Working in partnership with nurses

TWO important documents have been published recently which consider the future management of nurses working in the community. The National Health Service management executive report *Nursing in the community*[1] describes possible models of organization, and is intended to stimulate discussion. The Kings Fund Institute and Nuffield Provincial Hospitals Trust have provided a helpful document[2] which, among other things, looks at the management of nursing within the development of primary health care as a whole. The outcome of the debate will affect all general practitioners and nurses working in primary care, and could radically affect the concept of the primary health care team.

The community nursing report describes five possible models of organization for the future.[1] First, all community nurses could be managed by large independent community trusts or, secondly, within locally managed neighbourhoods. Thirdly, family health services authorites could assume responsibility for nursing services. The fourth model envisages hospitals or acute/community units being responsible for nurses providing outreach services. In the fifth model primary health care teams would control all community nursing services, described in the report as 'general practitioner managed'.

The Kings Fund report, following the fifth option, argues that general practitioners' surgeries logically offer a focus around which to construct a better, more coordinated pattern of overall care.[2] However, it also accepts that the true integration of general practice and community nursing services will be no easy task.

The government has stressed that any new orgnaization of nursing services should build on the importance of the primary health care team.[1] However, the concept of the team will be influenced by the organizational model chosen. The fact that reorganization is proposed is partly a recognition of the fact that although we pay lip-service to the concept of the primary health care team, it has rarely been a success in reality. When teamwork has been achieved, this has usually been due to like-minded individuals working together in spite of, rather than because of, the organizational arrangements. To expect teamwork to flourish was perhaps a naive and impossible ideal, given the disparate nature of our employment, with different professionals working for different employers, and often towards different ends, with little scope for negotiation. Teamwork has often been equated with democracy, an idea never likely to succeed when the doctors often own the building, employ most of the staff, and have a lifetime commitment to the practice.

Several recent developments will further expose the limitations of this idea of teamwork and will make us re-evaluate the concept of the primary health care team. First, increased management control has been a consistent theme of recent NHS policy changes. Good management encourages teamwork but within a context of leadership and accountability. As they plan their aims and strategies, practices will have to think more clearly about how leadership applies in the primary health care team. Attached nurses in particular may feel divided loyalties between the aims of the practice with which they feel involved, and the requirements of their employing health authorities. Secondly, the 1990 contract for general practitioners[3] has led to an increase in the employment of practice nurses, which some have seen as a sign of their new importance. However, other practice nurses are concerned that their role could be diminished as they have to carry out tasks delegated by doctors which they both feel are financially, but not clinically, worthwhile.[4] Thirdly, recent policy in the NHS has clearly identified health promotion and screening as the responsibility of general practitioners, which they are paid to organize.[3] Community nurses, especially health visitors, feel undervalued and marginalized by these changes.[5] The morale of health visitors is undermined by seeing general practitioner-employed practice nurses running health promotion clinics for which they feel more suitably trained.

How can we create a management structure which would enable genuine primary health care teams to flourish? A combination of two models from the community nursing report may provide the answer. Larger practices could employ and manage all their nursing staff including nurse practitioners, practice nurses, district nurses and health visitors. As a later development this may extend further to social workers and other community workers. All members of the team would be accountable to one organization, which can work towards common goals. An integrated medical and nursing service would be accessible from one focal point — the surgery or health centre. In parallel with this, the family health services authority would have a role in providing training, and in providing an overview to ensure comparability and minimum standards in practices. Family health services authorities might also act as an agency to provide specialized nursing staff, and to provide practice nurses and health visitors to practices too small or not wishing to employ their own.

The community nursing report describes the primary health care team model as general practitioner managed. This phrase alone could destroy the concept. One must recognize the reluctance that the nursing profession would feel, with good reason, towards all community nurses being employed by doctors. A better model would be one in which all staff, medical and non-medical, are accountable to a practice which is run by a multidisciplinary partnership. The nursing members of the practice would be accountable to a senior nurse, who would be a partner, along with the practice manager and the doctors. This idea is mentioned in both the community nursing report and the Kings Fund report, but is not expanded. The possibility of broadening medical partnerships is also listed as an option for discussion in the recent General Medical Services Committee document.[6]

Extending partnerships to non-medical professionals raises several problems. A partnership is defined in the partnership act of 1890 as 'the relation which subsists between persons carrying on a business in common with a view to profit'. The partnership advisory serivce of the British Medical Association have held that a nurse can not carry on a business in common with doctors, but only undertakes tasks delegated to her by the doctors as a servant of the practice (Colson A, British Medical Association, personal communication). However, one could argue that nurses and doctors are mutually involved in the common business of providing health care, and that senior nurses provide a complementary role rather than a subservient one.

Another problem concerns the fact that partners are mutually liable for each others' acts and omissions. At present a nurse is liable for her own actions but a general practitioner as her employer is also vicariously liable. In a partnership, a nurse would be equally liable for a claim against one of the doctors, a problem which could possibly be overcome by a suitable indemnity policy.

Multidisciplinary partnerships would not be viable under present arrangements which would prevent salary reimbursement to a nurse who was a partner rather than an employee. One

possibility would be to offer practices a nursing capitation fee in return for appointing a nurse partner. The income from this fee would cover the costs of all nursing services and include an element of profit to pay the nurse partner. Family health services authorities would determine the range and quality of nursing services to be provided, but the practice would decide how to meet those needs. This model is a logical extension of the payment structure for general practitioner partnerships, and would provide a flexible service at lower cost by eliminating several tiers of nursing administration.

The current discussions demonstrate that the present inconsistent pattern of nursing in the community should not continue. Doctors and nurses either have to propose structures that will put the primary health care team on a more sound managerial footing, or face an increasing division between themselves and a separately managed community nursing team. It is important that those actually working in primary care involve themselves in the discussions, so that decisions are not made only by those who have a vested interest in continuing a service managed from the centre. The reward could be a more integrated primary health care service offering better, more cost effective care through genuine teamwork.

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Care for patients discharged from psychiatric hospital

THE mental hospital closure programme is now well advanced. Approximately 30 hospitals have been closed and 100 000 longstay patients have been discharged.[1] About 4000 patients have found homes in various types of local authority or voluntary association accommodation, but little is known about the whereabouts of the rest. Some are with families, some are living independently or in lodging houses, some are on the streets, some in prison, some have died and some have returned to asylum care.

The psychiatric problems of this group vary. They include personality disorders, manic depressive psychosis, chronic depression, early dementia, mental handicap and alcohol psychosis. But by far the commonest diagnosis is that of schizophrenia, in various stages of activity and severity. It has been stated that about 25% of all schizophrenics will make a good recovery, 10% will not respond to treatment and will remain severely ill, and the rest will respond to a degree but will remain vulnerable and in need of long-term support and medication (Leff J, personal communication).

The social problems of schizophrenics are usually considerable and have been well documented; but these people also have a need for care from medical staff. It has been said that psychiatric patients are more likely than the general population to be harbouring physical disease,[2] and Brugha found that 41% of long-term psychiatric service users had serious medical problems.[3] Although accurate figures are scarce, there is fairly general agreement that 'the relative risk of death in schizophrenia is increased twofold'.[4] Certainly the impression is that these patients are prone to self-neglect, live in poor housing and poverty, and tend to smoke and drink too much. Suicide and accidents are the commonest causes of death in this group of patients.[3] Schizophrenics may not register with general practitioners and in a survey carried out in south Camden 25% of schizophrenics were thought to be out of touch with all medical services (unpublished results).

However, general practitioners are now taking on the care of longstay mental hospital patients living in local authority hostels and this is likely to affect their workload considerably. I visited three newly established hostels regularly for a year and collected information from the medical records about the health needs of the residents and about their contacts with doctors.[5] I also questioned the general practitioners providing care to the residents and the psychiatrists who were in contact with the hostels.

Twenty six people lived in the hostels and their age range was 24–77 years. The majority were chronic schizophrenics recently discharged from asylum care of between five and 60 years' duration. As well as their psychological disabilities, they had many other problems. Four suffered from diabetes, four suffered from epilepsy and several had behavioural problems including mutism and incontinence. During the year there were cardiovascular, diabetic and abdominal emergencies as well as several emergencies owing to falls and accidents. Three residents were readmitted to permanent asylum care and three needed short-term admission.

The hostels were staffed by trained psychiatric nurses and care assistants on a 24-hour rota system. A total of 24 staff cared for the 26 residents, the high ratio being necessary because of the nature of the work, staff absences and changes, and the need for constant cover. The residents were all registered with local general practitioners, although initial reluctance to accept these patients had had to be overcome.

Three patterns of care were found in the three hostels. In one, a general practitioner from a three-doctor practice shared the provision of care with a community psychiatrist, the one dealing with 'physical' problems, the other mainly with 'psychological' problems, although there was inevitably overlap. In the second hostel, nine general practitioners from four practices were involved but, in reality, care was provided by a hospital consultant psychiatrist who dealt with physical as well as psychological problems. In the third hostel, two practices were involved and the residents, a somewhat younger and less disabled group, were able to consult as ordinary National Health Service patients. A community psychiatrist made regular contact with the third hostel.

Thus, three models of medical care were demonstrated in the hostels. The first, shared care, worked well but there were problems in communication and in defining areas of responsibility, and this produced difficulties for the staff. In the second pat-