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Institute for
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COMMUNITY NURSING:

A Background Paper Exploring
Current Issues

Briefing Paper No. 9

Mark Exworthy
January 1993

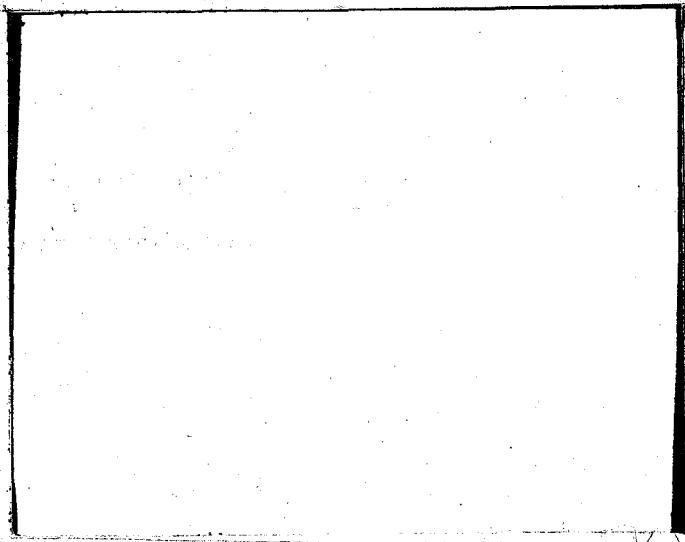
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COMMUNITY NURSING: A BACKGROUND PAPER EXPLORING CURRENT ISSUES

SUMMARY

The Briefing Paper attempts to tackle some of the many issues currently facing community nursing. Inevitably this is beyond the scope of one report. The Paper therefore discusses the more salient topics as they relate to DHA purchasing policies. It is hoped that the Paper raises areas of interest and concern to Consortium members which can subsequently be pursued. Feedback on the Paper would thus be welcomed.

The Paper focuses on two groups of community nurses: Health Visitors (HVs) and District Nurses (DNs). It is recognised that significant developments are occurring in other groups and that many factors influencing these two groups lie beyond their control. The current dilemmas and future prospects of HVs and DNs are addressed. Discussion about practice nurses is included later in the Paper.

Health Visitors

Particular attention is devoted to HV as this appears to be the group which is undergoing most change. Through an appreciation of the conflicting roles that HVs can play, their changing tasks in primary care can be better understood. This incorporates the balance between the "search for health needs", "stimulation of an awareness of health needs, "influence of policies affecting health" and "facilitation of health-enhancing activities." This is especially pertinent to the extension to the fundholding scheme. The public health role of HVs is an obvious example of the tension arising from their different types of work in the new contracting climate.

District Nurses

The role of DNs in the new structure of 'community care' will mean changes to the way in which they operate. Obstacles have arisen over differences of interpretation between definitions of health and social care. The Paper outlines some examples of where practical work has overcome some of these difficulties.

The Paper also suggests that changes in DN will arise from the changing balance between primary and secondary care, from the encroachment of other professions (eg. physiotherapy) into community settings and the changing skills of DNs themselves (eg. the increase in specialist nursing).

A number of factors face community nursing as a whole. These include:

Skill mix

This is a huge area of work and the Paper discusses projects examining some specific topics.

Whilst skill mix is often a professional/provider issue, there are important opportunity cost implications for one skill mix as opposed to another. The Audit Commission report identifies some such costs. However, the ability to change existing skill mixes is recognised in terms of labour shortages, training needs and time lags. Purchasers can thus play an important role in shaping policies towards training, labour flexibility etc.

GP fundholding: extension to the scheme from April 1993

This extension represents a fundamental challenge to community nursing, its professional basis and future direction. Specific issues addressed include quality standards, GP-employment of community nurses, the public health role of HVs, nurse referral protocols and the possibility of nursing agencies to 'compete' with GPs in certain tasks such as minor treatments or screening.

Practice Nursing

Given the current purchasing context of community nursing, a section on practice nurses was required. Given the recent rise in the number of practice nurses, it is important to determine how their work will coincide with community nurses from providers units. For example, with an overlap between practice and community nurses, it would be sensible to coordinate purchasing policies towards both groups so that HVs can be targeted in areas of most need. Coordination will be difficult as practice staff and community nurse contracts derive from separate GPFH budgets but FHSA reimbursement to GPs for practice staff should also be reviewed to examine possible changes. The Paper identifies the key task undertaken by practice nurses, highlighting areas of overlap with other nurses. The need for training of practice nurses is nationally recognised and the Paper summarises some of the key features that such training incorporates.

Conclusion

The Paper concludes by identifying some areas that will arise over the next few years. These include the partnership status of community/practice nurses in general practice, nurse prescribing and minor treatments. The Paper also suggests some areas of future work including an evaluation of GP contracting of community nurses, analysis of the public health role of HVs and analysis of different models of nurse employment.

1. INTRODUCTION TO COMMUNITY NURSING

1.1. Background to Briefing Paper

This Briefing Paper explores some policy issues involving Community Nursing (CN). To limit this study to the purchasing process was inappropriate as these issues are linked closely with the changing nature and direction of the CN profession in the next few years.

The Briefing Paper is divided into six sections. The rest of this introduction will address the reasons for studying CN. Current issues in CN will then be outlined. Although many groups comprise CN, attention will focus on Health Visiting (HV) and District Nursing (DN) (sections 2 and 3) because of their large establishments and role that they play in shaping other groups such as school nurses or health visitors to the elderly.

The fourth section tackles skill mix in CN, the costs and implications of altering the balance of staffing skills. The fifth area explores the implications of the extension to the fundholding scheme from April 1993 to include community nursing. The final section discusses some issues relating to nurses employed by GPs.

This Briefing Paper charts some areas that DHA purchasers may wish to explore further. Inevitably it has had to limit the range of issues and extent of discussion. It will hopefully point to areas of further work and therefore comments and feedback would be welcomed.

There are three reasons for addressing Community Nursing in this Briefing Paper.

The first relates to the broad theme of Locality Purchasing that has been addressed by the Wessex Research Consortium over the last year. Rather than purchasing all services at one level (eg. DHA or GPFH), a series of purchasing levels or tiers may be identified (Stockport, 1992) that range from the level of GPFH (9,000 population) to locality (30-60,000), DHA (250,000) and merged or consortia authorities (500,000+). Different services may be most appropriately purchased at each of these different levels. For example, CABGs (see Briefing Paper #4), as regional services, can be appropriately purchased at a DHA or regional level (figure 1). However, CN, by virtue of the prevalence of need for their services, may be purchased at a far more local level. Indeed the extension to the GPFH scheme from April 1993 facilitates the purchase of CN services, *inter alia*, by GPFHs. Nevertheless, DHAs will need to consider how they may purchase CN services on behalf of non-FHs and coordinate with GPFHs. This may be done at an individual practice level or at a locality level. To do so at a DHA level would lose a degree of sensitivity and responsiveness to the population's needs and the capabilities of local services to meet that need.

Secondly, the practice remains a key area where issues about the role and direction of CN are resolved. Whether CN adopt the practice will be a political/strategic decision as alternatives exist (eg. neighbourhood nursing (Cumberlege Report) and neighbourhood health units (Medical Practitioner Union)). The GPFH extension exemplifies this.

Figure 1: Purchasing hierarchies

	REPRESENTATION	POPULATION	AUTHORITY	FUNCTION	
Top down policy	Merger/ Consortium Purchasing Team	> 500,000	DHA Merger/ Consortium	Regional specialty e.g CABG	Bottom up needs assessment
	DHA Purchasing Team	> 250,000	DHA/FHSA	High risk purchasing e.g. renal dialysis	
	Locality Managers	c. 50,000	Localities	Locality purchasing/needs assessment e.g. community care	
	Practice Representatives	c. 10,000	GPs	Low risk purchasing e.g. cold surgery	

Adapted from: Northampton DHA (1992) p.16

The DHA purchaser has an important role in securing services for those who are not served by general practice. These include ethnic minorities, the homeless, travellers and other marginalised groups. This public health role could be secured through professionals such as HVs working in new patterns and structures (see 5.2.). DHAs will also need to secure CN services from Community Units on behalf of non-GPFHs. The role of Community Units as more GPs become FHS and contract, and possibly employ, CN remains uncertain as many primary care initiatives are based around the GP.

The third reason for this Briefing Paper centres on the professional part that CNs will be playing in relation to other nursing groups working in the community, viz. practice nurses, nurse practitioners, surgery nurses and nursing auxiliaries. The impact of the common training that CNs will receive before they specialise into, say, HV or DN will also have a bearing upon the tasks that they will perform. This redefinition of professional identity is occurring at the same time as discussions about skill mix, nursing outcomes and cost-effectiveness. These debates are more than simply arguments about finances and resources or professionalism. They are about the direction of and input to primary health care. Local variations in organisation and service are likely outcomes and hence the outline described here will need to be interpreted according to local circumstances.

1.2. Community Nursing: groups and numbers

As the DoH circular (EL(92)69, annex A) explains, "community and practice nurses have an important part to play in primary health care, but arrangements for obtaining and developing services involve:

- * a range of *different players* with responsibility for assessment of need, commissioning service provision, continuing education for the workforce;
- * *separate sources of funding* (HCHS revenue and capital and cash-limited GMS funds);
- * *a series of distinct, but possibly complementary, objectives*, relating to:
 - treatment, care and support of individual patients in general practice and the community;
 - education and intervention to promote the health of the wider community" (original emphasis).

These arrangements are based on the composition of nursing groups. CN covers a broad range of professions and services including:

Health Visiting	41%
District Nursing	25%
School Nursing	7%
Community Midwives	10%
Community Psychiatric Nurses	5%
Nursing Auxiliaries	12%

(Percentage figures of CN totals to the right taken from Cumberlege Report, 1986, p10)

Specialist Nursing (eg. incontinence nursing, family planning nurses)

Health Visiting to the elderly

(These last two categories have grown greatly in number since 1986 as have practice nurses which tend to be counted outside normal CN figures since they are employed by GPs)

The Cumberlege Report (1986) effectively divided CN into 'core' and 'peripheral' groups (Ottewill and Wall, 1990). The Report did this by using the term Community Nursing for HVs, DNs, school nurses and their associated registered and enrolled nurses. Other groups (eg. CPNs and specialist nurses) were specifically referred to by name. Whilst this distinction between core and peripheral groups may be misleading, it includes most CN staffing (73% in 1986).

Ottewill and Wall (1990) suggest that, nationally, about 53,000 nurses work in the community but it is unclear if these are whole time equivalents and it ignores the numbers of practice nurses employed by GPs.

The numbers of nurses employed in Wessex Research Consortium members are detailed in the table below.

Table 1: Number of Community Nurses in Health Commissions.
N.B. staff as whole time equivalents.

	HVs	DNs/ community nurse	Practice Nurses
Southampton	91	103*	103\$
Winchester	98	124*	108\$
Basingstoke	—		
Dorset	113	234	261
Hants FHSA	252	307	304\$

* denotes DN & community nurse

\$ figures derived from employed staff/principal ratios

Note: Hampshire staff are attached staff only

Sources: Dorset Health Commission, Dorset Health Care Trust, Hants FHSA "General Practitioners' Practice Annual Reports 1991/92" (Nov'92).

2. HEALTH VISITING

2.1. History of HV

Though the context of these issues are different, a brief background to HV can assist present debates.

HV had its origins in the social conditions of 19th century England. In the 1860s, the Manchester and Salford Reform Association employed women to visit mothers "to teach them how to look after their children and the importance of cleanliness and to help those who were unwell" (Ottewill and Wall, 1990, 32). Some were employed by the Manchester Public Health Department. HVs' early roles thus included teaching, counselling and nursing. By about 1915 most HVs had been professionally trained.

The 1946 Act required local authorities to provide HV. Their tasks included advice regarding the care of young children, mothers (to-be), those who were ill and the spread of infection. Training and qualifications became more rigorous as HVs' tasks became formalised.

The 1974 reorganisation relocated HV under the DHA. Moves towards HV attachments to GP practices increased greatly but eroded HVs' perception of autonomy as GP represented curative care rather than HVs' prevention. Though focusing on the 0-5 age group, HVs began to address the needs of other client groups such as older people and travellers. This coincided with declining births in the 1970s and '80s.

The 1986 Cumberlege Report, addressing all CN (see above), proposed that DHAs establish neighbourhoods (of 10-25,000) where CN could work with common needs and resources. A neighbourhood nurse manager, from any CN background, would professionally manage the CN in each neighbourhood. Many DHAs did establish neighbourhoods, though their duplication with primary care teams and GP attachments was problematical.

The 1990 'Roy Report' identified 5 models for organising community services and emphasised the need for joint working, shared visions and joint needs assessments between DHAs, FHSAs and Social Services.

2.2. Current Issues and Future Prospects

Current issues, echoing the past, relate to tasks, inter-professional collaboration and contribution to primary care, the balance between prevention and treatment, and the autonomy of HV as a profession.

Clay (1989) argues that recent government policy has systematically overlooked CN. This, he argues, will erode the role of CN and especially HV. Fatchett (1990) suggest that there may be a fragmentation of HVs' roles as cost-effectiveness and value-for-money clash with HV traditional roles of prevention and health promotion. Denny (1989), by contrast, suggests that, as GPs are linked so closely with the practice, there is scope for HVs in community work, exploring health needs and promoting health. However, moves towards this situation have been hindered by HV being "notoriously bad at explaining and defending their role"

(Fatchett, 1990, 220). This recognition has created a new impetus among many HVs towards a more proactive position. Proactive responses become difficult to implement as a longer time frame is needed to evaluate many HV developments.

Fatchett (1990) offers three possible scenarios for HV. First is a position of status quo which is largely contrary to events. Anticipation of change in PHC would assist CN in ensuring that there is a niche for them. A position of status quo would ignore this possibility.

Second, Fatchett suggests that management should be prescriptive about organisational arrangements (eg. advocating neighbourhood nursing). As many Community Units will now have to contract with GPFHs and as they must show evidence of their cost-effectiveness, this scenario also becomes problematic in that independent CN (within Community Units) may become less likely, though not impossible (see 5.3.).

The third response is one in which a central role within the primary care team is adopted as part of an acceptance that HV should be centred around general practice. HVs may be 'bought in' by GPFHs so it would seem appropriate that they make the most of this opportunity as GPFHs may increasingly opt for more practice nurses. The DHA has a role to play in securing (retaining) some HV finance to facilitate a public health role for HV (5.2.) or for roles that lie beyond the remit of GPFH (eg. stoma care). Given the development of general practice and practice nursing, HV responsibility to cover health promotion in 'community' settings might seem appropriate. HV skills could correspond to the aims of three health promotion 'bands':

Band 1 aims to "develop practice age-sex registers, record smoking habits; offer advice to reduce smoking";

Band 2 aims to "minimise mortality and morbidity of patients with hypertension, coronary heart disease and stroke";

Band 3 aims to "reduce incidence of coronary heart disease and stroke by a programme of primary prevention" (*BMJ*, 305, 1369).

Denny (1989) offers a different perspective for a proactive HV service. Four strands are presented which include:

- * needs based care ('selectivity within universality')
- * empowerment of individuals for their own care
- * health promotion
- * HV as specialist nursing (following the development of Project 2000)

Denny sees the universality of HV and their ability to employ all models of health (biomedical, psychological and sociological) in health promotion as being critical strengths that HV should build on for the future. These strengths might allow HV to adopt a more considered approach to their work than the move away from child-centred (0-5 years) work.

2.3. Conflicting Approaches to HV

The tension between different HV approaches is not new. Professional debate has long centred on HVs' role in primary care, the efficacy of managerial approaches ('HV by numbers') and the balance between different client groups. Twinn (1991) attempts to reconcile many of these tensions by placing them in an historical context of HV. Twinn's diagram (below, adapted from Beattie, 1988) illustrates this:

Table 2: Roles and paradigms in health visiting.

<i>Directive</i>	
<i>Individual</i>	<i>Collective</i>
<u>INDIVIDUAL ADVICE GIVING</u> -maternal & child welfare/ protection	<u>ENVIRONMENTAL CONTROL</u> -public health model
<i>Non-directive</i>	
<u>PSYCHOLOGICAL DEVELOPMENT</u> -personal support	<u>EMANCIPATORY CARE</u> -networking, community health

Twinn argues that, whilst individual advice-giving is often seen as being the traditional HV activity and also extremely important, many HVs embrace other professional 'domains.' Environmental control is situated within a public health approach, based on the search for and assessment of health needs. This process can help identify priority areas for HV and others. Psychological development refers to the individual but non-directive approach that many HVs use in supporting parents making their own choices. Emancipatory care encompasses a collective or community approach. Parents support or mother and baby groups exemplify this approach. Different perceptions of these domains has caused much debate about the direction of HV. Moreover, each domain incorporates a different model of health. Whilst some argue that this diversity has allowed innovative practice to flourish, others claim that it has eroded a distinctive HV identity.

Twinn sees the overlap between each domain but suggests that it is the inability "to adopt a practice-appropriate paradigm [that] has contributed not only to the inadequacy of health visiting in meeting the challenge of the current health needs, but also to the crisis of confidence in the profession" (p969). Changing health needs, social structures and government policy demand a revised balance between each domain. Twinn explains that HVs must continually re-evaluate their work according to these domains but also the profession must equally re-interpret its role. HVs, individually and collectively, need not become

attached to one domain but rather gain an understanding of the principles of each. Twinn advocates that HVs do this by 'reflection in action', a mixture of theory and practice (Schon, 1983).

2.4. HV Tasks

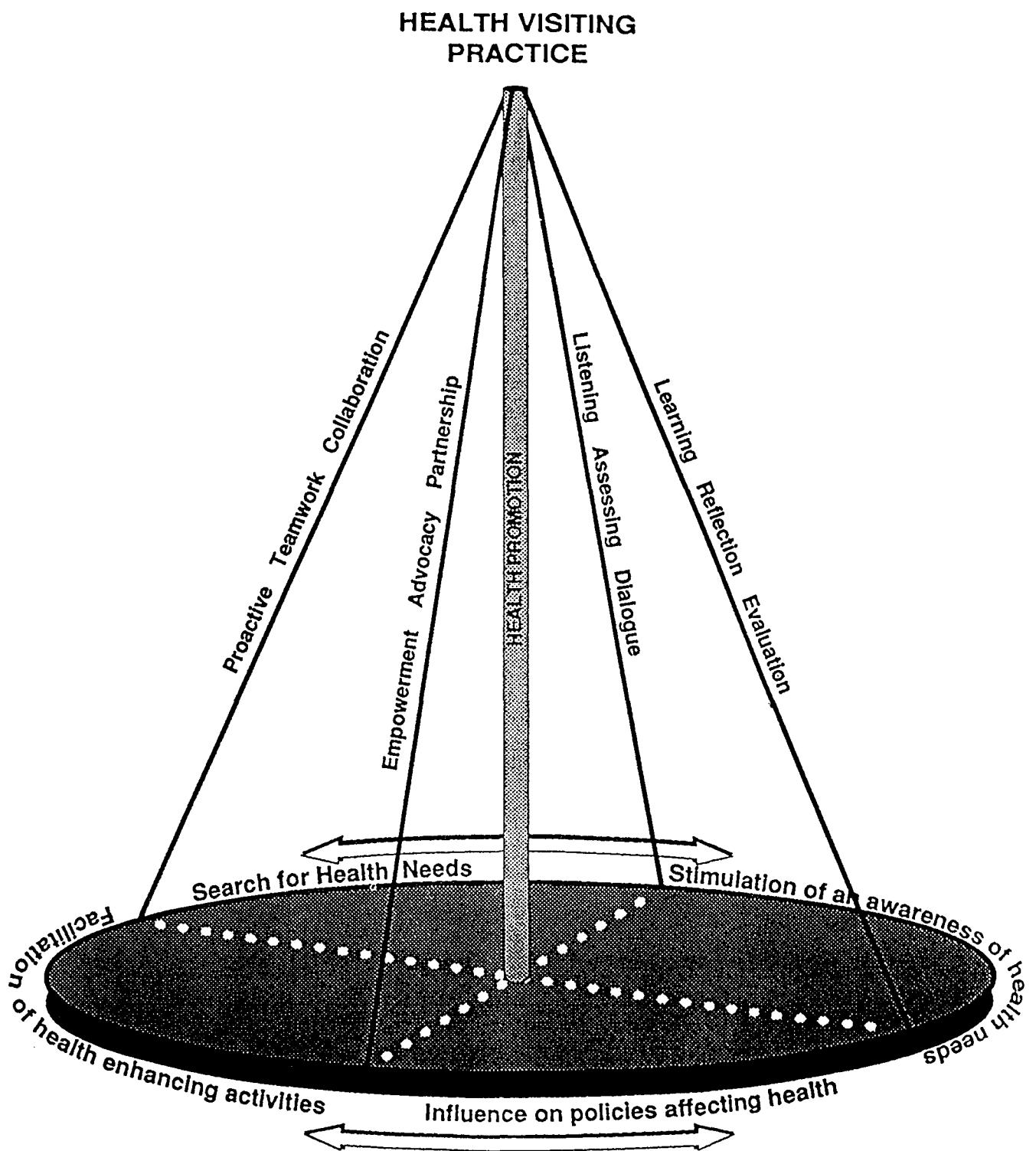
Twinn and Cowley (1992) report that the Health Visitor Association identifies four key principles which should guide the profession:

- * "the search for health needs
- * the stimulation of an awareness of health needs
- * the influence of policies affecting health
- * the facilitation of health-enhancing activities."

These principles were formulated in the 1970s but considered still valid in the 1990s. Though interlinked, single principles could be dominant within a "particular health visiting activity, or at a particular point in time" (p12)(see figure 2). The HVA (1992) recognises that "past experience has shown that attempts to specify the scope of health visiting or community nursing are open misinterpretation" (p7).

Although it is misleading to catalogue HV tasks, this was done in the DoH pilot project of the GPFH extension of CN in Ivybridge (Devon). A reason for measuring and accounting for the tasks undertaken by HVs, *inter alia*, was for financial and budgeting purposes. This is not the most appropriate basis for identifying HV roles.

Figure 2 Pictorial representation of the relationship between the principles of health visiting and the practice



From: Twinn and Cowley (1992) p.14 (fig.1)

The Ivybridge project: 6 types of HV task:

	% total activity
* advice and support in relation to health care	74 %
* advice and support in relation to social need	2.4%
* advice on health promotion	1.5%
* other advice	3.4%
* technical tests	12 %
* others (telephone, client not at home)	6.4%

Source: EL(92)48, Annex B, p.12.

The percentages represent the total activity (4,600 visits and contacts) spent on these tasks over an eight month period (August 1991-March 1992). The time HVs spent on 'liaison relating to Ivybridge health centre' varied from 21 to 41 hours per month (average 31 hours, 7.2 hours per week). (This figure might not be totally inclusive of their time). The time HVs spent on 'non-treatment activities' varied from 95 to 184 hours per month (average 140 hours, 32.5 hours per week).

The HVA (1981, 292) set out three categories of priority tasks in HV:

- * tasks recommended for HV working within "severe staff shortages",
- * additional work for those "under only average pressure",
- * tasks for those HVs "who may, one day, have really small case-loads."

Whilst the first category may be uncontroversial (eg. "urgent home visiting"), the second and third raise some difficulties. The definition of 'average pressure' would thus demarcate the resources put into "follow-up of immunisation failures" or "further liaison with hospitals and professional colleagues." 'Small' case-loads may be an unattainable goal but some tasks such as visits to play groups and nurseries are often done now. Time effectively limits activities to core tasks. Whether health promotion or education is included here is questionable. The activities whose benefits take longer to become realised may be overlooked. It might thus become more likely that child-oriented services are maintained whilst health promotion activities are reduced. White (1987) argues that it is misleading to talk about HV roles as these vary from area to area.

It is useful to consider how HV contracts may be drawn up as an indicator of how they functions and roles may be operationalised. For example, the HVA (1992) identify three different types of HV contract (see table 3):

Table 3: Contracting for Health Visiting services.

a. Activities-based contract:

Characterised by:

- pre-determined protocols and lists of screening procedures,
- groups of clients who are to receive HV services,
- number of home visits or contacts to be offered,
- strict controls but no way of evaluating effectiveness.

b. Current practice-based contract:

Characterised by:

- explicit formulation of objectives of the services,
- detailed underpinning philosophy,
- assumption of flexibility in practice,
- evaluation by examining outcome for client.

c. Needs-based contract:

Characterised by four sequential stages:

- initial stage of completing health needs profile,
- discussion of identified needs, priorities drawn up,
- specification of health promotion targets and planned approach,
- identify measurable objectives/outcomes, set date for review.

From: HVA (1992), Appendix. 1.

Recent HV history has shown that the profession needs to adapt its roles and tasks to the changing needs of its perceived population. Infant mortality rates have declined in overall importance but there are pockets where it may still be a significant factor. With health promotion and primary care being given more political import, HVs are well placed to support these changes. However, there are now more stakeholders in health care and so HVs need to state clearly their professional direction. Whether HVs can follow the path that they set for themselves is debatable. White (1987) urges HV managers to gain professional (cf. managerial) authority by discussing with their staff "a philosophy and a policy for that particular area" (p167). In advising that this policy should be reviewed and agreed with the District managers, White anticipated the contracting system introduced two years later. DHA (purchasing) managers have a large input into the direction of HV in their area as contracts will shape the balance between individual and collective, directive and non-directive work (Twinn, 1991). HV managers must now also consult with GPFHs about the philosophy and policy for different areas.

2.5. School Nursing

Although School Nursing is not formally part of this Briefing Paper, the results of a recent RCN survey illustrate how the roles of HVs and School Nurses are increasingly becoming

linked. In 60 DHAs surveyed, many had reduced the number of school nursing posts, frozen posts or appointed new staff for reduced hours or on lower grades (HSJ, 1992b). Of particular significance was the merger of HV and school nurse roles by some health authorities.

In terms 'Health of the Nation', HVs and school nurses would seem crucial elements in ensuring the success of the strategy. That the health promotion role of school nurses is being undermined, according to the RCN survey, does not place health promotion near the top of the agenda. Increased nursing numbers and/or reduced caseloads would be the obvious way to tackle this.

3. DISTRICT NURSING

3.1. Brief History

In 1862, Rathbone established a training school in response to Liverpool's social conditions. Nurses were assigned to 18 'districts' (hence DN), "based on groups of parishes, for organisational purposes" (Ottewill and Wall, 1990, 31).

The success in Liverpool spawned several other services across the country. Training developed as DNs were working without the immediate support of colleagues as in hospitals. Liverpool DNs spent three months in hospital to refresh their knowledge and up-date their skills.

The 1946 Act required health authorities to secure nursing services for those requiring it in their homes. This extended DNs' remit from certain categories and encouraged their direct employment. Previously nearly half worked with voluntary nursing organisations (Ottewill and Wall, 1990, 149). The DN attachment to GP practices, in the 1950s onwards, was facilitated by increasing DN numbers and health centres. The distribution of DNs was geographically uneven and did not always coincide with the patterns of need.

In a time of increasing skill shortage (due to government advice that one DN per 4,000 population was a suitable target in most areas), a survey published in 1966 found that:

- * DNs spent relatively little time with patients but more on travelling and administration,
- * much DN work did not require their professional skills,
- * DNs had relatively little contact with GPs, hospitals etc,

"Although there have been changes in the district nursing service since the mid-1960s, a number of these findings have a depressingly familiar ring about them" (Ottewill and Wall, 1990, 155).

Despite increasing DN numbers, there was a faster increase in demand. In 1986, some areas had not reached the 1972 DHSS target of 1 DN per 4,000 or 1:2500 in high need areas.

Early hospital discharge and hospital-at-home increased DN workload. Other service developments included 24 hour cover, increased specialisation (eg. incontinence care) and care of older people. The 1981 decision to make DN mandatory also enhanced DNs' profile in primary care.

3.2. Current Issues and Future Prospects

Although DNs' roles are less ambiguous than HVs' and perhaps less likely to radically alter, the changing pattern of need and service organisation has forced DN to consider modifications. Other professions (eg. physiotherapy) are working in the community which may undermine DNs' position. This is applicable in home care services where Social Services Departments (SSDs) have often overlapped with those by Community Units (eg. bathing older people).

Many concerns between DN and home care services have resurfaced tensions between definitions of health and social care (in 'Caring for People'). Following work in **West Birmingham**, Evers *et al* (1992) suggest that "it is a mistaken approach to attempt rigid definition of 'non-nursing, social care'" since this ignores individual circumstances. 'Extra care' may be a better term for nurses' activities than include their non-nursing or social roles. Whilst extra care tasks are numerous, they can only be defined according to clients' needs. They include food preparation, washing, personal care and toileting. Individual needs are determined by whether anyone else can help and whether the client is able to do the task themselves. This puts tasks into four categories: *essential, desirable, optional and proscribed*. DNs would take decisions regarding which category each client was in. It is important that DN and home care services follow these guidelines.

Hughes (1990) reports that, in **Halton**, workshops with DNs identified five main areas of DN work. They were immediate, skilled, unskilled, advice, and support/training of carers. Information systems showed how much time DNs were spending on each area. As part of a skill mix review, DNs debated whether these proportions were appropriate to their grade and whether their skills were being suitably employed. Such exercises are part reactive and part proactive, basing future work on an ideal but starting from existing patterns.

Specialist nursing posts has led some DNs to feel that their profession is under threat and liable to fragment. Some fear that the unwillingness to take a 'political' role to advance their profession in the light of many other changes will damage their professional basis (Young, 1988). However, until recently, DN was able to claim some areas of work that they alone occupied but now more groups work in the community.

Factors Affecting Both HV and DN

HV and DN are affected by common developments and policies. These include skill mix issues, the fundholding extension, the tasks of practice-based nurses and the trend towards generic community nurses.

4. SKILL MIX

Skill mix, the make-up of a unit's staff in terms of grade, cost and nursing skills, is a highly contentious issue. It would be difficult to do justice to the topic in this Briefing Paper. Recent literature (Audit Commission, 1992; VFM Unit, 1992; Laurent, 1992ab), raises issues regarding skill mix in community units.

Variations in the grades of nurses between and within Districts are usually historically-based and liable to incremental changes. The Audit Commission (1992) recognises that, with increasing demand, community units will have to justify the balance of staff since the opportunity cost can be significant. For example, DN salaries in 1988/89 totalled £250m but this would rise to £260m if all units used the 'richest' mix as observed in one DHA, or would fall to £230m if the most diluted mix observed was used. Among six DHAs observed, the percentage of DNs (grade G and above) varied between 65% and 37% approximately. The variation within localities in one selected DHA was similar. Between the most DHAs observed, there were opportunity costs of about £330,000 and £260,000 for the most 'rich' and 'dilute' skill mixes respectively. Most DHAs could have saved about £150,000 each by altering the skill mix of DNs alone.

Difficulty arises in determining skill mix because a richer mix does not ensure better quality services, nor vice versa. For example, higher grade nurses, though more expensive, might be able to keep clients at home longer, thereby obviating the need for acute admissions and hence expenditure. Determining the balance of nurses and their grades is a complex task since information is often incomplete and ambiguous.

The ability to change the existing pattern of nursing to one based on need will be difficult as many CNs will see changes as threatening: "I have never heard of a skill-mix review that says... 'Yes, you need more qualified nurses'" (Young quoted in Laurent, 1992b). Some see skill mix reviews as attempts to reduce budgets and the number of a particular grade, rather than a method to match nursing skills and levels to need. Some see reviews as a way of fragmenting nursing into separate tasks that should not be carried out by a certain grade of nurses.

Perhaps more threatening within a unit is the possibility that skill mix reviews may persuade managers and GPs that the advantages of employing practice nurses and/or nurse practitioners outweigh the disadvantages. Skill mix issues closely relate to professional identity and direction. The moves towards generic nursing might be thus be increased.

With poor information systems and little knowledge of local nursing outcomes, community units will find it hard to justify changes to the skill mix of CN, especially if more expensive. However, the extension to fundholding will alter HVs' and DNs' perceptions regarding staffing changes. Thus an incremental process of change may be expected as the skill mix is adjusted in an attempt to move towards an 'objective' position that reflects local needs. It is doubtful whether localities and GPFHs will be able to adjust greatly the mix of nursing skill within their area, at least in the short term. Constraints such as the availability of local staff, the financial resources and the information upon which to make decisions will limit the objectivity of decisions. Training and recruitment will aid the longer term changes in overall skill mix. Such factors do not mean that change will not occur, rather decisions might not be

as soundly based as they could be.

The recent NHS ME report ('The nursing skill mix in the District Nursing Service', 1992) mainly considers "good practice at provider level" although it recognises that "progress will be via negotiated agreements between purchasers and providers." Various local study sites indicate "the lack of correlation between the grade mix in District Nursing and the nature of the current anticipated workload." Drawing on 'successful' examples, the report considers a "structured and systematic methodology for the achievement of change" within local circumstances.

5. EXTENSION TO G.P. FUNDHOLDING

Whilst the contracting of CN occurred since April 1991, much attention has been devoted to the acute sector (perhaps to the neglect of community services), partly because of the difficulty in specifying and measuring the workload of community services.

The extension to GPFH raises difficulties regarding the contracting of, *inter alia*, community nursing. Issues to be addressed include the role and direction of community nurses, their tasks and contribution to PHC teams (cf. other staff eg. practice nurses), their public health function, their referral practices and their cost-effectiveness. Other issues include the transformation of GP-nurse relations when a contractual relationship has been formed (eg. in referral patterns) and the establishment of protocols between GPs and nurses regarding the latter's referrals being charged to the GPFH expenditure (under the Hospital and Community Health Services (HCHS) element).

The GPFH has also focused attention on the quality of CN services. Quality issues in CN contracting have included some or all of the following:

- * improved communication (acknowledgement of referrals within a certain time),
- * defined response times for visits,
- * targets for wound healing,
- * specified grades of staff to do certain tasks eg. bereavement,
- * targets for clinical outcomes,
- * agreement on how much of budget is to be spent on administration,
- * specified arrangements for cover during leave/sickness,
- * practices to be involved in selection of staff,
- * specific information which nurses must report back to the practice.

(Adapted from Medeconomics, 1992)

First Year and Beyond

Constraints have been placed on the contracting process for the first year. GPFHs are limited to "fixed price, non-attributable" block contracts with established NHS providers. GPFHs must contract for a "level of service equivalent to those which are currently available" (Wessex RHA, 1992). The provider need not be the one from whom community nurses are currently deployed. The competition between community units will, in practice, be rather limited, especially in rural areas. GPFHs on the edge of DHA boundaries will have more scope than others.

Various possibilities have been discussed regarding the direction of future providers of community nursing. They include:

5.1. GP Employment of Community Nurses

A possibility under GPFH might be the further employment of practice nurses/nurse practitioners at the expense of a provider's HVs or DNs. Many see GPFH contracting of CN as the first stage towards their full employment. (This scenario has been rejected by the DoH (EL(92)48, para.6.8) but projects (eg. in Lyme Regis, Argyll and Clyde) give some credence to nurses' claims). Fears relate to the control of one profession by another but also to the increasing entrepreneurialism of health care, treating the practice as a business (eg. non-medical staff as partners in a practice (Pulse, 1992)).

If (practice/community) nurses are increasingly employed and/or contracted by practices, the need to ensure that all members of the primary care team are working towards the same goal and share a common approach to referrals, good practice and 'house rules' will be greater. The issue of referral practice could be critical since even under the GPFH extension the cost of all referrals by CNs will be deducted from the HCHS budget. (Practice staff costs derive from the GMS budget). Protocols should thus be established but there might be some duplication of work between practices. Preparatory work by public health departments on protocols might be beneficial to practices. Savings of GPFH budgets, arising from CN, would need clarification. If CNs were saving the practice money, there could be a case for increasing the nursing numbers or enhancing the team's skill mix.

Nurses (CN/PN) employed in practices would be separated physically and professionally from other colleagues which may be detrimental to their professional development. Safeguards would need to ensure that regular training kept them aware of local and national changes. Training will remain the responsibility of employing agencies (usually community units). The cost of CN contracts might deter GPFHs from continuing CN contracts in favour of PN employment. Dyson (quoted in MacLachan, 1992) claims that "prices being quoted to fundholders for community services involved a 140 to 200 per cent mark-up on the salary costs involved." Dyson adds that these would need to be reduced as too much was being spent on management and training.

Despite possible under-expenditure of nurse referrals, **North Western RHA** has not included an element in GPFH budget for referrals from contracted CNs (Pulse, 1992). Due to uncertainties about financial and referral estimates and gaps in information, it was decided

that this money should be retained by providers. This does not obviate the need for protocols but rather takes the responsibility away from general practice. It is expected that referrals will be included in the second year.

Work has started on a pilot project in the **Argyll and Clyde Health Board** exploring the possible managerial and professional arrangements for CN in GP settings. The project involves 15 practices, divided into three groups. The first group is "a model of the Primary Care Team which would make health visitors and district nurses attached to the practices managerially responsible to the general medical practitioners." Basically this is a pilot employment of CN by GPs. The second group involves the community unit entering into "a 'service agreement' with the practices concerned." This is comparable to the current GPFH extension from April 1993. The third group of practices will "act as the 'control practices' for groups 1 and 2 and will continue to operate the existing system" (Argyll and Clyde Health Board, undated, p4). The operational phase began in October 1992 and will conclude with a report in October 1993.

5.2. Public Health Role of CN

Additional purchasers (GPFHs) have focused attention on the issue although the issue affects non-GPFH equally.

A distinction of public health duties might be between tasks undertaken inside or outside the practice's remit. There are certain difficulties in using such a definition as it is based on whether patients are registered with a GP or not. A patient living in the 'catchment' of one GP may not be registered with that GP. Likewise, a HV may conduct 'public health' duties with a mixture of registered and non-registered patients. Individual (cf. collective) approaches also make distinctions misleading. A task-oriented definition of public health duties of HVs does not seem to clarify the situation either. If CNs work in patches that correspond closely with GP practice 'zones', there will be less need for traditional public health tasks. The practice can thus form the basis of public health roles.

Twinn's (1991) approach recognises that HVs have a role in 'environmental control', a key feature of which is the 'public health model' (see table 2, p.7). "In adopting this approach, practitioners must establish the health needs from a health profile of their community, and use the findings to determine and target priorities and practice" (Twinn, 1991, 968). This suggests a role for HVs which overlaps, to some extent, with those functions of health care purchasers/commissioners. Not only is this approach a directive one, but it also moves HV away from a concern solely with one client group (especially 0-5) (eg. public health nurse employed by Hartlepool/North Tees (HSJ, 12.11.92, p.S12)). The location of a HV's employment might be important in conducting public health duties. HVs in post could spend a percentage of their time on public health duties or a HV in each locality could undertake such functions.

'Public health nurses' have been used in Sweden for many years as independent workers, responsible for about 1500 patients (Borg and Ramklint, 1987). It appears that such Swedish nurses are akin to HVs in the UK. Their tasks of prevention and health promotion seem similar.

The DoH guidance for GPFHs does not clarify HVs' public health role: "collaboration between the different agencies concerned will also be needed to ensure... that the role of health visitors in particular in public health is recognised" (para.1.4). DHA responsibilities, which are delegated to HV via community units/trusts, include the "facilities for care of expectant and nursing mothers and young children; the facilities for the prevention of illness, the care of people suffering from illness and their after-care" (DoH, EL(92)48, para.6.13). However, when the GPFH contracts HVs, they assume some responsibility for the provision of HV services. The DoH suggest that practice should only be charged for those services for which it has been funded. This does not resolve the problem: for which services the practice should be funded? The Ivybridge project made no mention of public health tasks for HVs. Measures that it did use (eg. time spent on non-clinical time) are unsatisfactory substitutes.

Such uncertainties may be partly resolved by the type of contract between the community unit and the purchaser (GPFH or DHA). It relates largely to the emphasis upon a needs-based contract rather than an activities or current practice model (see table 3, p.10). In sequential stages, a population's needs are identified (in a profile) and priorities determined. A plan of health promotion and targets are then established and implemented. A review of outcomes completes the process of feedback.

This 'needs-based contract' offers a means of using HVs to be local 'public health' workers in a bottom-up process of needs identification and assessment. This would also accord with one of the DoH's 'principles for the provision of primary health care' (EL(92)69, Appdx 1): "needs assessment for primary health care nursing services." GPFHs would need advice about needs assessment from DHA purchasers. (Other principles include "accessibility and responsiveness, personal responsibility taken by the patient, coherence and acceptability of services, availability of health services in the community"). This principle incorporates several aspects including "local population profiles established by general practice-based primary health care teams,... analysis of caseloads (HV, DN, CPN etc.),... FHSA population database..., information held by LA SSD, voluntary and private sector providers, information on activity held by community units and hospitals, consumer surveys."

The DoH is undertaking CN-related projects. They have been completed or will report in the New Year. They include:

- * Moores Review of community nursing (early-mid January),
- * Value for Money Unit: study of DN grade mix (already published),
- * HV and DN establishment setting (by SPRU, York University) (early 1993)¹.

If the numbers of practice nurses continue to rise, there will be fewer trained or experienced nurses to work in community units. Combined with under-funding, the number of nurses being employed or sponsored is declining (Walker, 1991). There will also be relatively less 'traditional' HV work but this can then release HV to develop public health and community development roles. Hartlepool and North Tees authorities (public health department) will employ a public health nurse ('I' grade) to be involved with prevention of spread of infectious diseases. Such a post recognises the work to be done outside a general practice setting, i.e., within the population at large. Most contracts assume CN are employed within the community

units and that some proportion of their time (say, the equivalent of one day per week) is spent on 'public health' duties. PNs' workload is entirely drawn from a practice list.

The public health role of DN is much smaller and less contentious than HV. It might include advice to residential homes and day centres. Further work might arise from the identification of needs undertaken by HVs.

5.3. Nursing 'Agencies'

Klein suggests that nurses (including practice nurses) may establish themselves as an NHS trust (agency) in a particular area to carry out 'ordinary' nursing tasks and to do some routine GP procedures (HSJ, 1992; GP, 1992). Nurses would 'compete' with GPs for certain tasks such as minor injuries or screening. Health promotion would be one area where HVs especially could replace much of the work of GPs. CNs could undertake one or more of the 3 new health promotion 'bands.' GPs could pay HVs to do this work. Increased nursing functions might become necessary as the number of entrants into general practice fall. Such a scheme would radically alter the basis of teamwork in primary care, making it largely redundant in favour of competition between professionals.

A recent report by **North East Thames RHA** (1992) outlined an option involving 'businesses', developed by a network of GPs, purchasing primary care. Although GPs cannot currently employ community health service staff, an independent company could bypass such requirements. Specialist community care businesses could meet the needs of particular client groups.

Simon (1992) describes one example of where community nurses run a nurse only clinic in **Manchester**. It began in 1989 with four 'F' grade nurses working as a 'minor injuries treatment clinic', the justification being that half of those who attended a local 'A&E' (before it was closed) came with minor injuries. Three HVs and five DNs now work from the clinic. It is staffed all year from 9am to 9pm, seeing nearly 400 people per week. GPs do run certain sessions at the clinic but as most of the local GPs have no practice nurses, they are able to refer to the nurses at the clinic.

6. PRACTICE NURSES AND NURSE PRACTITIONERS

6.1. Background

Practice nurses (PNs) have been in existence since the 1960s although it has only been recently that their status and training has been fully acknowledged. Many developments in PN have been with support from certain GPs. Some still remain sceptical. (In 1981, 35% felt threatened by nursing's extended role (Bowling, 1981)). Until recently the nursing profession was generally suspicious of such developments, fearing that their identity would be compromised if they moved into areas where medical and nursing roles overlapped (Bowling, 1981).

However, many PNs do not feel compromised by employment by GPs but rather innovators of new practice (Traynor, 1991). Surveys suggest that PNs have high levels of *perceived* responsibility and job satisfaction. In a Nottingham study, 75% of PNs felt they had high levels of responsibility compared to 49% of DNs. Podmore (1992) reports a survey which found that all CN groups were satisfied in their jobs but PNs and DNs found work significantly more satisfying than HVs.

Walker's (1991) study suggests that the average age of PNs is 39. Podmore (1992) explains that one tenth of PNs are aged over 55 years and indicates that 76% hold RGN qualifications and that 53% are 'G' grade nurses. (The next highest group are 'F' grades (29%)). On average, PNs work 24 hours per week, one third being in full-time employment (Walker, 1991).

PN's rising numbers indicates the changing patterns of nurse employment. PN numbers have risen from 4,000 to 7,500 WTEs (about 14,000 in total) between 1988 and 1990 (NHSME, 1991). DNs total around 14,000 (Taylor, 1991). This is partly explained by the 70% reimbursement that GPs get from the employment of practice staff from the FHSA. This has been available since 1965 but FHSA can now set their own rate. Cumberlege advocated that this reimbursement should be phased out. Walker (1991) reports that one FHSA has set a rate of 60%. This partly reflects the end of the 'honeymoon' period as attempts are made to cash-limit primary care. Such rates would need to recognise the contracting process with other CN groups.

6.2. Tasks

Although the RCN defines PNs as those nurses employed by GPs to work in treatment rooms, there is a wide variety of tasks that PNs undertake. In a study by Greenfield et al (1987), 300 PNs were found to undertake 500 different tasks, ranging from 3 to 52 tasks for any one nurse, usually dependent upon the their skills and training.

Greenfield et al (1987) found that PN claimed responsibility for the treatment of minor injuries (70%) and hypertension (52%). Significantly many more said that they could manage either problem with "appropriate training."

Walker's study identified PNs' tasks according to their frequency with which they were conducted.

Table 4: PN tasks by frequency

Procedures ranked by frequency:	Percentage:
1. Dressings, ear syringing, injections	81
2. Vaccinations/immunizations	70
3. Well women/man clinics	63
4. Health education/advice	41
5. Blood pressure monitoring	35
6. Sample colection/venepuncture	35
7. minor ailments/non-acute support	33
8. Family planning [*]	30
9. Counselling	22
10. Baby and ante-natal clinics	20

[*] 30% PNs had a family planning certificate and 30% worked in family planning clinics. Only 28% of employed staff in Hampshire FHSA reported having completed the Family Planning Certificate within the last 5 years (Hants FHSA, 1992).

From: Walker (1991, table 1).

Fowler et al. (1988) discuss the 'extended role of PNs in preventive health care, using the Oxford Prevention of Heart Attack and Stroke Project as a case study. PNs were used within the practice to screen patients for these conditions. Improved ascertainment of risk factors enables such factors to be controlled. Control of hypertension, for example, can reduce the incidence of strokes (Fowler et al., 1987, 86). Also the work of PNs can be thus greatly developed.

Although many PNs claim that they would be willing to take on new areas of work, evidence regarding the public perception of PNs appears contradictory. Taylor (1991) claims that patients are less likely to raise clinical problems with nurses than GPs but Wenger (1986) found that older people "revealed symptoms and worries to nurses that they concealed from their GPs." American research indicates that PNs can successfully help those with chronic conditions (Molde & Diers, 1985). Taylor (1991) sees the extension of PN work to chronically ill people in their own homes as being desirable.

6.3. Training

Despite the problems of nursing staff recruitment and shortages in the 1990s, the training issues of PNs demand increasing attention. Walker (1990) identified an immediate need for "recordable and mandatory training" for PNs. The RCN has agreed to cover PNs for those tasks they were "competent" to perform. However, GPs still take responsibility for many areas where the boundaries of responsibility are uncertain. Although the 1990 GP Contract required then to ensure that GP-employed nurses were 'appropriately qualified', this begs the question of what training is necessary. Walker (1991) calls for a mandatory course for new

PN recruits on a day release basis of 20-30 days in their first year.

The English National Board's report (1990) recommended more focused PN training within four strands:

1. employer-led induction programme,
2. PN course (recognised by UKCC),
3. continuing education,
4. opportunities for professional/academic study.

The East Sussex strategy (1992) advocated "a national framework that allowed for local flexibility, that had equal standing with other community nurse training, with a common core but not necessarily of equal length." Nationally recognised qualifications were central.

Walker (1990) sees Project 2000 as being crucial in developing new forms of PN training. "A nurse with at least one year's clinical experience might wish to take on further responsibilities such as are currently carried out by health visitors, district nurses and most experienced practice nurses. A community nurse practitioner [not PN] might replace the present variety of nurses in the community, who each require specific training." Nurse Practitioners differ from PNs in that the former demonstrate autonomy in PHC: the former working with rather than for GPs, accepting personal professional responsibility rather than expecting the GP to take responsibility (Bowles, 1992). After one or more years experience, courses would lead to community practitioner status. Walker (1991) suggest that this option, spread over 2-3 years, would cost less than full-time sponsorship although more than PN training.

6.4. Management and Development

Atkin and Parker (1992) see the management and development of PNs as critical and raise five issues regarding it:

1. "how DHAs and FHSAs see their role in relation to the growth in the number of practice nurses,
2. how GPs influence the nature and development of the work that practice nurses do,
3. how GPs are discharging their duty under the new contract to ensure that practice nurses are appropriately qualified and receive training,
4. what the majority of practice nurses want from their work and how they can best be accommodated,
5. what role practice nurses might have in the delivery of community care."

Given the potential for fragmentation with two broad groups of nurses working in the community under different agencies, these issues need to be addressed, especially in Wessex's Commission structure e.g. the reimbursement rate for PNs. Taylor (1991) claims that the strength of Community Units was their ability to identify, coordinate and manage nursing care. He adds, if there were variations in service organisation, then patients would be unaware of what was available, how to secure access to services. When there is a proliferation of service organisation and structures, it is vital that 'primary medical care' and community nursing are integrated and continuous.

The rise in numbers of PNs, employed by GPs, necessarily has an impact upon providers and DHA purchasers. There will be a need to compensate in contract with community nurses since some needs are being met by PNs. However, this demands that the skills of such nurses in different areas are taken into account so that the DHA can compensate by contracting with providers for areas (geographical and service-related) where there are deficiencies. Surveys of practice nurses (eg. East Sussex FSHA, 1992; Atkin and Parker, 1992) can help identify local skills. Thus different CN can achieve common standards and coordinated services.

A project based at the **Premier Health Trust, Tamworth** is exploring two possible models of PN-CN management. Based on two practices, one team of nurses working at or with the practice is led by a HV whereas at the other, a PN is leading the team. The Project hopes to identify areas of overlap and support and also clarify the role of the nurse leaders.

Areas of PN (and other CN) development that must be addressed in the near future include:

1. Partnership status

- * currently non-medical staff cannot become partners in a general practice but the notion of a multi-disciplinary partnership could extend to CN, fundholder managers etc.

2. Nurse prescribing

- * originally from autumn 1993 (but now deferred), nurses will be able to prescribe a limited range of drugs. The impact that this will have on GP practice and primary care costs is uncertain. It can be seen as part of a broadening of nurse practice.

3. Minor treatments

- * many nurses undertake tasks that are beyond their training but not their competency. Nurses undertaking minor treatments (see Simon (1992)) could help relieve GPs of routine workloads and could be combined with GP undertaking more practice-based minor surgery.

7. CONCLUSION

This Briefing Paper has skimmed over many issues and has deliberately not explored too deeply into any of them. Although the Paper was initially aimed at the extension to GPFH,

it was found that those issues were closely related to many other developments in CN. The shift towards broader issues has made the Paper an introduction to more in-depth reviews of particular aspects of CN including PN. It is therefore hoped that Consortium members will identify areas of interest and relevance that can be subsequently explored. Comments regarding the Paper would be most welcome.

There are a number of areas that I think would be applicable in any further study. These would be topics that appear important to me but would have to be negotiated with Consortium members. These topics include:

- * evaluation of GP contracting of CN after April 1993: particularly an assessment of the changing referral pattern of CN, before and after April '93.
- * assessment of the impact of skill mix changes in GPFH practices (and elsewhere),
- * analysis of the public health role of HVs,
- * analysis of different models of CN employment.

Footnote:

1. **HV/DN establishment setting project:**
at Social Policy Research Unit, York University.

This work predates the decision to extend fundholding to CN but it still reveals recent practices. Involving over 50 purchasers and more than 200 providers in all 14 Regions, initial results suggest that establishment setting was dominated by historical precedents and changes to staff levels were incremental. Revenue budgets were based on staffing. The study noted a shift in policy away from staffing levels *per se* and towards a concern with funding and nursing needs. Practice nurses were seen as a critical factor in determining the levels of Hvs and DNs.

Purchasers usually had a poor grasp of CN, being preoccupied with acute issues. Some DHAs had liaised with FHSAs to strengthen CN locally. Although establishment setting was deemed a provider issue, many DHAs were directly influencing providers.

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References

Argyll and Clyde Health Board, undated, Provision of CN services by and to General Medical Practitioners.

Atkin, K. and Parker, G. (1992) A national census of practice nurses." *Nursing Standard*, 15 April 1992, pp22-23.

Audit Commission (1992) Homeward Bound: a new course for community health. [HMSO, London, April 1992]

Beattie, A. (1988) Knowledge and control in health promotion: a case study in social policy and social theory. (Calman, M., Gabe, J. (eds)) Paper for conference on sociology of the health service (ESRC/BSA).

Borg, B. and Ramklin, G. (1987) Public health nurse - the core of primary health care? Chapter in Littlewood, J. (ed) Recent advances in community nursing (15) [Churchill-Livingstone, Edinburgh]

Bowles, A. (1992) What is a nurse practitioner? *Practice Nurse*, April 1992, p635.

Bowling, A. (1981) Delegation to nurses in general practice. *Journal of the Royal College of General Practitioners*, 31, 485-490.

British Medical Journal (1992) Medicopolitical Digest: New health promotion package. *BMJ*, 305, 28.11.92, p.1369.

Chalmers, K.I. (1992) Giving and receiving: an empirically derived theory on health visiting practice. *Journal of Advanced Nursing*, 17, pp1317-1325.

Clay, T. (1989) Clay on the review. *Nursing Times*, 85 (6), p21.

Cumberlege Report (1986) Neighbourhood Nursing: a focus for care. [HMSO. London]

Denny, E. (1989) The future of health visiting. *Health Visitor*, August 1989, vol.62, pp250-251.

East Sussex FHSA (1992) The way forward: practice nursing in East Sussex. A strategy developed with Practice Nurses. [July 1992]

English National Board (1990) The challenges of primary health care in the 1990s: a review of education and training for practice nurses. The substantive report. (ENB, Sheffield) (Damart Report)

Evers, H., Badger, F. & Cameron, E. (1992) Finding the limits. *Nursing Times*, vol.88, no.30, 22 July, p60-62.

Fatchett, A. (1990) Health Visiting: a withering profession? *Journal of Advanced Nursing*, 15, pp216-222.

Fowler, G., Fullard, E. & Muir Gray, JA. (1988) The extended role of practice nurses in preventive health care. Chapter 8 in Bowling, A. & Stilwell, B. (eds) The nurse in family practice: practice nurses and nurse practitioners in primary health care. [Scutari Press, London]

G.P. (1992) Nurse practitioners could compete with GPs. 23 October 1992, p19.

Greenfield, S. et al (1987) Practice nurses: social and occupational characteristics. *Journal of the Royal College of General Practitioners*, 37, pp341-345.

Hampshire FHSA (1992) General Practitioners Practice Annual Report 1991/92. [November 1992]

Hockey Report (1966) Feeling the pulse: a survey of District Nursing in six areas. (Queens Institute of District Nursing, London)

Health Service Journal (1992) RCN warning on school nurses, 12.11.92, p4.

Hughes, J. (ed) (1990) Enhancing the quality of Community nursing. [Kings Fund Centre, London]

Health Visitors Association (1981) Health Visiting in the 80s. [HVA, London]

Health Visitors Association (1992) Principles into practice: an HVA position statement on health visiting and school nursing. [HVA, London]

Jameson Report (1954) Report of a working party on the field of work, training and recruitment of health visitors. [HMSO, London]

Laurent, C. (1992a) Assistants for the future. *Nursing Times*, vol.88, no.43, 21 October, p66-67.

Laurent, C. (1992b) Mixed feelings. *Nursing Times*, vol.88, no.30, 22 July, p57-58.

Laurent, C. (1992c) Health Visiting revisited. *Nursing Times*, vol.88, no.34, 19 August, pp18-19.

MacLachlan, R. (1992) Let me through, I'm a fundholder. *Health Service Journal*, 17 December 1992, p.15.

Medeconomics, Fundholding supplement, The fundholding-community Nursing Guide, 7 September 1992, pp 17-20

Molde, S. and Diers, D. (1985) Nurse practitioner research: selected literature review and research agenda. *Nursing Research*, 34, pp362-366.

NETRHA 1992 Integration of primary and community care in east London: report to NETRHA by Office for Public Management.

NHS Management Executive (1991) Integrating Primary and Secondary Care. [NHSME, London]

NHS Management Executive (1992) Guidance on the extension of the Hospital and Community Health Services elements of the GP fundholding scheme from 1 April 1993. (EL (92) 48).

NHS Management Executive (1992) Development of primary and community care - support for commissioning of nursing services. The Value for Money Unit study - "The District Nursing Grade Mix." (EL (92) 69) (23.10.92).

Ottewill, R. and Wall, A (1990) The growth and development of community health services. [BEPL, Sunderland]

Podmore, J. (1992) What practice makes almost perfect? *Practice Nurse*, October 1992, p354355.

Roy Report (1990) Nursing in the Community: report of a working party. [DoH]

Schon, D.A. (1983) The Reflective Practitioner [Basic Books, NY]

Simon, P. (1992) No doctor in the house. *Nursing Times*, vol.88, no.28, 8 July, pp16-17.

Stilwell, B. (1991) The rise of the practice nurse. *Nursing Times*, 87, 24, pp.26-28.

Stockport NHS Authorities (1992) An approach to locality-based primary care-led strategic management of health services. [Stockport HA and Stockport FHSAs]

Sylvester, J. (1992) 'Buy-in nurses?' *Nursing Standard*, vol.6, no.34, 13 may, pp20-21.

Taylor, D. (1991) Developing primary care: opportunities for the 1990s. [King's Fund Institute, Nuffield Provincial Hospitals Trust]

Traynor, M. (1991) Practice nurses: at the crossroads? *Nursing Standard*, vol.5, no.2, September 11, pp33-35.

Twinn, S. and Cowley, S. (1992) The principles of health visiting: a re-examination. [HVA/UKCC]

Twinn, S. (1991) Conflicting paradigms for health visiting: a continuing debate for professional practice. *Journal of Advanced Nursing*, 16, pp966-973.

Walker, M. (1990) Is there a future for a community nurse practitioner? *KF News: the newsletter of the Kings Fund*, vol.13, no.4, December 1990.

Walker, M. (1991) Is there a future for the community nurse practitioner? *Practice Nurse*, May 1991, pp11-16.

Wenger, C.G. (1985) Old age, health and formal domiciliary support: a first report of a follow-up study of the old elderly in North Wales. [Bangor, University College of North Wales]

Wessex RHA (1992) Extension of the Hospital and Community Health Service element of the GP fundholding scheme: Contracting for Community Nursing. (J.Hawkes, 19.6.92)

White, R. (1987) Health Visitors: the willing horses. *Health Visitor*, May 1987, vol.60, pp163-168.

Young, L. (1988) Reaction to Agenda for Action. *Journal of District Nursing*, October 1988, pp12-14.

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