general practitioners might precipitate this unilateral action. From a managerial perspective such a trend would be disastrous. There is evidence that reimbursement of practice nurses is not the most effective way of funding nurses in the community and, although such an arrangement might foster interprofessional cooperation at a practice level, the professional autonomy of nurses would suffer severely and it would lead to a serious split in the profession.

The health care unit

A third option draws on the report's suggestion of a nursing care unit serving a population of between 10 000 and 25 000 patients. Although this is an arbitrary size for a 'neighbourhood', it provides a viable unit of professionals in which some degree of specialization can take place without loss of identity. It is not difficult to imagine groups of general practitioners forming a medical care unit to serve a similar number of patients. The unit would not necessarily be a group working from one health centre; it could consist, for instance, of several partnerships or single-handed doctors working from a health centre. Many variations would be possible, and a large partnership could be a unit in itself if the practice population were large enough. How closely participant practices would work together would obviously depend on how similar their philosophies were and their degree of commitment to the scheme. Health authorities and family practitioner committees would facilitate the formation of these units, but as Cumberlege points out, there are strong arguments for merging these two bodies in the long term, a view endorsed by the recent report of the Social Services Committee.⁴

Each medical care unit would select a manager from among the doctors, who would establish the medical needs of the unit and work with the doctors or practices involved to develop and implement policies. Such a post could be half time, and possibly funded by the health authority. Postgraduate training in epidemiology and community medicine would obviously be desirable and this post would cover many of the functions previously described under the title 'community general practitioner'.⁵ Day to day management would be performed by a unit administrator, who would work with the employed staff in the practices. Again, whether such management led to developments such as joint employment of staff between practices would depend on the cohesiveness of the practices.

The health authority would set up a nursing care unit linked to the medical care unit, serving the same population; the two units would together form a health care unit. The nursing unit might consist of four district nurses, four health visitors, four practice based nurses and several auxiliary nurses, the exact numbers depending on workload and need. Specialized nurses could be attached to the unit where necessary. Each member of the nursing team would be salaried by the family practitioner committee or district health authority. The nursing unit would make their own detailed contractual arrangements with the medical unit and be led by a nursing manager who would be a nurse with a clinical load, again perhaps half time. The nurs-

ing unit manager would coordinate the nursing needs of the health care unit and work with the medical unit manager to coordinate activities. One of the members of the nursing care unit, perhaps a health visitor, would liaise with specialized community nursing, hospitals, social services departments, schools, probation services and voluntary organizations. Each health care unit would be encouraged to have a users' group, so that the patient's voice could be heard.

The scheme is only presented here in outline, but there would appear to be certain advantages:

- Community nurses would have more autonomy.
- The primary care team could become a reality because doctors and nurses could identify with a single population unit.
- Management would be directed towards grassroots level.
- Management of both medical and nursing services could become integrated, to the benefit of patients.
- General practitioners would still retain their partnerships and autonomy, but would benefit from working more closely with other medical and nursing practitioners.
- Policy decisions would be taken by mutual agreement and therefore have a better chance of being implemented.
- Patients would have a direct say in both medical and nursing services.
- General practitioner services would develop towards a neighbourhood base and would be compatible with a salaried option for general practitioners in inner city areas.

Conclusion

The proposal outlined here extends the Cumberlege report recommendations to incorporate general practitioner as well as nursing services.

No single system of delivering medical and nursing care in the community answers all needs or is applicable to all areas: variety is the essence of such care and a flexible response is essential. We may need to experiment⁶ with different systems in one or two districts and evaluate the schemes over a period of two years or more. This is in keeping with the sentiments of the green paper⁷ and is a policy we would urge the Department of Health and Social Security to consider.

Our proposal has major implications for general practice as well as community nursing. Issues such as how practices can be brought together and what happens to doctors who will not participate, are too complex to discuss in a paper focussing on community nursing. It could be that the changes will evolve gradually, with nursing units set up before their corresponding medical units emerge. Similarly, practice employed nurses are likely to continue in the short term, and be incorporated into the nursing team as the scheme develops.

What our proposal lacks is the concept of a clearly identified neighbourhood, which is one of the attractions of the Cumberlege proposals, and a starting point for the development of 'community care areas' with coterminous political wards and social services and health services areas.⁸ Adoption of such rigid zoning might militate against other less tangible but equally important developments in primary care. Nothing in this proposal precludes health care units from defining their catchment area more and more closely, and so the end point might be very similar to that advocated by the community nursing review. We feel that what we have proposed, however, is less likely to disrupt what is of value in the present system, and make the journey there more acceptable to all participants.

References

1. Department of Health and Social Security. *Neighbourhood nursing — a focus for care. Report of the community nursing review (Cumberlege report)*. London: HMSO, 1986.

2. Reedy BLEC. Teamwork in primary health care — a conspectus. In: Fry J (ed). *Primary care*. London: Heinemann, 1980.
3. Hicks D. *Primary health care*. London: HMSO, 1976.
4. Social Services Committee of the House of Commons. *Primary health care*. London: HMSO, 1987.
5. Mant D, Anderson P. Community general practitioner. *Lancet* 1985; 2: 114-117.
6. Marinker M. Experimentation: the next step. *J R Coll Gen Pract* 1987; 37: 125-128.
7. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care — an agenda for discussion (Cmnd 9771)*. London: HMSO, 1986.
8. Jarman B, Cumberlege J. Developing primary health care. *Br Med J* 1987; 294: 1005-1008.

Acknowledgements

We thank colleagues within our department with whom we have discussed the issues in this paper.

Address for correspondence

Dr Andrew Wilson, Department of General Practice, The University of Nottingham, Queen's Medical Centre, Clifton Boulevard, Nottingham NG7 2UH.

INFORMATION FOLDERS

The College continues to expand its two series of information folders — the clinical series edited by Dr Colin Waine and the practice organization series edited by Dr Robin Ridsdell Smith.

Parkinson's Disease

Statistics show that 1 in 100 of the population will develop Parkinson's disease and, despite recent advances, treatment of the disease remains a challenge to the general practitioner. This folder aims to increase general practitioners' awareness of the problems facing patients and their families and the extent to which they can be managed without anti-Parkinson drugs. Included are a clinical book and protocol on management, together with details of helpful organizations.

Price £7.00 (members), £8.00 (non-members)

Asthma

Asthma is a condition ideally suited to management by the primary care team, yet too often general practitioners rely on hospital specialists for care of their patients. The folder contains a clinical book, examples of a patient-held record card, a flow chart on management and normal peak-flow meter charts for children and adults.

Price £9.00 (members), £10.00 (non-members)

Medical Records

This information folder provides a general insight into the structure and process of keeping medical records, with descriptions of the various forms of record and suggestions on improving the value of records to both doctors and patients.

Price £5.00 (members), £6.00 (non-members)

Practice Information Booklets

As patients become more interested in the style and organization of care offered by their doctors, many practices are producing information booklets. This folder has been compiled to encourage and aid this process, with monographs and examples of booklets written by providers and receivers of care. The folder will be launched at the Annual General Meeting on 14 November.

These titles are available from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. Payment should be made with order and cheques made payable to RCGP Enterprises Ltd. Visa and Access welcome. Details of other titles in the series are available from the Central Sales Office.