A primary health care team manifesto

ADELAIDE MEDICAL CENTRE PRIMARY HEALTH CARE TEAM

SUMMARY. Over a two year period an inner city primary health care team constructed a manifesto which defined the common aims and objectives of the team. The statement was not comprehensive, but it served a variety of purposes. Audit was made explicit and a framework was provided for the team's annual report. The manifesto has proved useful for trainees and other new members of staff. It has given the team a sense of direction, and it is hoped that it will foster teamwork through team members feeling that they have 'ownership' of the plan.

The manifesto was conceived in advance of the government's white paper and new contract for general practitioners. It addresses the perceived health needs of the practice population in a practical way. Other primary health care teams may wish to adapt or use the framework of the manifesto to produce their own version.

Introduction

UNDER their former terms and conditions of service general practitioners were required to 'render to their patients all necessary and appropriate medical services of the type usually provided by general medical practitioners'.[1] The inherent weakness of this definition, that a general practitioner did what a general practitioner did, has steadily been exposed over the last decade, and the government has now placed contractual obligations on general practitioners to provide a specified range of services.[2]

There is general agreement that primary health care is best provided by a primary health care team comprising general practitioners, nurses and others working together from good premises and, in the UK, serving the population registered with the practice.[3] The aim of developing primary health care teams has been a clear policy of governments since at least 1974.[4] The Cumberlege report acknowledged in 1986 that community nurses work best as part of an active primary health care team.[5] General practice, however, has been beset by major difficulties — lack of direction, relative lack of accountability, poor measurement of outcome of care, inconsistency of service provision and the problems of marrying the salaried community health service with the self-employed independent general practitioner service.[6] The result has been that the ideal of properly functioning primary health care teams has yet to become a universal reality.[7] It has been argued that general practitioners need a clearer definition of working standards,[8] and in Newcastle upon Tyne the local medical committee planning group proposed that each practice should be responsible for providing a 'minimum guaranteed service', including traditional demand-led care, care of specified chronic conditions to agreed protocols and certain preventive programmes.[6] Others have suggested that general practitioners could become community general practitioners and assume the role of the former medical officers of health.[9,10] The Royal College of General Practitioners has also attempted an explicit definition of the content of patient care.[11]

In inner city Newcastle one primary health care team has attempted to overcome some of these difficulties by drawing up a team manifesto, setting out their 'product definition'. The whole exercise was stimulated by a chance remark by one of the receptionists, who complained that 'come Friday I don't feel as though we've achieved anything'. This begged the question: what was the team trying to achieve, and how could success be measured?

Team meetings dedicated to the manifesto took place sporadically over a period of about two years. Progress was hampered intermittently by such problems as a lack of direction to the project, waning enthusiasm of the group, other priorities arising, pressure on time and changes in staff. Lack of a feeling of 'ownership' of the manifesto among some team members and too great a concentration on detail were also significant barriers.

A careful record of the team's deliberations was kept, however, and from this a draft manifesto was drawn up. After several more meetings and much detailed debate, the team felt confident they could match the standards set in the manifesto. An absolute requirement was that the manifesto should be realistic, practical and achievable.

The production of the manifesto was time-consuming for all team members, but the meetings allowed members to ventilate their ideas and views. Most of the objectives were derived from the meetings of the whole team, although those concerning prescribing were produced by the doctors alone.

The manifesto

Aims

- To provide an exemplary primary health care service for patients registered with the practice.
- To work together as a team.
- To educate ourselves, our patients, our colleagues, trainees and students from any discipline.

The following objectives were stated:

Acute care

1.1 On weekdays patients with non-urgent problems will be offered the opportunity to consult a doctor or nurse, at home or in the surgery (as agreed with the patient) within 24 hours of their request.

1.2 Patients with non-urgent problems will be offered an appointment with the doctor of their choice within one week of their request (except when the doctor is away).

1.3 At any time patients with urgent problems (as perceived by the patient) will be advised by a doctor as soon as practical, and seen as necessary, at home or in the surgery (as agreed with the patient).

1.4 Through the receptionist patients will be able to contact the practice nurse, district nurse, health visitor, community midwife, community psychiatric nurse and dietician.

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Prescribing

2.1 As a general rule all drugs, except combination preparations, will be prescribed generically by doctors using their own prescription pads.
2.2 The doctors will strive to comply with *A basic formulary for general practice*[12] in 90% of prescriptions.
2.3 Trainees will prescribe on partner A's prescription pad using the 'D' facility.[a]
2.4 Potential and known drug abusers will not be given prescriptions for drugs that can be abused.[b]
2.5 Antibiotics will not be prescribed for viral illnesses, and patients will be encouraged to use simple and effective symptomatic treatments for the common self-limiting conditions.
2.6 Appetite suppressants will not be prescribed.
2.7 Benzodiazepines will not be prescribed *de novo* except in exceptional circumstances, and long-term users will be encouraged to withdraw from the drug.
2.8 Patients on long-term medication will be reviewed at least annually.

Women's health

3.1 Women will be offered the full range of contraceptive services, provided by a woman doctor if desired.
3.2 Pregnant women will be offered shared antenatal and postnatal care.
3.3 Requests for home confinement will be considered individually.
3.4 Women aged 20–65 years will be offered a cervical smear every three years (unless inappropriate) until they have had two normal post-menopausal smears.[b]

Health promotion and preventive care

4.1 All children (whose parents have given consent) will be fully immunized.
4.2 All children will be screened at the appropriate intervals for treatable undetected conditions.[b]
4.3 All adults aged 20–75 years will be screened opportunistically for hypertension every five years.[b]
4.4 All adults aged 20–65 years will be offered a health check for coronary heart disease risk factors, and appropriate advice on lifestyle changes every five years.[b]
4.5 All patients aged over 75 years will be functionally assessed annually.[b]
4.6 Travellers abroad will be given appropriate advice and immunization.

Chronic care

5.1 Each diabetic patient will have a complete check annually.[b]
5.2 Each hypertensive patient, once stable, will be reviewed six monthly.[b]
5.3 Each patient on thyroxine will be monitored by blood test annually.[b]

Terminal care

6.1 Any patient with terminal illness who wishes to die at home will be cared for by the team.
6.2 Bereaved relatives will be visited soon after a death.

Patient relations

7.1 Any patient (or at least one family member) wishing to register will meet a doctor and be provided with a practice information leaflet.
7.2 The team will endeavour to maintain contact with or visit hospitalized patients.
7.3 Health education leaflets and practice library books (for loan) will be available in reception.
7.4 Patients will be able to see information held about themselves on the computer on request.
7.5 Suggestions from patients will be welcomed. Complaints will be discussed openly and taken seriously.

Teamwork

8.1 Each team member will be offered feedback and discussion as a means of personal development at least once yearly.
8.2 Each team member will be encouraged and expected to pursue their own further education and training.
8.3 All team members will have ease of access to each other, and be respected as an integral part of the whole.
8.4 There will be regular team meetings, *ad hoc* meetings for sub-groups and occasional social outings.

Teaching

9.1 The trainee will have at least two, and preferably three, sessions with a principal each week.
9.2 Patients will be informed of the presence of medical students, and given the opportunity of discreetly saying no without embarrassment.

Audit and information systems

10.1 All records will be summarized, and screening cards regularly updated.
10.2 Manual registers will be maintained for births, deaths, malignant disease, minor surgical operations and dangerous drugs.
10.3 Protocols and objectives will be amenable to audit, and audited regularly.
10.4 Medical students attached to the practice will be encouraged to undertake audit exercises as projects.
10.5 An annual report for the calendar year will be produced by March the following year for consideration by the team.

Discussion

Lack of common objectives has been identified as the main obstacle to the development of teamwork in primary health care.[13] The Cumberlege report suggested that each practice be obliged to have a written agreement with their attached community nurses, defining each team member's responsibility.[5] Such written agreements are only favoured by the government if they help doctors and nurses to work together.[14] We believe a team manifesto which the primary health care team has drawn up itself will help the members work towards common goals. It seems unlikely a team would respond as positively to an agreement imposed from outside.

The manifesto was not comprehensive, nor was it intended to be. However, it served a variety of purposes. Audit was made explicit and a practical framework was provided for an annual report, as suggested recently by Keeble and colleagues.[15] The manifesto has already proved useful for trainees and other new members of staff. It is to be used as a basis for individual staff appraisal. It has provided a useful focus through which team members can understand the roles of other members. Above all, it should foster teamwork and provide a sense of direction. Professional satisfaction and better patient care should follow.

From management perspective the manifesto has only been the beginning of a process which will lead to the development

[a]The 'D' facility enables trainees to receive their own prescribing analysis and cost (PACT) reports from the Prescription Pricing Authority.
[b]Denotes practice protocol.

of a strategic plan for the team with appropriate supporting management structure. To this end the post of practice manager has been upgraded, the internal administrative structure reorganized and one partner has been given responsibility as 'executive partner'. The executive partner and practice manager axis is seen as crucial to the implementation and monitoring of the manifesto.

The idea that practices should develop business plans and a 'product definition' is new. In the current more aggressive business climate, primary care teams may need to consider the need for proactively seeking out patients' views, employing techniques such as market research, focus groups and individual interviews. They may also need a more structured approach to team member education and training.

It should be noted that the manifesto was conceived in advance of the government's white paper *Working for patients*[16] and the new general practitioner contract.[2] In a practical way it addressed what were perceived as the real health needs of the patients. Minor modifications are now necessary in response to the contractual obligations imposed from outside. Other primary health care teams may wish to use the manifesto as a model, and amend it for their own purposes.

Finally, the team recognizes the need to be aware of the likely gulf between objectives as stated and the achievement of those objectives. So far most of the objectives have not been formally audited. In cases where formal audits have been undertaken (objectives number 2.1, 2.2, 2.6, 3.4, 3.6, 3.7, 3.9, 4.1, 4.3) reasonable success has been demonstrated. A thorough review of the manifesto with a supporting audit of all the objectives will be carried out in 1992.

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