Primary and community health services in Newcastle upon Tyne — a joint statement of intent

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SUMMARY. In the absence of a single primary health care authority (except in Scotland) district health authorities and family practitioner committees must cooperate in planning health services for the community. Equally, in the field, the potential for teamwork between salaried district health authority nursing staff and the independent general practitioners remains largely unrealized. Yet the government has restated its commitment to the development of primary health care teams as the best means of delivering health care in the community.

In Newcastle upon Tyne the local medical committee and the community health services management team have set out their shared aspirations for future development in a joint 'Statement of intent'. This statement, since endorsed by the district health authority and family practitioner committee, includes a number of key principles as a basis for future joint working. These principles emanate from an understanding of the complementary nature of general practice and district health authority community services, and firmly support the primary health care team approach.

This statement of intent could serve as a useful model for collaboration and planning of services elsewhere in the country.

Introduction

RECENT publications[1-5] have generated much discussion on the future shape of primary health care services in the United Kingdom. There is general agreement that this care is best provided by a primary health care team, comprising general practitioners, community nurses and other staff working together from good premises and caring for the population registered with the practice.[6] The government has committed itself to a policy of developing such teams.[3]

However, in the absence of a single primary health care authority (except in Scotland) district health authorities and family practitioner committees must cooperate in planning this development, and the difficulty of marrying the salaried community health service with the entrepreneurial and independent general practitioner service is well recognized.[2,7,8]

In Newcastle upon Tyne, as in most localities, the potential of primary care health teams has not been fully realized. The family practitioner committee was only granted independent status in 1985, and in common with others is still without a proper infrastructure to support planning. The district health authority has been forced during this period to focus on problems associated with its overall financial position and this has distracted attention from its external links.

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The local medical committee and the community health services management team have therefore collaborated in the production of a joint 'Statement of intent', setting out their shared aspirations. This statement was published in advance of the government white paper on primary health care,[3] but nothing in the white paper has subsequently caused either party to retract or reconsider. The family practitioner committee and district health authority have both since endorsed the statement, which describes six critical principles underpinning the future joint development of services.

Joint statement of intent

1. The primary health care team should be the main focus for providing a comprehensive continuum of health care in the community setting to include: 24 hour care of acute illness, continuity of care (including terminal care), management of specified chronic conditions according to agreed protocols, preventive programmes (assessment, surveillance, screening and health promotion).

2. The primary health care team should consist of an identified group of professionals who are recognized as practitioners in their own right, with particular skills to bring to the work of the team. Their work should be based on a clear understanding of each others roles and commonly agreed objectives for jointly delivering a service to the population served by the practice.

3. The community health services unit, in addition to its management role in relation to health visitors and district nurses working as members of teams will:
   (a) Provide services which are required to complement or which cannot realistically be provided through each primary health care team. These may include, for example: school health services, stoma care and continence specialists, evening and night nursing services, community mental handicap services, specialist contraceptive services, chiropody, physiotherapy and speech therapy.
   (b) Identify the need for preventive medical and nursing services in specific areas of the city (principally areas of special social needs) where general practice has not yet assumed these responsibilities. The long term aim is to facilitate a primary health care team approach in such areas; the community unit has a defined responsibility to identify such needs in the interim and, in collaboration with other services, define a plan to meet the identified needs.
   (c) Promote the development of integrated services between general practice, the hospitals, the local authority and the voluntary sector for the benefit of the local community.

4. General practitioners and the community unit will work together to promote good practice by:
   (a) Establishing a dialogue with each practice with the aim of agreeing objectives.
   (b) Encouraging and disseminating examples of innovative practice.
   (c) Encouraging evaluation of practice and quality assurance in primary and community services.

(d) Developing shared programmes of training and continuing professional education.
(e) Developing ways in which users of services can participate in the planning of services in a way which is responsive to their needs and wishes.

5. General practitioners and the community unit will aim to facilitate joint working by:
   (a) Promoting effective communication; this will include making the best possible use of exchange of information and information technology.
   (b) Encouraging flexibility in the use of resources, to accommodate the extension of professional roles.
   (c) Ensuring integration by consultation on selection of team members and continuity of membership of individual teams.

6. There will be a joint commitment to work towards common boundaries, while recognizing the need to retain patient choice.
   (a) Nursing and other community health staff working as part of a primary health care team will normally provide care to the patients of the practice with the exception of those whose needs it is mutually agreed are best covered by delegation to colleagues from an adjacent area, for example those who are highly dependant or live far away from the main base.
   (b) Practices will be encouraged to define their practice areas based on the feasibility of delivering an effective and economic service.

Discussion

The planning sub-committee of the local medical committee had previously proposed a plan for the future of general practice in Newcastle whereby each practice would be collectively responsible for providing a package of guaranteed minimum services — 24 hour care of acute illness, continuity of care, management of specified chronic conditions to agreed protocols and certain preventive programmes.[8] The statement of intent represents a further development of this plan.

To have obtained a joint commitment to the statement is no mean achievement, but the next stage of converting aspiration into action is likely to be equally difficult. Sceptics can point to the rhetoric of the last 20 years which has favoured the development of primary health care teams, and contrast this with the continuing fragmentation of services. Special skill in communication and planning may be required.

The statement is more than simply ideas. Within it there are a number of practical first steps. For example, a dialogue is to be established with each practice towards agreeing objectives, and there is to be consultation on the selection of team members.

Initial progress is encouraging. The local medical committee has sought and obtained funds to appoint a general practitioner researcher, whose first task is to complete a detailed survey of all practices in the city. The district health authority have appointed a health promotion facilitator. There has been a dramatic increase in the number of practice nurses appointed. A variety of collaborative ventures are under way, including an attitudinal survey of all primary health care personnel, a project to feedback immunization uptake figures to general practitioners and health visitors, and a programme of practice visits to establish the content of pre-school child health surveillance.

Specific areas have also been identified where collaboration is likely to be particularly necessary or fruitful. These include child health surveillance, family planning, health promotion, the attachment of community health staff to practices and services for the inner city area.

A number of issues emanating from the primary care white paper will only be resolved by negotiation with the professions. It will also take time for the family practitioner committees and district health authorities to organize their joint planning arrangements. Indeed, the ability of family practitioner committees to undertake a management role in respect of general practice has been questioned.[9,10] In the interim there is an opportunity for community health service managers and the local representatives of general practice to provide leadership and a much needed sense of direction.

There are advantages to this scheme in Newcastle upon Tyne that may not apply elsewhere. The family practitioner committee and district health authority areas are essentially coterminous, although many practices serve patients registered in other family practitioner committee areas. There is goodwill and an evident ability to tackle at local level those aspects of joint working which are amenable to change, even within the existing structural and resource constraints. Nevertheless, in the absence of a single primary health care authority (or any likelihood of its creation in the foreseeable future) this approach could be a model for collaboration elsewhere in the country.

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