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A STUDY OF DISTRICT NURSING

The development and progression
of a long-term research programme

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Submitted for degree of Doctor of Philosophy

The City University

Department of Social Science and Humanities.

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ABSTRACT

The thesis defends a long-term empirical research programme as a helpful way of studying the district nursing service.

The long-term programme consists of four separately published studies undertaken between 1964 and 1971. The studies were planned as a cohesive progression, the findings of one generating the next. The studies are summarised in the thesis but emphasis is given to those aspects which provided the link and the progression between them.

Progression in research design is demonstrated by the sequence of the studies from a limited descriptive exploratory approach to a study designed to test specific hypotheses, followed by a quasi-experimental study; the programme was concluded by a major national survey which showed progression in terms of its complex sampling method with resulting national applicability of the findings. Further analyses of the national data after completion of the programme are included and can be regarded as another stage in the progression.

Over the period of the programme a variety of data collecting instruments were designed; they include interviewing shcedules, postal questionnaires, diaries and several versions of instruments for the recording of district nurses' activities. The development of the most advanced and sophisticated of these instruments is described in detail showing its use and potential.

It is contended that a long-term programmatic approach is necessary if empirical research findings are to be helpful for the formulation and implementation of policy. A conceptual model, demonstrating this contention, is offered.

A research approach, which is not formulated within a specific academic discipline and not guided by a specific academic theory is

defended. It is submitted that it is legitimate and helpful to use established theory or a principle within a theory to explain empirical findings. Criteria for such a use are provided. Through the conceptualisation of factors known to be related to the type of care provided by district nurses, suggestions for further research are made. A long-term cohesive and preferably multi-disciplinary approach is advocated.

A review of the literature covering a 25 year period is included as well as a chronologically ordered bibliography which adds a historical dimension to the research programme.

NOTES

Abbreviations

The following abbreviations are often used for ease of expression and/or because they are part of normal nursing terminology -

SRN	State Registered Nurse
SEN	State Enrolled Nurse
RGN	Registered General Nurse (used in Scotland)
HV	Health Visitor
GP	General Practitioner
MOH	Medical Officer of Health
NHS	National Health Service
QIDN	Queen's Institute of District Nursing.

Statistical tests

Statistical significance tests were carried out where appropriate. The results are used to give verbal expression to the findings. No result is referred to as significant when the probability of it occurring by chance was greater than one in twenty cases, i.e., $p > 0.05$.

Gender for Nurse and for Patient

Nurse

For ease of presentation the feminine gender is used throughout the thesis. Male nurses were included in the studies.

Patient

The masculine gender is used.

Investigator refers to the writer of the thesis.

INTRODUCTION

The thesis propounds that a better understanding of the British district nursing service has been gained through a long term, cohesive and progressive research programme. It contributes to knowledge on two counts: -

methodological and substantive.

The methodological contribution lies in demonstrating the progression of research design and method in a way which was new to the nursing field. It demonstrates the systematic building up of knowledge from a deliberately planned sequence of individual studies.

The purposely designed research instruments show an increase in usefulness and sophistication over the period of the programme, which was a learning experience for the investigator. The design of a recording instrument for district nursing activities, which links nursing activities with patient characteristics (Chapter 9) is an example.

The substantive contribution lies in the progression of subject matter. The district nursing service had not been studied in a systematic manner before the programme began and the findings of each stage created new knowledge which, in turn, provided the basis for the next stage. It is argued that: -

a. cohesion and progression in research design are important factors in the systematic building up of knowledge and its potential usefulness,

b. empirical investigations which are not designed to test specific established theories are defensible,

c. selected theoretical propositions can usefully contribute to the explanation of empirical research findings and their use in this way can strengthen their validity.

The research programme, made possible through the creation of a research base covers the period 1964 to 1971 and includes four

separately published but related studies.[1,2,3,4] The studies represent cohesion and progression in design and content.

The first chapter in the thesis sets the scene for the research programme, it describes the base and explains the reasons for the initiation and direction of the research. The second chapter deals with the chronological progression of the individual studies and the structure underpinning their coherence. The meaning of district nursing is explained in the third chapter, which also describes the organisation of the community nursing services. The main part, Chapters 4 to 12, is concerned with the community nursing service as it was found to function on the basis of the empirical work undertaken by the investigator between 1964 and 1971. As the individual studies have been published, only those elements which led the investigator from one project to the next have been selected for detailed discussion.

Chapter 13 deals with theoretical issues. The research approach is defended and the relationship between theory and empirical data is discussed. Some findings related to the structure of the district nursing service, to teamwork and to the work pattern of district nurses are identified as requiring explanation. Theoretical propositions expounded by Blau, Mauksch, Durkheim and Kratz are invoked to provide tentative explanations, using as a basis the criteria suggested by Glaser and Strauss. (References are given in Chapter 13).

Conceptual diagrams are presented in support of three assertions made by the investigator;

i. Nursing is a unique contellation of other disciplines, the uniqueness lying in their qualitative and quantitative mix. The attempt by nurses to identify a unique theoretical foundation for

nursing is linked with this conceptualisation of nursing.

ii. Nursing takes place within a social and organisational context; many factors, apart from the nursing needs of patients, influence the type of care provided.

iii. Nursing research needs to go through a series of progressive stages before it can be appropriately used in policy formulation.

Conventionally, a research programme starts with a review of the relevant literature. In this instance, for reasons stated in the first chapter, such a review was not undertaken. A review of the literature published during the research programme (Part I) and since its completion up to 1978 (Part II) can be found in Chapter 14. Part I is arranged chronologically to add an historical perspective to the development of the research.

The concluding section which identifies the benefits of a long term programme, includes suggestions for further research.

Annexes 1, 2, 3 and 4 consist of further relevant material related to the four studies respectively. Annex 5 demonstrates some actual and potential uses of the national data base.

Addendum 1 shows the number of learners entering for basic nurse training courses over 14 years up to 1977.

Addendum 2 indicates important events relating to the district nursing service in the period

Addendum 3 summarises the main legislative and administrative changes since completion of the research programme.

The chronologically arranged bibliography is included to illustrate matters of concern and interest over time.

CHAPTER 1.

THE RESEARCH BASE AND FACTORS INFLUENCING THE DIRECTION OF THE RESEARCH

The research programme was begun in 1964 when the investigator was afforded the opportunity to develop a Research Unit under the auspices of the Queen's Institute of District Nursing. At that time, the Queen's Institute was in control of the training of district nurses in the United Kingdom. It exercised this control by determining the training syllabus, by approving centres for training, by setting and marking written examinations and by conducting practical examinations through its central team of Nursing Officers. The practical examination, which consisted of the Institute's Nursing Officer accompanying the student district nurse on a round of selected patients, enabled the Institute to retain a measure of control over the standard of the district nursing service. It was this relationship between education and service which proved to be a significant factor in the development and direction of the Institute's research programme.

It was recognised, by the Institute's Education Committee, that the training syllabus should be relevant to the needs of the service and in 1962 the Committee initiated a national survey of district nurse training which was undertaken by the author of this thesis. A report of the survey was prepared for internal use, (Q.I.D.N. 1963)[5]. The need for continuing investigations became apparent and the interest in planning and designing an extended programme of research was generated at that time. The broad remit under which the programme was developed was

> 'To ascertain the actual and potential contribution of the district nursing service to community care'.

The programme was directed by two main factors. The first of these was the need for knowledge which could be applied for the

benefit of the district nursing service. The second factor was the need to observe the fundamental rules relating to research methodology. The programme is described in its chronological progression, its underlying structure being explained in Chapter 2.

The most urgent problem requiring investigation at that time concerned the methods of sterilising equipment in the patient's home. A report of this study was published in 1965.[6.] It was the author's participation in that study which led her to the contention that the activities of members of an occupational group are not merely determined by the nature and type of the occupation, but at least as much (if not more so) by the individuals involved and by the organisational setting in which they operate. In other words, how people do their work is related to who they are, when and under what conditions they work and how they were prepared for it. The above contention had been generated initially by personal experience as a district nurse, as an administrator and as a teacher. As a practising district nurse it became obvious that work priorities and methods were not only individually determined but depended to a considerable extent on the policy of the employing authority. Administrative experience had shown that a change in policy, whether in terms of constraints, relaxation or direction had the capacity of altering the work content, methods and patterns of work of district nurses. At the same time, a change in policy, unless it was an explicit directive or rule could easily be ignored by district nurses who tended to create their own individual work regime. As argued by Jupp (1971)[7.] the district nursing service was a front line organisation, each member of the service taking clinical and managerial responsibility for her own group of patients and planning her own working day. As a teacher of district nurses it became abundantly apparent that it was not feasible to attempt to

prepare student district nurses for all the eventualities they were bound to encounter in their work. Although the training syllabus ensured a measure of uniformity in teaching and a measure of uniformity in practice during the training period, the qualified district nurse soon began to add her individual ideology and to adapt her work as she thought best. The national survey of district training referred to earlier (Q.I.D.N. 1963)[5], included interviews with a random sample if district nurses approximately one year after they qualified. The individuality of their work and their ideas was striking and seemed to be directly related to the comparative isolation in which they functioned. In hospital nursing such individual differences would not be possible as some continuity of methods has to be maintained; the working pattern is set by the Ward Sister, individual preferences being subordinate to the policy determined for the nursing team. The work undertaken in connection with the study on the sterilisation of equipment in the patient's home, mentioned above, once again demonstrated considerable differences in the methods of work between district nurses. Although the Queen's Institute had assembled a great deal of knowledge about training centres and examination achievements, there was little, if any, information available about the factors which influenced working patterns of qualified district nursing staff. National conferences and refresher courses provided a medium through which comments could be channelled to the Queen's Institute. These comments, re-enforced by the observations of the Institute's Officers during practical examinations, drew attention to concern about the appropriate deployment of qualified district nursing staff. Highly qualified nurses with considerable experience appeared to undertake a large amount of work which, on the face of it, could have been undertaken by less qualified personnel. It was in line with the Institute's remit, therefore, to study the service provided by the district nurses in

some detail in order to assess their current contribution to health care. The investigator, at that time employed as tutor to the Institute, was asked to explore the feasibility of initiating a research programme.

The paucity of information available indicated that any such programme would have to begin with a basic descriptive study providing a foundation on which further projects could be built. A literature search in the field of district nursing in Britain produced two studies, one of which had been undertaken by the Queen's Institute in conjunction with the Marie Curie Memorial Foundation (1952).[8] It was limited to the needs of patients suffering from cancer, who were being nursed at home. The other study (Brewin 1963)[9] was restricted to the activities of district nurses in one local health authority. It is only in the last two decades that British nurses generally began consistently to examine their own work, attitudes and problems and to document their findings. Simpson (1971)[10] traced the development of nursing research in Britain showing how studies in nursing education, selection and wastage preceded and outnumbered those in nursing practice. Research in the community nursing field seemed to lag behind research related to hospital nursing.

An attempt to find reasons for the slow beginning of research in nursing in Britain yielded the following suggestions; some of which were also advanced by Simpson.

1. Submissiveness of the nurse to the system resulting in an unquestioning acceptance of the status quo,
2. Inadequate general educational background with little or no opportunity for the acquisition of research expertise,
3. Lack of financial and other resources,
4. Difficulty of defining the content and ambit of nursing.

The community nursing field presents additional difficulties as a research setting. First, the patient at home tends to have a more personal relationship with the nurse than the patient in hospital. Objective data collection regarding the work of the nurse is, therefore, more difficult. Moreover, although the ethical code of professional research practice demands respect for privacy and informed consent for all patients, the patient in his own home has no peer group example to follow; he also may feel less need to comply with requests made of him than the hospital patient. Second, the community nursing service at that time had a fragmented administrative structure. (Addendum 3 refers to the post 1974 period). The administrative units, then local health authorities, were smaller than the Regional Hospital Boards which controlled the hospital service. As local health authorities were independent and autonomous they would have had to provide their own research resources which they would be unlikely to use for research outside their own boundaries. For each local health authority to set up its own research mechanism would have been unreasonable. Third, whereas the hospital service was financed directly by Central Government revenue, payment for the community nursing service came from local rates by decision of the local authority membership. Although this system might, in principle, have increased or restricted the freedom of expenditure it is likely that research ranked low in order of priority for financial resources. Research takes time and is not easily recognised as being of immediate and direct benefit to the consumer, who, as rate payer, is also the paymaster. Moreover, local authorities, being politically orientated organisations, are influenced in their expenditure by prevailing party priorities. Fourth, the problem of defining community nursing as a scientific discipline with its own professional content amenable to research, is even greater than that of defining nursing in general terms.

This is probably due to the more widely ranging functions of a community nurse, which are determined by the varying and often unpredictable physical, emotional, social and economic condition of patients and of those who care for them. Many community nurses at that time, combined the functions of district nurse and midwife and some undertook health visiting in addition, a pattern which is becoming less common. It is not easy to study such a diffuse work role in a systematic manner.

Before embarking on a major research programme, such reflections on the possible reasons for delay in community nursing research were necessary in order to assess its feasibility when the opportunity presented itself. Given the urgent need to study the district nursing service in relation to the educational programme to which the Queen's Institute was committed and in relation to the standard of service for which it was responsible in 1964, the difficulties outlined above did not appear insuperable. Apart from the financial considerations, there appeared to the Institute's Education Committee, to be no serious reason why research should be further delayed. A full-time investigator who would be able to apply herself to the planning and design of research and would be sufficiently detached from the Institute's own programme was appointed, in the person of the author of this thesis. The Queen's Institute being a voluntary organisation outside the National Health Service was thus able to provide the base from which the research programme could be undertaken and was also able to attract finance from Charitable Trusts and from Central Government Research Funds. The Institute's Governing Body thus accepted research as a suitable on-going activity and charged the investigator with the responsibility of planning the first study.

Although all the studies discussed in this thesis were

separately planned, funded and reported, they formed part of a long-term coherent programme which is explained in Chapter 2.

CHAPTER 2.

THE PROGRESSIVE STRUCTURE OF THE RESEARCH PROGRAMME

In 1964 knowledge of the district nursing service was so sparse that any factual enquiry, however basic and limited, was likely to be helpful. It was appreciated from the outset that the programme would have to be planned in small steps, with one research project leading to the next. Such an approach was necessary for two reasons. In the first place, it seemed easier to attract finance for a small, clearly circumscribed study; secondly, and more importantly, findings were eagerly awaited and it was considered prudent, therefore, to publish the report of each study speedily, providing it warranted publication at all. 1.

The first study, published as 'Feeling the Pulse' (Hockey, 1966) was planned to be mainly descriptive in order to establish a contemporary picture of the district nursing service in the six areas in which it was undertaken. The investigator and her steering committee were aware of the limitations of such a relatively small study, whose findings could not be generalised. A larger survey of a sample of areas representative of the whole country was considered but the idea was discarded mainly, but not only, because of the limited resources and the time pressure. Another important reason for not pursuing the national survey approach was the known variability of the district nursing service in different parts of the country. An unduly large sample of areas would have been necessary to reap the benefit of a national survey. Stratification of the sample was given careful thought, but there seemed to be too little information available to make relevant decisions on the bases of stratification. It was decided that the most helpful course would be to study a limited number of areas of different types and geographical locations. Findings could possibly be applicable to other areas of similar

characteristics although this could not be assumed. At least, attention could be drawn to certain issues whose relevance in other areas could be tested.

The study, 'Feeling the Pulse'[1] was intended to describe the district nursing services, by establishing who the district nurses were, what their work consisted of, how they related to other health care workers and how the service was organised. There was also an exploratory aspect to the study, in that it attempted to elicit the views of the district nursing staff, the general practitioners and the administrators regarding current practice, expected changes and plans. It was hoped that, in this way, priorities for further research might be identified. The study resulted in the first research report in the extended programme. For the purpose of this chapter, only those findings which were used as a basis for progressive planning are highlighted.

The most striking results were first, that the professional qualifications of the district nursing staff did not seem to be fully utilised, thereby supporting the opinions and views which prompted the research programme in the first instance. The second relevant finding concerned the poor or non-existant communications between district nurses and general practitioners, who, ostensibly, shared the care of their patients. Roughly about the same time and published in the same year a similar, but independent study was undertaken in Scotland (Carstairs 1966).[11] Although the findings of both studies are not comparable in every detail there was abundant evidence to show that the situation in Scotland did not differ a great deal from that in the English research areas.

The investigator, having been a practising district nurse herself, realised that there was a functional connection between the district nurses' work and their communications with general

practitioners. At the time of the study, the district nursing service was, to a large extent, dependent on the general practitioners for the referral of patients for nursing care. Therefore, only those patients for whom the general practitioners considered nursing intervention to be needed, became the concern of the district nursing staff.

Most, but not all, patients cared for by the district nursing staff are referred by the general practitioner. For patients who have been in- or out- patients some nursing may be requested by hospital medical or nursing staff. In order to complete the picture of the nurses' actual or potential work load the next study, published as 'Care in the Balance' (Hockey 1968)[2.] was initiated. It set out to determine, more specifically, the extent and type of contact and collaboration, if any, between hospital and district nursing services. It showed some progression from the first study in terms of specificity. Whereas that study deliberately collected data on several diffuse issues, the second study in the programme was generated from two specific questions and planned to test two specific hypotheses formulated from the questions in the course of the pilot work. The hypotheses were:

1. Patients are recalled to hospital as out-patients for treatment or care which could be provided by the district nursing service,
2. Patients are discharged from hospital after in-patient care without available and desirable community services, especially district nursing care, being invoked on their behalf.

The study, which forms the content of Chapter 6, was again limited. A small number of selected hospitals of different types and geographically scattered, were selected. Generalisation was not

possible but pointers to weaknesses in collaboration were provided. As was the case with the first study, so it happened in this instance, that a similar, though not strictly comparable study, (Forsyth and Logan, 1968)[12] was published in the same year. Again the findings of both studies supported each other. Research published two years later (Skeet 1970)[13] and seven years later (Roberts 1975)[14] further corroborated the findings by showing continued gaps in the continuity of patient care between the hospital and the domiciliary services.

Thus, 'Care in the Balance' (Hockey 1968)[2] produced findings which, though supported by other similarly limited studies, were not in themselves adequate or suitable to form the necessary basis for a change in policy on a national scale.

Simpson (1974)[15] is reported to have said:

> 'Research cannot take decisions, only provide information on which decisions can be made'.

Research available so far, though amenable to professional interpretation, did not even provide the type of information on which decisions could be made. Description rarely warrants prescription without intervening experimentation and in this awareness the idea of a quasi-experiment was conceived as a next stage in the progression of thought in the building up of the research programme.

It was an experiment, in that a situation was artificially created for a study of the effects of the experimental factor. It was a quasi-experiment as there was no attempt at a scientific control of variables. The experiment consisted of attaching a district nurse to the surgical department of a general hospital. It was an attempt to establish a synthesis between two types of care, each of which was operationalised by its own autonomous bureaucratic administrative structure. Hospital care was supported within the gigantic hospital system financed from national taxation and the provision of home care was the responsibility of local health

authorities and financed from local rates. General medical practitioners had yet another administrative machinery controlling the organisation and delivery of domiciliary medical care.

The experiment was based on the following assumptions: - If a patient's total care embraces both hospital and home care, nursing in both settings must be synthesised into one system whose successful functioning will depend on mutual understanding and collaboration. Before such synthesis is recommended as a matter of policy it seemed necessary to establish: -

a) descriptively, what the result of such synthesis would be,

b) evaluatively, whether such synthesis would be desirable or not.

The progression in the design of the research programme lay in setting up the experimental situation and attempting a simple evaluation of it. Chapter 7 describes and discusses this third study, published as Cooperation in Patient Care Part I (Hockey 1968)[3.] in more detail. The findings of the study suggested that an extension of community care by earlier planned discharge of patients would seem a rational proposition. The feasibility of such an extension was seen to hinge to no small extent on available nursing manpower in the domiciliary nursing service.

District nurses in the United Kingdom are either registered or enrolled. Some of both types of nurse have taken an additional course in district nursing, although such a course is not a legal requirement for license to practise. Recruits for the training leading to enrolment had, in recent years, overtaken those who embarked on training for the register. (Addendum 1). It was, therefore, a logical next step in the progression, to examine carefully the work and deployment of the enrolled nurse vis-a-vis the registered nurse in the district nursing service. As far as the

research method was concerned, it can be argued that it was a retrograde rather than a progressive step to proceed from an experiment to a descriptive survey. However, it was a national survey whose design warranted claim for nationally applicable findings. This is one of the two respects in which this national survey showed progression. The other respect was the tool for data collection used. For the first time, one document linked information about the nurses' work activities throughout the 24 hour period with information about their patients including the place at which the care was given. Details of this major study; published as 'Use or Abuse?' (Hockey 1972)[4.] form the subjects of Chapters 8 - 12. Although the main benefit of that study lay in its applicability over the United Kingdom, the Government Department responsible for health in England was anxious to isolate that part of the country which came under their auspices. As the national sample of local health authorities had been stratified by region and by the type of area it was possible to undertake further, more sophisticated analyses of the data for district nurses in England, which represented yet another stage in progression, described more fully in Annex 5. The investigator planned, initiated and supervised this stage of the programme but the analyses were carried out by a research assistant (Potter and Hockey 1975).[16.] A sophisticated data base may now have been established from which further work could be developed.

The research programme can thus be seen to have led from a limited descriptive case study of the district nursing service to a national data base, which encompasses not only details about the nursing staff and every aspect of their activities but also about their patients. The patients' age, sex, type of condition and degree of mobility are variables included, as is also the place at which the nurse gave care. (Chapter 9).

Such information linked with demographic prediction and morbidity trends provides a basis for long-term planning and decision making.

The thrust in the thesis is the progressive structure of the programme with its cementing conceptual framework which links the individual projects and demonstrates gradually increasing sophistication in research design.

CHAPTER 3.

THE MEANING OF DISTRICT NURSING AND THE ORGANISATION OF THE COMMUNITY NURSING SERVICES. *

To define 'district nursing' as 'nursing on the district' would be correct but tautological. Definitions of 'nursing' have been offered in profusion thereby demonstrating the difficulty in establishing a generally acceptable and comprehensible definition. Many of the problems highlighted by the empirical work undertaken in the course of the research programme appear to be associated with the lack of a clear undisputable perception and appreciation of 'nursing' activity and, therefore, of an established nurse's role. Whilst it would seem reasonable to refer to nursing as 'activities performed by nurses in the course of their work' it becomes immediately obvious that such a description would be at the same time too broad and too narrow. It would be too broad as nurses undertake many 'non-nursing' duties and it would be too narrow as it would exclude nursing activities undertaken by people other than nurses such as informal carers. Moreover, within professional practice the boundary between nursing and non-nursing duties is blurred and constantly changing. It is blurred because it cannot be static and it cannot be static because it is related to other constantly changing disciplines such as social work, physiotherapy or medicine, to mention just a few. Nursing care is merely a part of a patient's total care, albeit the most intimate and continuous part; it is usually the part which is not the prerogative of any other paid professional worker with a responsibility for the patient's care. Therefore, the nurse's role changes as other workers change theirs

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* The description of the organisational framework applies to the time of the research programme.

and such changes may be the result of policy expediency or extension of knowledge. To give examples: - a district nurse's employing authority may make a policy statement indicating that a certain procedure, e.g., venepuncture will in future fall within her province; it may also happen that a district nurse gives her patient specific physiotherapeutic exercises because there is no physiotherapist available; lastly, an extension of medical knowledge in terms of new methods of prophylaxis, diagnosis or therapy may extend the role of a nurse to take her part in applying such methods.

Linkage of nursing with nurses suggests an area of nursing activity for which the specific skills of a qualified nurse may be necessary. Ambiguity and diversity of interpretation are again inherent as the skills of a qualified nurse have not yet been defined. Moreover, the nursing structure in the United Kingdom incorporates two levels of qualified nurses, the registered and the enrolled nurse.* Although, theoretically, the two levels are clearly distinguishable on the basis of their formal training and the paper qualifications, the distinction may in practice be obscure. The major empirical study in the research programme is more specifically concerned with the second level district nurse and highlights some problems of skill demarcation.

For the purpose of international co-operation in nursing the International Council of Nurses is committed to a definition of a 'nurse'; this was revised at the I.C.N. Congress in 1973 and defines a nurse as: -

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* Registered Nurse (SRN in England and Wales, RGN in Scotland) - Three years basic training.

Enrolled Nurse (SEN in England and Wales, EN in Scotland) - Two years basic training.

> 'A person who has completed a programme of basic nursing education and is qualified and authorised in her/his country to provide responsible and competent professional service for; promotion of health, the prevention of illness, the care of the sick and rehabilitation'.* 17.

Thus, both levels of qualified nurses are included and entitled to international recognition as 'nurses'.

In the context of this thesis 'district' is used in contrast to 'hospital' or other institution. District nursing, therefore, refers to the nursing care of patients within the purview of the National Health Service,** outside a hospital or other institution, mostly the care given in their own homes. Terminology is, however, further confused as the activity described above as 'district nursing' may be referred to by a variety of other terms. Historical documentation tends to use the term 'district nursing', the Queen's Institute of District Nursing featuring prominently in the development of this type of nursing (Stocks 1960).[18.] The National Health Service Act 1946 introduced the term 'home nursing',[19.] rendered somewhat contradictory or at least inaccurate by legislation in 1968[20.] which legitimised the work of 'home nurses' in places other than the patient's home.

Sometimes the term 'Community Nursing' is used but 'community' also defies easy definition to which a large volume of literature testifies; it most commonly denotes a group of people united by a specific bond, such as race, creed or colour. Community nursing also tends to include other forms of 'nursing', such as health visiting or domiciliary midwifery. In 1972 the Report of the Committee on Nursing[21.] introduced yet another term 'family clinical nursing' for the activity of the home nurse whom it names 'Family

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* It is recognised that this definition was agreed for the specific purpose of international relations and has little to offer within the U.K. health service context.

** It therefore excludes private nursing and occupational health nursing.

Clinical Sister'. To minimise confusion the terms 'district nurse' or 'district nursing' are used consistently in this thesis apart from instances when quotations from documents are given.

District nursing is distinguished from health visiting or as the Committee on Nursing calls it 'family health nursing', the conventional health visitor having been named 'Family Health Sister'. It refers to nursing rather than preventive or educational activities although these are not mutually exclusive. It must also be recognised that one person may combine the formal functions of the clinical and the preventive worker, thereby complicating the issue still further. In order to lend a measure of clarity to the term district nursing it refers in this thesis to the service which local health authorities were committed to provide under section 25 in Part III of the National Health Service Acts* amended by the Health Services and Public Health Act 1968. The profound legislative and administrative changes brought about by and since the reorganisation of the National Health Service in 1974 are outlined in Addendum 3

The National Health Service Act 1946 decrees that: -

> 'It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by these organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes'. (Section 25)

The same Act explains 'local health authority' in section 19: -

> '....the local authority for the purpose of this Part of this Act, who shall be called the 'local health authority' shall for each county be the council of county and for each borough be the council of the county borough.'

Officially then the National Health Service Acts for England and Wales and for Scotland placed upon local health authorities the responsibility for a service which had previously been provided by

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* (National Health Service Act (1946)) HMSO.
(National Health Service (Scotland) Act (1947)) HMSO

voluntary enterprise through the medium of voluntary organisations.

As the wording of the relevant legislation indicates, voluntary organisations could continue this work though no longer by voluntary enterprise but as agents of the local health authorities in the area of their operation. The agency basis of organisation implied a change in the financing arrangements; whereas, before, the voluntary organisations had to raise the necessary finance themselves, partly through contributions from private insurance or provident schemes, partly through direct payment for services rendered and partly through various fund-raising activities, they now received a substantial grant from the local health authority, the voluntary component being retained on a merely nominal basis. The transition from a voluntary to a statutory provision had far-reaching implications. Statutory services may guarantee a certain minimum standard in quality as well as quantity but they are less flexible, less amenable to experimentation, more inhibited by bureaucratic organisational machinery.

As far as district nursing was concerned the National Health Service Acts legitimised a fragmented organisation of health care and strengthened the functional boundaries. The assertion is not that the National Health Service has introduced barriers and conflicts but merely that it has legitimised them and that its rigidly defined organisational framework has lessened the probability of experimentation and change.

District nursing care became indisputably divided from hospital nursing care thereby erecting a barrier to the continuity of a person's health care over time. Moreover, not only was there a legitimised division in the longitudinal time continuum but also in the organisation of community care for the same person at any one time. This organisational division was two-fold; in the first

place it divided the medical care from nursing care and secondly, it divided preventive and after-care nursing services from those provided for illness. To this could be added a further division between physical and mental care.

Medical care and nursing care in the home had never been administratively linked but the separation was perpetuated and formalised by the establishment of separate Executive Councils under Section 31 in Part V of the National Health Service Acts.

Although the Executive Councils were co-terminous with local health authority areas they were separate autonomous entities and the Act decrees that: -

> 'It shall be the duty of every Executive Council in accordance with regulations to make as respects their area arrangements with medical practitioner for the provision by them as from the appointed day, whether at a health centre or otherwise, of personal medical services for all persons in the area who wish to take advantage of these arrangements .....'

A close scrutiny of the detailed wording of the respective legislation exposes a further point of conflict which was found to have important implications in practice. Whereas the private sector of domiciliary medical care is retained and general medical practitioners are free to receive fees from their private patients, the district nursing service must be provided for all sick patients who need it. The division between preventive and after-care nursing services from those provided for illness was perpetuated under sections 24 and 28 in Part Three of the National Health Service Act.

Section 24 states: -

> 'It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors, to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.'

Section 28 describes the permissive provision of preventive care

and after-care services: -

> 'A local health authority may, ... make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after-care of such persons ....'

District nursing has already been presented as a complex activity which involves co-operative effort. Most patients nursed by district nurses are under the supervision of a general medical practitioner; collaboration between him and the district nurse is essential to efficient patient care. Most patients nursed by district nurses require some advice and tuition; their relatives also require advice and tuition regarding the care of the patient and their own care with a view to the prevention of illness or infection; most patients nursed by district nurses require help with a view to prevention of complications and to rehabilitation. It emerges, therefore, that the administrative boundaries between medical and nursing services and those between preventive, rehabilitative and curing or caring nursing services are artificial, necessitating deliberate effort to minimise them. The need for such deliberate effort to establish co-operative and co-ordinate systems of community health care paved the way for the creation and proliferation of nursing teams attached to general medical practitioners.

Over the period of the research programme the structure of the community service began to deviate from that which the National Health Service Act had formalised. Yet the only relevant intervening legislation was the Health Services and Public Health Act 1968 which removed some constraints in the field of community nursing as follows: -

> 'A local health authority may make provision in their area for securing the attendance of nurses on person who require nursing elsewhere than in their own home.' 22.
>
> 'A local health authority may make arrangements with another local health authority for there to be made available in that other authority's area, ... the services of nurses employed by them ..... 23.

The structure of the service had changed in response to the need for a partnership in patient care. Some local health authorities had freed themselves from legislative restrictions before 1968, to others the Act gave the required authority to change.

The 1968 Act extended the sphere of activity of district nurses enabling them to give care in general medical practice premises, in health centres and in other places outside their patients' own homes. It also made it possible for them to cross local health authority area boundaries. It became increasingly easier, therefore, for nursing teams to work in functional partnership with general medical practitioners by assuming nursing responsibility for the same group of patients for whom the doctors had medical responsibility, the operative criteria of an attachment arrangement.* The administrative arrangement remained divided, the doctors working in contract with the Executive Council, the nurses being employed by the local health authority. The nurses working in attachment schemes remained accountable to their employing authority but continued also to be responsible to the doctor for specific aspects of patient care. Employment of nurses by the doctors themselves added a further element to an already complex organisational pattern. The structure of the community nursing service of which district nursing is a part represents a multidimensional hierarchy.

It could be that the new possibilities of shared responsibility for patient care as well as the emerging problems and administrative

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* 'Attachment' - A scheme in which a nurse employed by the local health authority is responsible for providing local health authority services to all patients on the list of specified general practitioners with whom she has regular consultations. She is not limited to working within a geographical district. (Definition originally provided by Anderson, et al (1967) 24. and adapted by Abel, (1969) 25.

complexities stimulated enquiry. In sharp contrast to any earlier period, the decade 1965-74 has produced a sizeable number of research reports covering various aspects of community nursing, some of which might well have influenced the shaping of policy in the community nursing field.

The first study of the district nursing service undertaken by the investigator is the subject of the next chapter.

CHAPTER 4

DISTRICT NURSING IN SIX AREAS I
THE DESCRIPTIVE BASE LINE STUDY

Aims of study

The resources available, at the beginning of the research programme were limited and the base-line study had to be designed within those modest limits. In view of the fact that knowledge of the district nursing service was so sparse, it was recognised that any factual enquiry, however basic or limited, was likely to be helpful.

The aim was to establish a picture of contemporary district nursing in a small number of areas.

The study was descriptive and exploratory in content but only the descriptive part of it is summarised in this chapter.

Choice of areas

The choice of areas was the first major decision which had to be made. A random sample of areas, stratified to achieve representativeness of the country as a whole, would have been the ideal method. However, the variability between the different areas was known to be considerable and, therefore, it would have been necessary to draw a large sample if the results were to be useful for generalisation. A large sample was beyond the resources and a purposive selection of areas was, therefore, decided on; the selected areas and the reasons governing their selection are described below.

Three types of areas, industrial, retirement and rural, all of which present different problems for the district nursing service, were studied in detail. Two of each type were investigated, for purposes of comparison, making six in all. Local health authority administrative areas were used as a basis, as it was felt that only a unit of this kind would allow a study of the administration and planning of the nursing service, as well as the interaction of various components of nursing and other related services.

The areas selected include two counties and four county boroughs. The paired areas were matched as closely as possible so as to make comparison more valid. In all cases they were matched for population and size of area, medium-sized local health authorities being chosen as being more representative than extremes. For example, the rural areas were selected from among counties with a population between 100,000 and 150,000, the urban areas from boroughs with a population between 125,000 and 175,000, and the retirement areas from boroughs with a population between 50,000 and 100,000. Other required characteristics for the three types of areas were as follows: -

Urban areas	-	an industrial rather than commercial character, dense population and a small immigrant community.
Retirement areas	-	seaside resorts, middle class in character with aged population in excess of 20%
Rural areas	-	a truly rural character, predominantly agricultural, with a scattered population and no large urban or industrial centres.

The six authorities finally selected were widely scattered throughout the country, each in a different Hospital Region. The two retirement areas were on the coast, one in the North and the other in the South. The urban areas were in the Midlands and South West and the rural areas in the West Midlands and East Anglia.

All but one of the local authorities in these areas were directly responsible for the running of the district nursing service, at the time of the survey; one was still the responsibility of a voluntary association acting as agent for the local health authority.

Codes

The following codes are used for the research areas: -

Industrial Towns

'A' Midlands
'B' South West

Retirement Towns

'C' South
'D' North

Rural Areas

'E' West Midlands
'F' East Anglia

The area types were chosen on the basis of the Queen's Institute's and the investigator's experience of their relevant characteristics for the district nursing service.

For example, urban areas, of a mainly industrial character, were known to have the health problems of a rapidly expanding population including an increasing component of immigrants attracted by employment possibilities. The numbers of general medical practitioners and district nurses had not kept pace with the population increase, thereby causing work pressures. The doctors tended to work from outdated and inconveniently situated practice premises. Demolition work within the towns had caused the patients of individual general practitioners to be dispersed in housing schemes resulting in scattered practice populations. At the same time the inevitable increase in road traffic complicated the domiciliary visitation of patients by doctors, nurses and others. One of the industrial towns had become an important educational centre and the University with its student population featured prominently in the life of the town. In both industrial towns the district nursing staff undertook general nursing only and the three community nursing services, that is district nursing, midwifery and health visiting were separately administered under the overall

direction of the Medical Officer of Health.

Retirement areas were chosen because of the known imbalance in the age structure of the population. Not only are the elderly, particularly the very old of 81 years and over, vulnerable as far as their health and welfare are concerned, but owing to the decline of the younger population in those towns there were less younger friends and relatives available to help. The elderly population made heavy demands on the health and welfare services which were increased by its rapidly changing social circumstances. Whereas many old people had been able to live in their own houses with domestic help, or, alternatively, in private Nursing Homes, such possibilities became increasingly prohibitive in cost. Moreover, attitudes to state care were beginning to change making it a more acceptable proposition.

In both retirement areas, the district nursing staff undertook general nursing only, but administratively, there were differences between the areas. In Area 'D', the district nursing service was administered as a separate entity by a Voluntary Committee on an agency basis; administrative responsibility for the local authority nursing services in Area 'C' was divided between two officers, a superintendent of health visitors and a superintendent of district nurses and midwives, who also supervised the home help service. Overall responsibility was vested in the Medical Officer of Health, although his authority over the delegated district nursing service was effected through his membership of the voluntary committee only.

The problems of the two rural areas from the point of view of the health and welfare services were those of comparatively remote districts with a scattered population. Distances between villages and between patients caused doctors and domiciliary nursing staff to spend considerable proportions of their time in travelling. Most weaknesses thought to exist in rural areas were related to difficulties in communication. Administrative arrangements between

the two rural areas differed. In Area 'E' generalised workers were employed, who combined general nursing, midwifery and health visiting in their duties. In Area 'F' general nursing and midwifery were combined, but separate workers were employed for health visiting and for supervision of the home help service. In line with the national pattern at that time the Medical Officer of Health had the highest administrative authority over the local authority nursing services and in Area 'F', he was also responsible for the welfare services. The areas studied represented, therefore, most of the problems and administrative pattern thought to exist when the research programme was begun.

Choice of respondents

The other main methodological decisions to be made were the type and number of respondents and the methods of data collection. Both decisions were based on professional experience rather than on proficiency in research methods. Professional experience suggested that information about the district nursing service could be provided from three main sources; these were the district nurses themselves, the general medical practitioners who shared with the district nurses the responsibility for domiciliary care and, thirdly, the nursing administrators, who were responsible for policy in the respective areas. In order to provide as full a picture as possible, it was decided to seek information from the total population of district nurses and general practitioners in the selected areas. As far as policy was concerned, it was considered desirable as well as feasible to include the administrators of the district nursing services in the whole of England and Wales in the study. It was, thus, possible to set the findings from the small number of selected areas against a national background of district nursing policy. In this context, policy refers to the interpretation of legislation by nursing administrators and to their use of permissive powers.

Methods of data collection

Three methods of data collection were used. The district nurses and general practitioners were interviewed by a member of the research team who used a semi-structured interviewing schedule for the purpose. The district nursing staff also completed a purpose-designed record form for a ten day period, which gave details of their activities. (Annex 1). Postal questionnaires were sent to all district nursing administrators; they were too widely scattered to make personal interviews a possible proposition; it would have been a time-consuming and excessively costly exercise.

The data were processed partly by means of a mechanic card sorter and partly by an Elliott 803 computer, using general tabling and correlation screening programmes.

Exploratory and Pilot Studies

Exploratory work was undertaken in order to test the feasibility and likely acceptance of the proposed study. It suggested that a descriptive study of the district nursing service would not only be accepted but also warmly welcomed. The exploratory work also served to discover the most suitable methods of obtaining a factual picture of nurses' work. A thorough pilot study, designed to test all data collecting instruments was undertaken in two areas, one in London and one in a Home County. It resulted in some minor modifications, which were then re-tested.

Time of Study

The summer months were chosen for interviewing for various reasons. First, it was expected that more co-operation could be expected on the part of the respondents; pressure of work and bad weather conditions do not predispose favourably to any additional demand on time. Secondly, it was easier to recruit suitable interviewers during the summer months and last, but not least, fine weather makes life more pleasant for the interviewers. If they are

happy and relaxed they do better work.

To give a truer picture of the work load of district nurses the work sheets were completed in the winter.

The number of nurses employed and interviewed is shown in Table 1. The response rate of 97% was encouraging.

TABLE 1

Number of nurses employed and interviewed

Areas	No. of Nurses employed	No. of Nurses interviewed
Industrial		
A	26	24
B	26	26
Retirement		
C	21	21
D	19	19
Rural		
E	47	46
F	41	41
	181	177

Findings

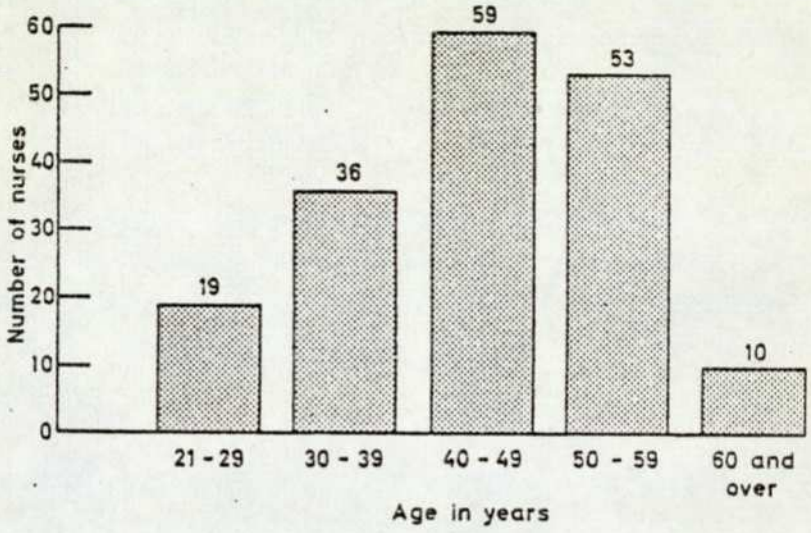
The findings presented in this chapter are mainly those on which the subsequent studies were built. They include the major personal data of the nursing staff and basic information about their communication patterns.

Personal data

As can be seen in Figure 1, the age distribution is slightly skewed toward the older age groups, drawing attention to the need for adequate recruitment, if staffing levels were to be maintained.

FIGURE 1

Nurses' age distribution



Fifty per cent of the nurses were married and two-thirds of these were mothers of young children. Analysis of the data in the rural areas showed that these areas, especially Area 'E' relied heavily on older unmarried nurses. Attention was drawn to the potential difficulty of staffing in rural areas, given the current and predicted demographic data. Restricted job opportunities for husbands in rural areas would be a likely reason for less married nurses working there.

As one of the reasons for initiating the research programme was provided by the Queen's Institute's interest in improving its post-basic training programme, it was pertinent to obtain detailed information about the educational background as well as the professional qualifications and experience of practising district nurses. The findings showed that 73% of the nurses in the study had no educational qualifications of any kind, having left school before the age of 15 years. Twenty-one had reached university entrance level and 33 had a school leaving certificate or at least one GCE 'O' level. The educational heterogeneity of the group has implications for the curriculum construction of a post-basic course.

Table 2 suggests that the sample of district nurses were, on the whole, well qualified professionally, only 29% having the bare minimum for licence to practise nursing. Less than half, however, held the certificate relating to their specialty, that is, the District Nursing Certificate.

The level of professional qualifications in the sample, the fact that 85% had post-basic hospital experience and, most importantly, the stability of the staff shown in Table 3, indicated to the Queen's Institute that the continued development of district nurse training was a worthwhile activity. It was hoped that employing authorities would recognise the value of such training, which, in view of staff stability, would be a sound investment and use their powers to increase

TABLE 2

Nursing qualifications

SEN only	5
SEN with course of instruction in district nursing	2
SEN., SCM	13
SRN., no others	48
SRN., SCM	76
SRN., HV Cert.	0
SRN., SCM., HV Cert	33
In addition	
District Nursing Cert.	81
RMN or RMPA	3
RSCN or RFN	17
BTA Cert	7
Others*	14

*These included ophthalmic, orthopaedic, and nursery nurses' certificates.

TABLE 3

Number of nurses related to length of time in present post

Length of time in present post	Industrial Areas		Retirement Areas		Rural Areas		Total Number of nurses	
		%		%		%		%
Less than one year	3	6	5	12	9	10	17	10
One to four years	16	32	13	33	23	26	52	29
Five to nine years	13	26	7	17	12	14	32	18
Ten years or more	18	36	15	38	43	50	76	43
	50		40		87		177	

secondment.

Type of work

The preparation of staff for a specific type of work must be related to that work. For this reason, the study included not only a description of the work actually undertaken, but it also made provision for the nurses to express their views on possible delegation of work to other types of staff.

The purpose-designed record form (Annex 1) was designed in two parts; one made provision for an analysis of the nurses' work and on the other the nurses were asked to indicate at each visit whether they considered the delegation of that particular visit to less qualified staff advisable.

The descriptive section analysed: -

a. the nurse's working day, according to time spent in patient contact, on travelling and on other activities.

b. the time spent in patient contact according to the type and age of the patient, the purpose of each visit and the time spent on each visit.

c. time spent on other activities.

Most nurses undertook general nursing only; those nurses who were employed for the dual functions of district nursing and midwifery spent 61.6% of their time and those, who were employed for the triple functions of district nursing, midwifery and health visiting, spent 63% of their time on general nursing.

The division of the nurses' working day, the analyses of nurses' visits including views on delegation, but, most importantly, the descriptive data and views on communications with general practitioners and hospital staff are relevant to the research programme's progression. Figure 2 illustrates the broad division of the nurses' working day in the three types of areas.

The analyses of the nurses' visits are shown in Tables 4 and 5.

FIGURE 2

Division of nurses' average working day

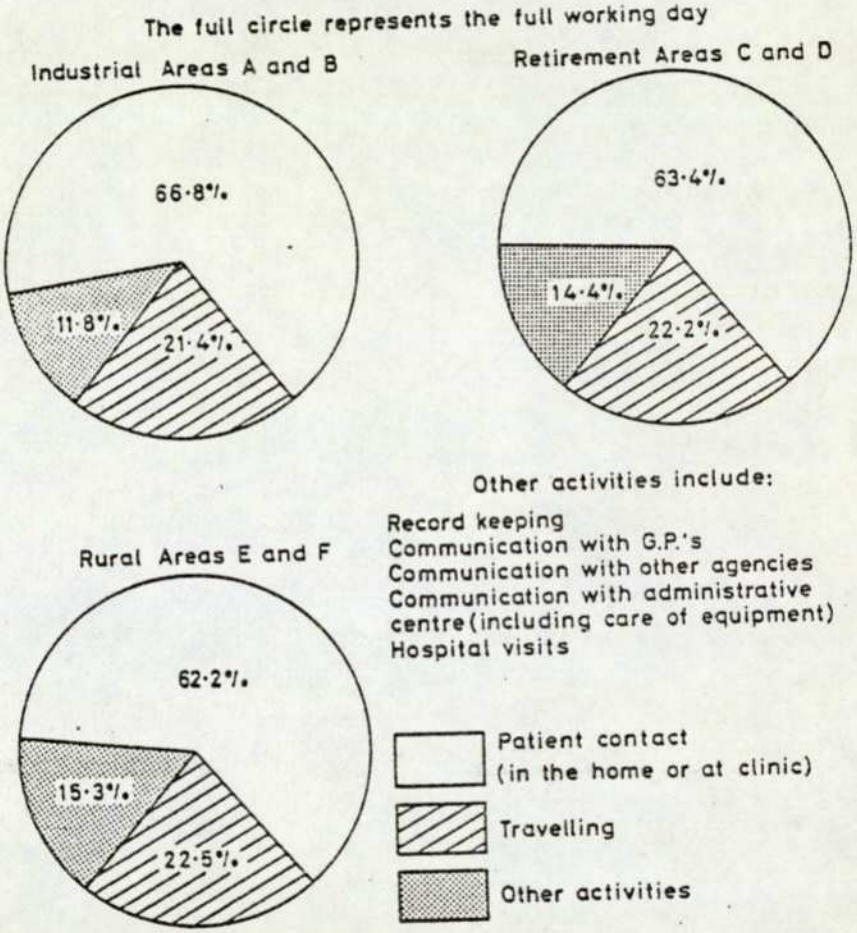


TABLE 4

Analysis of time spent with patients according to purpose of visit

Purpose of visit	Areas		
	A and B combined	C and D combined	E and F combined
	%	%	%
Dressings	16.5	12.0	9.2
General nursing care	42.8	46.4	24.9
Douche or bladder lavage	1.0	1.3	0.8
Enema or catheterisation	1.5	2.7	0.6
Treatment to eyes or ears	0.7	0.5	0.6
Rehabilitation exercises	0.3	0.5	0.3
Pre-symptomatic tests	0.4	0.0	0.9
Maternity nursing	0.1	0.0	-*
Calls to assess need	0.1	0.3	0.9
Calls to check equipment	0.0	0.0	0.2
Supervision	1.0	0.8	2.6
Injection only	13.3	19.0	9.6
Injection + other purpose	2.0	3.3	6.9
Other dual purpose visits	19.8	11.0	18.4
Other purposes not listed above	0.2	1.6	1.6
No reply	0.2	0.6	0.2

*Maternity nursing in 'E' and 'F' undertaken by nurses in their capacity as midwives.

TABLE 5

Analysis of total time spent with patients in their homes according to type of case and age group of patient

Type of case	Under 5 yrs.	5-64 yrs.	65 and over	Total
	%	%	%	%
Combined areas A and B				
Medical	0.1	19.9	58.5	78.5
Surgical	0.0	7.0	9.3	16.3
Gynaecological	0.0	0.9	0.5	1.4
Tuberculous	0.0	1.0	0.1	1.2
Other infectious diseases	0.0	0.0	0.0	0.0
Mental	0.0	0.0	0.0	0.1
Dual cases*	0.0	0.8	1.5	2.4
Total	0.2	29.7	70.0	99.8
Combined areas C and D				
Medical	0.0	19.4	66.6	86.0
Surgical	0.0	2.9	7.5	10.4
Gynaecological	0.0	0.0	0.7	0.8
Tuberculous	0.0	0.0	0.0	0.0
Other infectious diseases	0.0	0.0	0.0	0.0
Mental	0.0	0.0	0.0	0.0
Dual cases*	0.0	0.3	2.1	2.4
Total	0.0	22.7	76.9	99.6
Combined areas E and F				
Medical	0.1	7.7	38.6	46.4
Surgical	0.2	4.4	6.4	11.1
Gynaecological	0.0	2.5	0.1	2.6
Tuberculous	0.0	0.0	0.0	0.0
Other infectious diseases	0.0	0.1	0.2	0.2
Mental	0.0	0.1	0.2	0.3
Dual cases*	0.0	0.2	2.2	2.4
Total	0.3	15.0	47.7	63.0

*Dual cases refers to patients who fall into more than one of the listed categories.

Views on delegation, presented in Table 6 suggest a considerable potential for a less qualified worker to assist the district nursing

TABLE 6

Percentage of visits suitable for delegation
(total 11,474 visits)

Areas		Complete delegation	Partial delegation
		%	%
Industrial	A and B	7.2	46.1
Retirement	C and D	22.6	23.1
Rural	E and F	22.5	36.0
Total - six areas		15.1	37.2

staff. Some of the work undertaken by this well qualified work force included time-consuming non-nursing duties. (Table 7).

TABLE 7

Non-nursing activities undertaken
(nurses in all areas)

	Cooking or giving food	Fetching fuel, lighting fires, etc.	Shopping, fetching prescriptions or medicaments
Regularly (at each visit)	9	6	39
Periodically, eg. at weekends	22	16	89
In emergencies	92	112	167
Never	54	43	59
Total No. of times mentioned	123	134	295

Conversely, half the nurses, 50.2% said that they would appreciate an extension of their duties. They also made suggestions on how, in their view, the service to patients could be improved. Communication

included professional contact between nursing staff and the general practitioners with whom they shared the care of their patients and also between district nursing staff and their colleagues in the hospital service. The next chapter describes why and how the study was designed to obtain some data on communication problems as a springboard for further work.

CHAPTER 5.

DISTRICT NURSING IN SIX AREAS II
DISCUSSION OF FINDINGS WHICH GENERATED THE NEXT STAGE OF THE PROGRAMME

District nurses in relation to general practitioners

Most patients nursed by district nurses are under the medical supervision of a general practitioner. At the time when this study was undertaken, district nurses had almost all their patients referred to them by a general practitioner. It was he who decided when to enlist the help of the district nursing service and he gave the initial instructions on the care to be provided. Therefore, the general practitioner largely determined the actual role of the district nurse, whatever this role might have been in theory.

At the time of the initiation of this study there were roughly 21,000 general practitioners in England and Wales, most of whom worked within the National Health Service. Some doctors had private patients in addition to their National Health practice population.

The intention of the investigator was to obtain personal interviews with all general practitioners in the six research areas. As the selection of the research areas had been made on the basis of their character in terms of being described as industrial, retirement or rural areas, it was considered desirable that the doctors should, as far as possible, be concerned with the medical care of the people who lived in those areas. In the event, the selection of doctors was far from easy, as their practice areas were not contained within the research areas. Many doctors who had mainly rural practices lived in towns and, conversely, many who lived in the country were found to have predominantly urban practices. It was finally decided to seek interviews with all those doctors who had more than 100 patients in the area to be studied. Doctors' names were obtained from the lists maintained by the Executive

Councils. Those doctors, whose names were on the list, but whose activities were almost entirely confined to hospital or local authority duties were excluded from the population; such doctors were, for example, responsible for the health of hospital staff or of residents in Old People's Homes. It was not easy to obtain this information and its accuracy could not be accepted with complete confidence.

Table 8 shows the distribution of doctors in relation to National Health and private practice and also shows the number of respondents in the survey. As can be seen of a total population of 375 doctors it was possible to obtain 306 interviews representing a response rate of 82%. There was a significantly higher population of doctors without private patients in the industrial areas and also a greater number of larger practices, that is in the upper region of the allowed maximum of 3,500 patients per doctor. The number of private patients a general practitioner has and the view he holds about their care are relevant to a study of the local authority district nursing service. There was much difference of opinion among doctors and nurses as to whether private patients should have the benefits of the district nursing service. Some doctors felt strongly that private patients should have private nurses and pay for them, while others expected the district nurses to give their patients preferential care. Whether private patients were nursed by the local authority district nursing staff or not, many of them appeared to pose problems of pressure for the general practitioners, particularly in the retirement areas where most of them were in the upper age groups. National statistics, as published in the Annual Reports of the Chief Medical Officers in the Government Health Departments are consistent with the above findings[26.] and demographic predictions indicate an increase rather than a decrease in the trend

TABLE 8

Distribution of GPs in relation to National Health Service and private practice.

	Industrial Areas A	B	Retirement Areas C	D	Rural Areas E	F	Total
Total population of Doctors*	82	84	39	42	62	66	375
Number of respondents.	73	73	23	25	57	55	306
N.H.S. only	35	51	3	3	9	9	110(36%)
N.H.S. and private	37	22	20	20	47	46	192(63%)
Private only	1	0	0	2	1	0	4 (1%)

* Population refers to the total number of possible respondents.

Table 8 illustrates a difference in distribution pattern in the three types of areas.

TABLE 9

Distribution of various types of practices

	Industrial Areas A	B	Retirement Areas C	D	Rural Areas E	F	Total
Total population of Doctors	82	84	39	42	62	66	375
Number of respondents	73	73	23	25	57	55	306
Single-handed	7	12	3	15	11	6	54) 19%
Single-handed with assistant	1	1	0	0	2	0	4)
Partnership of:							
two	20	26	2	9	20	13	90 (29%)
three	24	18	6	0	11	12	71 (23%)
four	13	16	12	1	12	14	68 (23%)
five or more	8	0	0	0	1	10	19 (6%)

of the elderly featuring prominently in the British population.[27.]

The trend away from single handed practises toward partnerships was discernible in the research areas and was considered by the investigator to be important in the context of the study. Table 9 shows the distribution of the various practices in the six areas. A grouping of doctors to form partnerships was seen to have the potential for interdisciplinary team work being a work pattern stated by the Government to be a desirable development of community care[28.] and a staff team in a study of General Practitioners in Wessex[29.] found that doctors would welcome more nursing help in their practices. At the time of this study the attachment of local authority nursing staff to general medical practices was only just beginning and the attachment of health visitors preceded any schemes for the attachment of district nurses. The grouping of doctors made the attachment of district nurses a more feasible proposition but interviews with district nursing administrators and Medical Officers of Health indicated that some had serious reservations.

Table 10 presents the answers of the general practitioners respondents to a question on whether they would like a district nurse attached to their practice or not. As can be seen, there is a positive correlation between the numbers of doctors in a practice and their wish for an attached nurse. The exception was found to be in the rural areas where nurses have always worked closely with the general practitioners, usually covering the same villages. A formal attachment in those areas might, therefore, not have been seen as a priority development.

Moreover, some general practitioners who had formed partnerships were employing or were planning to employ nurses themselves to help them in their practice. This was particularly so in cases where the local authority machinery was seen to be too complex

and too rigid in the rules for the attachment of nursing staff.

TABLE 10

Percentage of doctors in each type of area and type of practice wanting attachment

Type of Practice	Industrial Areas	Retirement Areas	Rural Areas
	%	%	%
Single-handed	10	25	10
Partnership of 2 - 3	22	33	20
Partnership of 4 and over	50	50	14

The prospect of a new Charter making provisions for some financial reimbursement of doctors for the employment of nurses made it an attractive proposition.[30] Whether district nurses were to work in attachment schemes or whether general practitioners were to employ nurses themselves, the role of the nurse and her working pattern were thought to be liable to change.

Contact and communication between doctors and nurses were found in all areas to be less than desirable by both the general practitioners and the nursing respondents.

When doctors require district nursing care for their patients, they make contact either direct with the district nurse concerned or through an administrative centre. At the time of the study it was common practice for the former method of contact to operate in the rural areas and the latter in towns. With very few exceptions this was the pattern in the six research areas.

The doctors in the country areas attempted to make direct contact with the nurses concerned but often encountered practical

difficulties epitomised in comments such as, 'I hardly ever get a reply from the nurse's house' or 'By the time I contact the nurse and she gets to the patient I can do the job myself'. As most nurses in the rural areas were also responsible for midwifery, frequent unexpected absences from their houses were inevitable. There were no telephone answering machines nor radio-fitted cars available for the nursing staff.

Administrative centres for the reception of calls were appreciated by the busy town doctors. In the opinion of 32, this system, however, also had its faults, particularly the time-lag between a message being given to the centre and its reception by the appropriate nurse. Moreover, they felt that messages which had to be handed on through a third and sometimes a fourth or fifth person might easily become distorted on the way and thus lead to serious confusion. A few doctors commented on the need for a professional person to take telephone messages, as otherwise too much time was spent in giving detailed explanations and spelling out simple medical terms; there was also a grave risk of misunderstanding.

Inadequate arrangements for contacting district nurses in the evenings and at weekends were commented upon by 24 doctors, mostly in areas where the administrative centre functioned during office hours only.

About 15% of the nurses were not on the telephone. As with the nurses without cars, those without telephones were mostly in the retirement areas. In the north-western retirement town 'D', more than half of the staff were not on the telephone at home. In the industrial area 'B', where five of the nurses had no cars, there were six nurses without telephones. In 'D', both doctors and nurses believed that the Superintendent was actively hostile to direct messages being passed between them. One general practitioner

confessed to feeling guilty if he was seen by the Superintendent talking to a nurse in the street.

A recently initiated experimental 'direct contact' scheme in 'B' was appreciated by the doctors involved.

There were in all, 49 doctors (16%) who considered that different arrangements for contacting district nurses were urgently needed. A further 73 (24%) felt that there was room for improvement. A total of 122 (40%) were, therefore, not completely satisfied. Translated into national figures, this would be almost 9,000 doctors who would welcome a change in the method of contacting district nurses.*

Nurses who wanted to get in touch with the doctor normally did so by telephone. Those who had no private facilities for doing so usually made their calls from the administrative centre, which involved additional travelling. Several nurses found the alternative of using public telephone boxes frustrating, as they could not always speak to the doctor himself at the first attempt, and they, therefore, had to waste time looking for vacant boxes and for the right kind of coinage.

Nurses without telephones were unanimous in their dissatisfaction on this point.

Because they covered geographically confined areas, individual district nurses looked after patients of several doctors and most doctors had several nurses caring for their patients (Table 11)

Six of the eight doctors who worked with one nurse only were in the rural areas 'E' and 'F', which included the only practice with an 'attached' nurse. One doctor had a compact residential suburban practice in 'C' which coincided neatly with the nurse's working district, and another was responsible in the main for a large new housing estate in 'B', which also had one nurse allocated to it.

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* As dissatisfactions were fairly evenly distributed among all types of areas, this generalisation appears reasonable although statistical significance cannot be claimed for it.

TABLE 11

Table Number of doctors and nurses working together

No. of doctors	No. of nurses	No. of nurses	No. of doctors
8	One	0	One
114	Two to four	25	Two to four
81	Five to ten	70	Five to ten
56	More than ten	75	More than ten
47	Don't know	2	Don't know
0	Not answered	5	Not answered

TABLE 12

Table Doctors' responses concerning meetings with nurses

Number of meetings	Areas						Total	
	Industrial		Retirement		Rural*			
	Number of doctors who met nurses		Number of doctors who met nurses		Number of doctors who met nurses			
		%		%		%		%
Never or less than ten times a year	83	57	25	52	18	16	126	41
Between once weekly and once monthly	57	39	23	48	67	61	147	48
More than once weekly	6	4	-	-	36	23	32	11
Not answered	-	-	-	-	1	1	1	1

*Midwifery undertaken by district nurses in the rural areas, entails more professional contact between doctor and nurse.

Thirty-six nurses were responsible to more than 15 doctors for the nursing care of their patients. With two exceptions, these were in the industrial towns 'A' and 'B', the areas which also had the greatest proportion of doctors whose patients were divided over more than ten nurses' districts.

Understandably, therefore, many doctors did not know which nurse to contact on the behalf of a particular patient and in any case they found communication through the administrative centre clumsy and time-consuming. As one doctor put it: I'd like to be able to talk to the nurse direct; there just isn't time to hang on the telephone for hours to find out who she is and then it's usually just a matter of giving a message to a third person'. Or another: 'Telephoning to the centre does not help at all; I'd like a report from the nurse who has seen the patient, and mostly I don't even know who she is'. One doctor recently appointed to a large group practice said: 'If there were just two or three of them we could have our morning coffee together, but we can't cope with a dozen or so'.

In answer to a question about the nurse who looked after most of his patients, several doctors were surprised and seemed unaware that district nurses usually had responsibility for a geographical area. One said: 'I never see the same nurse twice and didn't know there was a regular one'.

Increases in the number of district nurses were planned for almost all areas; this meant that nurses' geographical districts would be made smaller, resulting in even more nurses covering medical practice areas.

In the absence of any geographical limitation of medical practice areas, attachment schemes seem the only way to limit the number of doctors and nurses working together.

There was surprisingly little personal contact between doctors and nurses. Most of their meetings, over 60%, took place at the patient's home or in the street and almost always they were entirely accidental. About 25% occurred when the nurse either called at the doctor's surgery on her own initiative, or, more rarely, was asked by the doctor to do so. Only about 10% of the nurses had a regular arrangement with a doctor or doctors to meet for professional discussion.

The fact that 41% of the doctors never, or hardly ever, met the district nurse who looked after most of their patients is alarming. Equally disturbing was the figure of 45% of the nurses who met the doctor who was responsible for most of their patients less than ten times a year (Tables 12 and 13). One nurse who had been in the area more than a year had never met any of her patients' doctors.

The accepted practice of the doctor and sister together seeing a patient in the hospital ward was rarely reproduced on the district. Two hundred and ninety-one (95%) doctors had never, or hardly ever, paid a joint visit with the district nurse to a patient and one in four of the nurses had never met a doctor for that purpose; 70% had done so very rarely over the course of several years. Sometimes the nurse had asked the doctor to visit with her, sometimes it was the other way round. The most common circumstances was when a doctor wished to examine a wound and wanted the nurse to deal with the dressing for him. The next most common reasons were to assess progress or discuss the problem with the family. Twenty-six nurses had been asked by a doctor to meet for a joint visit so as to act as a chaperone.

Ninety-nine per cent of the nurses, only two dissenting, felt that a nurse should discuss her patients with the doctor. Only half considered that they had sufficient opportunity to do so,

TABLE 13

Nurses' responses concerning meetings with doctors

Number of meetings	Areas						Total	
	Industrial		Retirement		Rural*			
	Number of nurses who met doctors		Number of nurses who met doctors		Number of nurses who met doctors			
		%		%		%		%
Never or less than ten times a year	27	54	28	70	24	27	79	45
Between once weekly and once monthly	22	44	10	25	42	48	74	42
More than once weekly	1	2	-	-	16	18	17	10
Not answered	-	-	2	5	5	7	7	3

*Midwifery undertaken by district nurses in the rural areas, entails more professional contact between doctor and nurse.

TABLE 14

Meetings between doctors and nurses related to number of doctors

Number of meetings	Number of doctors worked with		
	5 or less	6-14	15 or more
	% nurses	% nurses	% nurses
Never or less than ten times	17	47	68
Between once weekly and once monthly	66	46	30
More than once weekly	13	4	1
Not answered	4	3	1

most of whom were nurses who had comparatively recently embarked on a district nursing career. The more experienced nurses recognised the value of discussion and had met the doctors more often. Either these nurses were more insistent or the doctors considered that talks with them were more worthwhile. However, as shown by the Tables 14 and 15, opportunities for meetings and discussions, even for the most experienced nurses, decreased as the number of doctors for whom they worked increased.

While about one in every three of the nurses had the impression that the doctors did not wish to discuss their patients with them, half of the doctors regretted their limited contact with the nurses.

Doctors working in large group practices were consistently keener than the others on frequent meetings with the nurses. They generally showed a greater interest in improving liaison and collaboration with all other workers and also in new ideas and experimentation. This is not surprising, as doctors who form a group practice are likely to be forward looking, to represent a wide variety of interests and to have an organisation which reduces the pressure on each individual.

The trend toward group practice was seen as having a potential for improving collaboration between doctors and nurses.

A striking inverse correlation was found between the length of time doctors had been in general practice and their efforts to get to know district nurses and meet them and other workers for discussion. This is shown in Table 16.

It is probably true that the younger generation of general practitioners is more aware of the other community services and the benefits of a team approach to medical care, and one would like to interpret this table in this way. It could, however, also indicate that, among the older doctors, there is a waning of interest in meeting colleagues.

TABLE 15

Opportunities for discussion related to number of doctors

Number of meetings	Number of doctors worked with		
	5 or less	6-14	15 or more
	%	%	%
Nurses who had sufficient opportunity for discussion	77	50	33
Insufficient opportunity for discussion	23	49	64
Not answered	-	1	3

TABLE 16

Relationship between length of time in practice and interest in other workers

	Length of time in practice		
	5 years or less	6-20 years	21 years or more
	%	%	%
Not interested in discussion with other workers	13	20	27
Not interested in nurse's specialist qualifications	58	61	70
Not interested in meetings with other workers	24	32	58

District nurses in relation to the hospital service.

Information about the relationship of district nurses with the hospital service was obtained as part of a sub-study designed to examine the extent of collaboration between the district nursing service and various other services, both statutory and voluntary. No systematic measurement of collaboration was attempted although this appeared as a worthwhile field for future investigation.

The sub-study was undertaken mainly by means of unstructured interviews with members of staff with responsibility for those allied services with whom the closest liaison was anticipated. They were not the same in each of the research areas; as the available services differed so did their links with the district nursing service. For these reasons and also because of the small number of respondents involved, structured interview schedules were considered unsuitable, but predetermined topics were discussed in all interviews.

The service with which the district nurses had most contact was the home help service which is the concern of a whole chapter in 'Feeling the Pulse'[1.] (pp 82-88).

In this chapter the relationship with the hospital service is singled out because it provided the reason and impetus for the progression to the study described in Chapter 6 which was designed to test specific hypotheses. The hospitals with whose staff interviews were sought were those reputed to have the most contact with the domiciliary services, that is to say, those who referred most patients or into whose care most patients were admitted. There were student or pupil training schools in all but two of them. Nine general hospitals and two geriatric units were involved in the enquiry.

As far as could be assessed, the formal relationship between the hospitals and the district nursing service appeared to be good at the

administrative level. It was common practice for the superintendent of the district nursing service to serve on the Hospital Management Committee or on the Area Nurse Training Committee. Further links between the hospitals and domiciliary nursing services existed in those hospitals which were nurse training schools; learners from those schools usually spent a day with a district nurse and/or a health visitor in order to be introduced to the work of nurses in the domiciliary setting. Additional opportunities for staff in the hospital and in the domiciliary nursing services to learn more about each other, were available in two areas. In one of these, the district nursing staff were given observational experience in a general hospital and in the other, a scheme encouraging ward sisters to observe district nursing practice, had been launched just before this study was undertaken.

All respondents commented on the value of these contacts in promoting relationships on a personal level but indicated that these did not necessarily result in professional liaison at field level on behalf of individual patients. The need for such liaison seemed to be generally appreciated and formal mechanisms to achieve it had been established in all but one area. These formal lines of contact consisted either of regular meetings which were attended by representatives of the various services concerned or of visits by domiciliary staff to the hospital in order to discuss the care of specific patients. In practice, the liaison was in the main restricted to maternity patients and to the elderly. Only in one of the two retirement areas was a district nurse field worker involved; liaison in the other areas being effected at administrative level, liaison committees being attended by heads of departments. Direct contact between ward sisters and district nurses to discuss continuity of care of individual patients was, in all areas, considered to be a

rare exception. Health visitors, often designated as 'geriatric health visitors' tended to effect liaison on behalf of elderly patients. Thus, although the potential benefits of direct and close contact between hospital and district nursing staff were generally agreed, the practicality of such contact was called into question by some administrators of both services. Thus, in one of the areas, the matron of the largest hospital considered direct contact 'impracticable for a busy hospital'; in another area, the matron in charge of two hospitals expressed regret over the lack of response to her invitations to district nursing staff to visit the hospitals, but the administrator of the district nursing service considered that the advantages of such visits would be negated by the amount of time and travel involved.

This study was undertaken before the attachment of district nursing staff to general medical practice became common practice. Therefore, the mobilisation of the district nursing service was dependent on referral by the general practitioner.

Eighty-six (28%) doctors considered that the domiciliary team were often prevented from giving patients full care through inadequate liaison on discharge from hospital. Delay in notification was the most commonly mentioned grievance. This was particularly so in both industrial towns. It was also in 'A' that the highest proportion of all nurses complained of insufficient information about patients discharged from hospital. In spite of the doctors being more scattered in the rural areas, fewer of them commented on communication problems with the hospitals as far as the care of patients was concerned. It was common practice in those areas for the hospital authorities to notify both the general practitioner and the district nurse of the discharge of a patient needing nursing care, a procedure which inevitably reduced the time lag between the

patient's discharge and the nurse's first visit. In the urban and retirement areas, notifications of discharge were usually sent only to the doctors, who then had to contact the district nursing service. As calls in these areas were mainly channelled through administrative centres, further delays tended to occur which have already been mentioned.

The medical social workers, through whom referrals were mostly made, advanced lack of clerical staff in the hospitals as one of the main causes of delay in notification. The medical social workers in two hospitals stressed the advantage to them of general practitioner groups with public health nurse attachments. Under such conditions it was easier and less time-consuming to establish contact with a professional person with whom the medical and social conditions of the patient could be discussed.

Several doctors mentioned that they were not always notified of the death of their patients, and often had to glean the information from the newspaper. In the country, where doctor-family relationships are on the whole closer and where doctors know more members of a family who might live in adjoining villages, this lack of up-to-date information tended to cause embarrassment. Some doctors thought that it might undermine the family's confidence in them.

A few doctors said that occasionally patients were discharged to unsuitable home conditions and saw in the assessment of patients' homes a useful practical activity for the health visitor. In the northern retirement town, patients who, in the opinion of the doctors, needed 24-hour nursing care, were often sent home and the district nursing service was expected to provide coverage. This was particularly difficult in that area where the nurses were already grossly overworked. This was also the only place where quite a number of doctors spontaneously commented on unco-operative relatives

who 'tend to take advantage of the health service and take all they can'.

The results of the national postal questionnaire to superintendents showed that among personnel with whom liaison was thought to need improvement, local hospital staff ranked highest - 65 superintendents (44%).

There was evidence that, in spite of amicable formal administrative relationships between the three branches of the health service, field level contact and co-operation was on the whole poor and almost wholly confined to the care of maternity and geriatric patients. General practitioners, district nurses and ward sisters considered that patient care could be improved by more effective liaison. Interviews with sisters in charge of wards, outpatient and casualty departments revealed that they were often dealing with patients who did not require hospital care. For example, in one of the industrial areas the investigator observed a patient who had been requested to attend the hospital to be instructed in the self-administration of a hypodermic injection. Several hospital sisters expressed surprise when they heard more about the potential contribution of the district nursing service.

There was a particularly effective working relationship between the hospital and community services in one of the rural areas where the matron of the main hospital had herself been a health visitor. She had, no doubt, helped to convey her own co-operative attitude to her staff. The ward sisters seemed more aware and more appreciative of the domiciliary services in general than did those in other areas.

It seems, on the basis of this investigation, that the domiciliary nursing service was not always fully exploited for the patient's benefit. This was at least partly due to inadequate knowledge of its function by the hospital staff and to insufficient attempts on

all sides to establish effective contact.

The analyses of the district nurses' work presented and discussed in Chapter 4 further showed that by far the largest proportion of their patients were the elderly. Two questions, therefore, needed to be answered. First, were some younger patients who might have benefitted from the help of a nurse after discharge from hospital denied such help? and second, were some patients who could have been cared for by district nurses for, say, post-operative dressings, recalled to hospital outpatient departments for such care?

The two questions were re-stated as hypotheses which the next study in the research programme was designed to test. It is summarised in the following chapter.

The findings of this study (Chapters 4 and 5) also suggest that the work of district nurses is determined by many factors, especially by the administrative structure within which they operate. This point, which was consistently supported throughout the research programme, is taken up again in Chapter 13.

CHAPTER 6

PROGRESSION TO A STUDY DESIGNED TO TEST HYPOTHESES

Whereas the study summarised in Chapters 4 and 5 was of an exploratory descriptive nature the research which followed it progressed to the testing of two hypotheses. The hypotheses were: -

1. Patients are discharged from hospital without having the full domiciliary facilities made available to them.

2. Patients are requested to attend hospital as out-patients for treatment which could be given in their own homes.

The first part of this chapter explains why and on what basis the hypotheses were formulated and the second part deals with the method and main findings of the study.

Two sets of data were used to provide the basis for progression to the formulation of hypotheses, namely the work of district nursing staff including their views on the work and also the information on relationships between district nurses, general practitioners and hospital staff.

As shown in Tables 6 and 17 it seemed that district nurses, many of whom held qualifications over and above the minimum for licence to practise, were spending much of their time on tasks which, in their view, could have been undertaken by less qualified staff with or even without a qualified nurse's supervision. The evidence, therefore, came from two sources; the work record completed by staff and also from personal interviews with them. As far as the patients cared for by the district nurses in the study were concerned, Tables 18 and 19 are relevant. They show that the patients of 65 years and over received around 70% of the nurses' time except for the rural areas, where the nurses' time was more evenly distributed over all age groups. Expressed as percentage of all visits, those to the elderly amounted to at least 64.5% in the rural areas and to

TABLE 17

Suggested delegation to SEN

	Needed for longer	Suggested as new worker	
	No. visits	No. visits	%
Areas A and B			
Under 65 years	0	336	19*
65 years and over	1	1,279	30*
Total		1,615	29
Medical		1,407	25
Surgical	1	200	4
All other and dual cases		20	0.4
Areas C and D			
Under 65 years	0	147	18*
65 years and over	6	464	18*
Total		611	18
Medical	5	582	17
Surgical		25	7
All other and dual cases	1	6	2
Areas E and F			
Under 65 years	0	141	20*
65 years and over	1	462	26*
Total		603	24
Medical	1	534	21
Surgical		71	3
All other and dual cases		11	0.4

* Percentage of visits to respective age groups

The kinds of care suggested suitable for delegation to SENs were: -

Simple basic care (72%), dressings (43%), injections (36%), foot toilet (27%), others (16%)

TABLE 18

Time distribution on home visits by patients' age group

Areas	Under 5 % of total time	5-64 % of total time	65 and over % of total time
A	0.3	30.2	69.3
B	0.1	29.3	70.6
C	0.0	17.8	81.3
D	0.0	28.6	71.4
E	0.5	16.6	55.8
F	0.3	14.2	43.8

TABLE 19

Percentage distribution of nurses' visits

Areas	Under 50	50-64	65-70	71-80	81-90	90+	Total to 65 and over
Industrial	14.5 (under 5 3.2)	17.1	32.4	26.4	6.8	2.8	68.4
Retirement	3.3	3.6	13.0	34.0	39.1	7.0	93.1
Rural	19.3 (under 5 4.3)	16.2	20.0	25.2	14.3	5.0	64.5

just over 93% in the retirement areas. It was not the intention to suggest that the care of the elderly population can be delegated to unqualified staff in all instances. It seemed, however, that a proportion of that care was of a kind which would have been undertaken by a relative or friend had such a person been available. It was precisely because the age of the patient or the type of procedure undertaken does not indicate the level of skill required, that the views of the staff were sought.

The relevance of the data on the predominance of the elderly in a district nurse's work load for this study lies in the absence of the younger age groups from it. It must lead one to ask where the younger patients were cared for and where technical procedures for all age groups were carried out.

At the time of this research district nurses were dependent for the referral of patients to them. The largest proportion of a district nurse's patients was and still is referred to her by the general practitioner and, therefore, their knowledge and use of the district nursing service was examined in some detail, as was also their working relationships with district nurses. Chapter 5 presented some of these findings and also described part of a cursory exploratory enquiry designed to examine the extent of contact and communications between the district nursing service and other community services, the part exploring its relationship with the hospital service.

The exploratory enquiry suggested that contact between the district nursing and hospital nursing services was not always considered effective.

In the earlier studies, district nursing staff had expressed concern about what appeared to them to be unnecessary visits by patients to out-patient departments. They felt that the treatment

for which patients had to attend hospital could be given by them. They contended that such out-patient visits were not merely unnecessary but also inconvenient for the patients and might imply lack of competence of district nursing staff, thereby undermining patients' confidence in those responsible for their long term care. Furthermore, the expensive ambulance service was often used for the transport of these patients.

The trend to reduce the patients' stay in hospital upon which the local authority 'Developments for Community Care' (op cit)[28] were based, did not appear to be reflected in the work pattern of district nurses demonstrated in various recent surveys. This suggests that some patients were either retained in hospital longer than their medical condition demanded, or that they were discharged without having the district nursing service made available to them. The importance of effective arrangements for after-care of patients discharged from hospital has been stressed in a variety of reports and documents.[28,29].

Studies of out-patient departments had pinpointed weaknesses there also, particularly excessive waiting time and overcrowding.[31,32] Within the period 1959 to 1965, the increase of new out-patient attendances was roughly half a million.[33]. Hospital staffs and facilities had not increased at the same rate, resulting in heavy overloading of individual out-patient sessions. Given that the increase of new out-patient attendances was inevitable, one way of reducing the pressure on the hospital was seen to be a diversion of potential re-attenders to the general practitioner and the local authority nursing services.

In a circular concerned with management problems in out-patient departments[34]. it was noted that several consultants were of the view that general practitioners tend to refer patients to out-patient

departments for treatment which could be given at home. Conversely, general practitioners have also been known to complain that patients of theirs who, in their view could have been satisfactorily treated at home, were attending hospital as out-patients*.

A specific detailed study concerned with relationships between hospital and district nursing services seemed a logical next step. At no stage was any attempt made to assess the appropriateness of treatment or care suggested by doctors within or outside the hospital. The aim was rather to obtain factual information about current practice and to answer three specific questions.

(a) What type of patients attend hospital as out-patients, and for what reasons?

(b) What referral procedures between hospital and domiciliary services are adopted?

(c) Is the district nursing service in the selected areas able to absorb additional work?

It was hoped that this study might show one way to reduce the burden on the hospitals and, at the same time, mitigate some of the general practitioners' discontents and increase the variety and responsibility of the district nurses' work, commensurate with their qualifications. Most important of all, the changes might lead to a better service for the patient.

Preliminary work

Some preliminary investigations were carried out. These took the form of: -

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* 'The retention of patients for out-patient supervision, often without the knowledge and usually without the consent and co-operation of the patient's doctor, is perhaps the most potent source of frustration and humiliation in general practice under the National Health Service to-day.'

Letter to the British Medical Journal, November, 1964.

Study of relevant background material.

A series of questions about the out-patient services, inserted into the pilot questionnaire completed for another survey by general practitioners and district nurses.

Periods of observation in the out-patient and casualty departments of a medium sized hospital, combined with a brief study of patients' records.

Visits to six hospitals to get some idea of the problem by discussions with matrons, sisters and medical social workers, as appropriate. The hospitals visited were:

a London teaching hospital,

a large non-teaching hospital in London,

a small hospital in outer London,

two hospitals in the Home Counties, and

one hospital in a busy Midland county borough.

The results of these investigations emphasised the need for a study on the lines described.

Before such a comprehensive study could be planned in detail it was necessary to conduct a pilot study; this was undertaken in two hospitals, a teaching hospital and a non-teaching hospital. District nursing staff in three local authority areas participated in the study.

The purpose of the pilot study was to find out: -

Whether the information needed for the proposed main survey was available and could be collected by the means suggested.

Whether the type of interview suggested could be conducted without disruption in a busy out-patient department.

Whether the questionnaires were suitable, and the questions clear and answerable.

How many discharged patients per day an interviewer could be expected to visit.

Whether the district nursing staff would find the proposed questionnaires and work sheets suitable.

The pilot work fulfilled its purpose, although even in the

finally amended questionnaires, used for the main study, some ambiguous questions came to light.

The pilot study suggested difficulty in obtaining hospital records at the time. No alternative seemed possible and the problem was met in full force during the main study, particularly in two of the six hospitals.

The interviews in the out-patient clinics presented no difficulty in the pilot study and full co-operation was received from staff and patients. The pilot pattern was therefore adhered to.

It was found that approximately three addresses had to be visited to achieve one actual interview. It was considered that an interviewer could be expected to visit twelve addresses per day, conducting four effective interviews. This figure represented a crude average and depended on the type of area and transport facilities. The district nursing enquiry was substantially modified in the light of the pilot study.

Design and method of main study

It was decided to obtain information for this study from four main sources. These were patients, hospital staff, general practitioners and district nursing staff. It was necessary, in the first place, to select the hospitals whose patients were to be studied.

Selection of hospitals

The possibility of a national sample survey by various multi-stage random sampling procedures was initially considered. It was, however, found that such an extensive survey would be beyond the resources of the Queen's Institute. It was decided, therefore, to undertake a study in depth of six hospitals and the district nursing service in the areas where most of the hospital patients lived. A purposive selection was made and the hospitals chosen were of various kinds and located in very different parts of the country.

Hospital 1. A teaching hospital outside London.

Hospital 2. A London teaching hospital.

Hospital 3. A hospital in an industrial town.

Hospital 4. A non-teaching hospital in a University town.

Hospital 5. A hospital in the Home Counties.

Hospital 6. A hospital in a seaside town.

All these hospitals had 300-700 beds, a criterion which was applied because: -

(a) Hospitals with less than 300 beds are not usually autonomous unless they cater for particular specialties.

(b) Hospitals with more than 700 beds could be expected to have a very wide catchment area making follow-up difficult.

In the selection of the hospitals it was appreciated that, first, the teaching hospitals might demonstrate a-typical referral patterns as patients may be retained under hospital care for teaching purposes; secondly, that a London teaching hospital, in addition to meeting local needs, might serve an exceptionally wide catchment area, and cater for a large number of commuting patients whose follow-up may be deemed impossible. Nevertheless it was considered that a study of teaching hospitals would be useful, and might disclose points not otherwise covered.

Selection of patients

The base line study of the district nursing service (Chapter 4) and other studies undertaken by individual local authorities, analysed the work of district nurses. The findings indicated that the main types of patients notably absent from the case load were acute medical patients, surgical patients and children. It was thought that the problem of child patients was a different one from that of the adult patient and it was agreed to exclude children as well as all types of specialties, that is to study general medical and

surgical patients only.

Two groups of patients were studied: -

(a) Patients discharged approximately two weeks before the enquiry, from selected general medical and surgical wards.

(b) Patients re-attending general medical and surgical out-patient clinics.

Selection of wards

Prompted by the pilot study it was decided to aim at four interviews a day per interviewer, a total of 120 effective interviews over a two week period undertaken by three interviewers. Allowing for patients who, for various reasons, could not be seen, a list of approximately 150 patients discharged over a two week period was obtained from the hospital. In order to get this number of discharges it was necessary to include a varying number of wards depending on the discharge rate. Once the necessary number of wards was established, a random selection of an equal number of medical and surgical wards was made.

Selection of out-patient clinics

The initial plan was to include, in the sample, only one clinic per day for five days. This decision was prompted by the pilot study which suggested that it would be unwise to aim at a larger number. However, on days when clinics were exceptionally small, additional sessions were included. This gave a better balance of medical and surgical clinics and also increased the overall number of respondents.

Selection of general practitioners

The purpose of the general practitioner enquiry was to find out whether the general practitioners were satisfied with the existing patterns and channels of communication between the hospital medical staff and themselves, whether referrals either way presented problems and, if so, the nature of these problems.

A statement about the survey asking for general practitioner co-operation was sent to the respective Executive Councils, that is to the Councils of three of the six hospital areas in which it was decided to interview a sample of doctors. The sampling frame was compiled from the list of general practitioners whose patients were in the survey. This method of selection ensured that all respondents had recent experience of patients who had either attended hospital as out-patients or who had been in-patients. A one-in-ten simple random sample of these doctors was then drawn.

Further details and findings of the general practitioner enquiry are described in 'Care in the Balance'.[35.]

Selection of hospital staff

Where possible, the sisters of those wards from which the patients in the sample had been discharged and the out-patient sisters were interviewed. Discussions with medical social workers, consultant medical staff, matrons and hospital secretaries yielded further information which is described in 'Care in the Balance'.[36.]

Selection of district nursing staff

The district nursing staff of those local authority areas in which most of the hospital patients lived were invited to participate in the study. A description of this part of the study is presented in 'Care in the Balance'.[37.]

Method of data collection

Data from the patients were collected by means of schedules which consisted of two parts. The first part was completed from the hospital records, the second recorded information obtained from personal interview with the patient.

Out-patients were interviewed at the clinic in the hospital, discharged patients in their homes.

Information from general practitioners and hospital staff was

obtained in free interviews and discussions covering pre-determined topics.

The district nursing staff participated by completing personal data schedules and work record forms. (Annex 2)

The testing of hypothesis I

In theory the required information regarding the involvement of the district nursing service for discharged in-patients should have been obtainable from a study of the patient's medical notes or/and the district nursing records, thereby avoiding the need for extensive home interviewing. However, the pilot study had shown that such an approach would have been abortive. Hospital medical records could not be relied on to indicate any referral to other services and the district nursing service is, in any event, often mobilised by the general practitioner after the patient's discharge, perhaps at the request of relatives. District nursing records did not usually indicate the source of referral and, even less often, the name of the hospital or the date of the patient's discharge. It was considered, therefore, that personal interviews with discharged patients would be the only reasonably reliable way to obtain the desired information. Moreover, home visits afforded the further opportunity of eliciting the patients' views regarding their own after-care. Whilst it was impossible to attempt an objective assessment of the nursing needs of those patients for whom no further nursing care had been arranged, it was considered that patients who express a need may require some help, even if this is only reassurance. Similarly, no attempt was made to assess the need for district nursing care where this had been arranged.

The aim of the data collection was the completion of both parts of the schedule, alluded to earlier, for each patient. This aim was not always achieved. Some patients could not be interviewed and,

therefore, only Part I of the schedule could be completed; for some patients, who were interviewed, medical notes could not be obtained. There were, therefore, three kinds of documents for final analysis: -

Complete schedule - information from medical records plus interviews, i.e., Part I and Part II,

Part I only - factual data from medical notes of non-respondents,

Part II only - information from interview only, medical notes not available.

The small number (17) of non-respondents whose records were not available could not be included in the survey, as there was no information about them.

The distribution of interviews and non-respondents in the six areas is shown in Table 20.

TABLE 20

Distribution of interviews of discharged in-patients and non-respondents

Areas	Complete schedules	Incomplete schedules		Total number of documents analysed
	Part I and Part II	Part I only	Part II only	
1	136	104	5	245
2	73	47	30	150
3	139	25	4	168
4	131	34	2	167
5	65	28	-	93
6	134	16	8	158
Total	678	254	49	981

Respondents and non-respondents were compared in respect of age, sex and length of hospital stay. There was no significant difference on any of these variables between the two groups. For the analysis of factual data extracted from the medical notes, respondents and non-respondents were, therefore, summated. The same procedure was adopted for the second part of the schedule; in the absence of a significant difference between the patients whose medical notes were and those whose notes were not available, all information obtained from interviews was summated (Table 21).

TABLE 21.

Summated documents of respondents and non-respondents
(discharged patients)

Areas	Complete schedules plus Part I only	Complete schedules plus Part II only
1	240	141
2	120	103
3	164	143
4	165	133
5	93	65
6	150	142
Total	932	727

Data collected from the hospital records included age, sex, diagnosis based on the International classification of diseases, length of hospital stay, disposal patterns and services arranged for the patients. An attempt was made to identify which specific variables, if any, were related to discharge policy and to after-care

arrangements for patients. Comparisons between the hospitals were also made, where appropriate.

Tables 22 and 23 demonstrate a marked difference in the age groups of patients being cared for in medical and surgical wards and those being cared for by district nursing staff. Thus, whereas, 36% of the hospital beds were occupied by patients of 45-64 years of age, only 18% of district nursing visits were paid to patients of this age group. It is, of course, pertinent to note that geriatric wards were not included in the study.

As far as the patients' sex distribution is concerned its difference between Hospital 4 and the other five hospitals is significant (Table 24). The explanation lies in the inclusion of a Five Day Ward in the sample, which was a male surgical ward in Hospital 4 and, by definition, had a quick 'through-put' of patients. The Hospital In-Patient Enquiry Statistics were used to assess whether the patients in the study were representative of the normal hospital population. There was a difference in the excess of male patients in the study, even after removal of those discharged from the Five Day Male Ward. The reason was found to lie in the exclusion of gynaecological wards from the study patients. As demonstrated in Table 25, the study patients showed an excess of Diagnostic Group IV patients, which is not explained and a deficit of Diagnostic Group XIII patients which can be explained by the exclusion of orthopaedic wards from the study.

As can be seen from Table 26, the patients' length of stay was remarkably similar in the six hospitals, except for a significant difference in the London Teaching Hospital in its small percentage of patients discharged within 48 hours. The difference is more clearly demonstrated in Figure 3 , where the London Teaching Hospital is set against all other hospitals summated. Again, there was an obvious

TABLE 22

Age distribution of discharged in-patients

Age	Areas						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
5-14	1	3	7	2	1	-	2
15-24	12	13	9	15	26	5	12
25-44	27	26	30	28	26	16	26
45-64	36	41	33	33	31	43	36
65 and over	23	17	21	21	16	35	23
Not stated	1	-	-	1	-	1	1
No. of patients (100%)	240	120	164	165	93	150	932

TABLE 23

District nursing visits* classified by age and sex of patients

Age	Male		Female		Total	
	No.	%	No.	%	No.	%
0-4 years	19	2.8	7	0.5	26	1.2
5-14 years	12	1.8	10	0.6	22	1.0
15-64 years	210	30.7	401	26.0	611	27.5
65-74 years	212	31.0	433	28.1	645	29.0
75-84 years	160	23.3	493	32.0	653	29.3
85 years and over	71	10.4	197	12.8	268	12.0
Total	684	100.0	1,541	100.0	2,225	100.0

For 36 visits this information was not available.
*Number of visits is not the same as number of patients.

TABLE 24

Sex distribution of discharged in-patients

Sex	Areas						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Male	47	43	52	63	54	55	52
Female	53	57	48	37	46	45	48
No. of patients (100%)	240	120	164	165	93	150	932

The area numbers correspond with the hospital numbers. Area 4, which represents Hospital 4, included a Five Day Ward for male surgical patients.

TABLE 25

Rank order of diagnosis for survey patients and HIPE by major diagnostic groups

Diagnostic Groups	Survey Ranking	HIPE Ranking
I. Infective and Parasitic Diseases	12	11
II. Neoplasms	4	5
III. Allergic, Endocrine System, Metabolic and Nutritional Diseases	7	10
IV. Diseases of the Blood and Blood-forming Organs	10	15
V. Mental, Psychoneurotic and Personality Disorders	15	14
VI. Diseases of the Nervous System and Sense Organs	8	7
VII. Diseases of the Circulatory System	2	6
VIII. Diseases of the Respiratory System	9	2
IX. Diseases of the Digestive System	1	1
X. Diseases of the Genito-Urinary System	6	4
XI. Deliveries and Complications of Pregnancy, Childbirth and the Puerperium	-	-
XII. Diseases of the Skin and Cellular Tissue	11	12
XIII. Diseases of the Bones and Organs of Movement	13	9
XIV. Congenital Malformations	14	13
XV. Certain Diseases of Early Infancy	-	-
XVI. Symptoms, Senility and ill-defined conditions	3	8
XVII. Accidents, Poisonings and Violence	5	3

(Deliveries and Complications of Pregnancy (XI) not included).
(Diseases of Early Infancy (XV) not included).

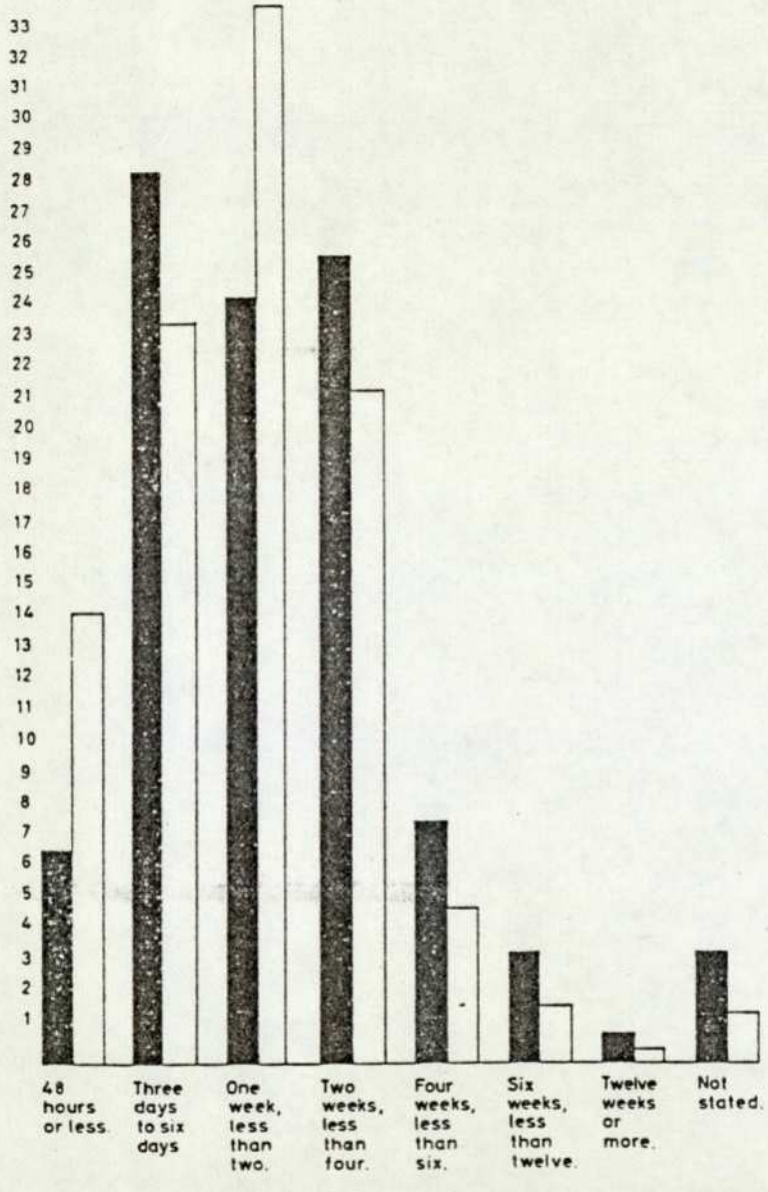
TABLE 26

Length of hospital stay

Length of hospital stay	Hospitals						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
48 hours or less	15	6	10	16	16	13	13
Three to six days	28	28	23	28	22	16	24
One week, less than two	27	24	40	33	32	35	32
Two weeks, less than four	20	26	18	16	22	31	22
Four weeks, less than six	5	8	5	2	6	3	5
Six weeks, less than twelve	1	3	3	2	-	1	2
Twelve weeks or more	-	1	1	-	-	-	-
Not stated	4	4	-	3	2	1	2
No. of patients (100%)	240	120	164	165	93	150	932

FIGURE 3

Comparison of length of stay for discharged in-patients from London teaching hospital with the other hospitals summated



Height of block = percentage of total patients.
London teaching hospital (shaded block): total 120 patients
Other Hospitals summated: total 812 patients

reason for the discrepancy, in that the London Teaching Hospital drew its patients from a wider catchment area. Another difference between the London Teaching Hospital and the other hospitals summated, lay in the larger proportion of patients who were asked to re-attend the out-patient department. In a study, such as this, designed to test the hypothesis that patients are requested to attend out-patient departments for treatment which could be given in their own homes, such discrepancies warrant further investigation. A total of 727 patients were interviewed in their own home as close to two weeks after discharge as possible. The following information was collected, the most relevant data being presented in Annex 2.

1. The socio-economic class, using the Classifications of Occupations 1966.
2. Accommodation occupied by the discharged patients and the size of their household.
3. Patients' sanitary facilities.
4. Patients' home commitments.
5. Patients' mobility.
6. Household duties and simple personal care.
7. Continued treatment.
8. District nursing care.
9. Consultation with the general practitioner.
10. Return visits to the hospital.
11. Patients' preference for place of care and views on length of stay in hospital.
12. Patients' assessment on their state of well being and needs mentioned by them.

Table 27 shows the number of times various needs were mentioned by discharged patients as their priority.

TABLE 27

Number of times various needs were mentioned by discharged in-patients as their prior requirements

Group of need	No. of times mentioned as first need
Domestic and/or simple nursing help	33
Medical or nursing advice, reassurance	30
Other services, e.g., chiropody, appliances, medical loans, one patient wanted 'alcoholics anonymous'	27
Financial help	26
Convalescence	11
Advice about housing, employment, etc.	9
	136*

*Some of the 136 patients expressed more than one of the above needs.

Table 27 alone shows that there are among discharged patients those who have needs of one sort or another. Some of those needs could possibly have been alleviated or met by available services had they been mobilised. Only a small proportion of the needs seemed to be of a definite nursing nature; all of the needs might, however, have been investigated by a suitably qualified worker, such as a district nurse or health visitor, who would be able to reassure, to advise, to identify real need and to initiate appropriate services.

Such a small amount of evidence regarding the needs of discharged patients is not adequate as either support or as refutation of a hypothesis.

Testing of Hypothesis II

The second hypothesis related mainly to out-patient attendances and the process of testing it included a study of records, interviews with re-attending out-patients and with medical and nursing staff, both in hospital and in the domiciliary setting.

In selecting the sample of patients for this part of the study, those patients attending out-patient departments for the first time as 'new patients' were excluded on the assumption that they would have been referred for a consultant's opinion, for which a visit to the hospital was necessary. The sampling frame consisted of all re-attenders to general medical and surgical clinics which were selected mainly on the basis of achieving a balance between medical and surgical patients.

As in the earlier part of the study the data collecting tool consisted of two parts. The first part recorded data from the hospital medical records and the second part was concerned with the information obtained from interviews with the out-patients. The interviews took place at the clinic after the patients had been seen by the physician or surgeon. Table 28 shows the distribution and number

TABLE 28

No. of summated documents of respondents and non-respondents (out-patients)

Hospitals	Complete schedules plus Part I only	Complete schedules plus Part II only
1	424	318
2	422	324
3	400	226
4	387	270
5	203	145
6	394	241
Total	2,230	1,524

of schedules in relation to their completed component parts.

Also in line with the previously described schedule, Part I recorded the patient's name and address, age, sex, diagnostic group and services arranged. In addition, the number of previous visits to the out-patient department and the decision on future care, if any, referred to as disposal, were extracted.

Many problems were encountered which are fully described in 'Care in the Balance'.[2].

Information collected from the patients included: -

1. Distance between their home and the hospital they attended as out-patients.
2. Mode of transport.
3. Loss of working time due to hospital attendance.
4. Duration of journey and loss of income.
5. Expenditure of journey for patients and those accompanying him.
6. Patients with children and other dependents.
7. Involvement of general practitioners and district nurses with hospital out-patients.
8. Other community services received by out-patients.
9. Care received at the hospital visit.
10. Patients' preference for place of care.

Again only one table is presented here merely in order to show that out-patient attendances may not be convenient for patients, being costly and time consuming. Therefore, alternatives to hospital out-patient care are worth pursuing. Annex 2 provides further data.

Table 29 demonstrates that only eight per cent of 1524 patients were able to reach the hospital on foot. For the others the journey required public or private transport, both methods being expensive. For nine per cent, a sizeable number, a hospital car or ambulance had been provided, an important item of public expenditure.

TABLE 29

Mode of Transport

Mode of transport	Percentage of patients in each hospital area						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
On foot	9	6	9	7	11	7	8
Public transport	45	58	48	46	22	43	45
Private car (Patients)	17	10	18	21	34	17	18
Private car (Friends)	16	10	10	19	18	22	16
Bicycle or motor-bike	1	1	-	2	1	-	1
Taxi	-	2	2	1	3	7	2
Ambulance or sitting car	10	12	12	4	10	3	9
Not stated/not applicable	2	1	1	-	1	1	1
No. of patients (100%)	318	324	226	270	145	241	1,524

Again there was a marked difference in referral patterns between the London hospital and the other hospitals summated (Figure 4). Such small amounts of evidence regarding the needs of discharged in-patients and inconvenience to re-attending out-patients are, of course, in no way adequate to provide either support or refutation of for the two hypotheses. However, one contribution of this research to the available knowledge about patient care was its inclusion of patients as respondents. For a balanced interpretation, it is necessary to study all sources of information, hospital records, medical and nursing staff as well as the patients concerned. In Annex 2 additional findings are provided. The purpose of this chapter is merely to show the type of information which was collected for the purpose of testing specific hypotheses. In order to draw conclusions from the diverse data, the strands from the various sections of the study need to be pulled together.

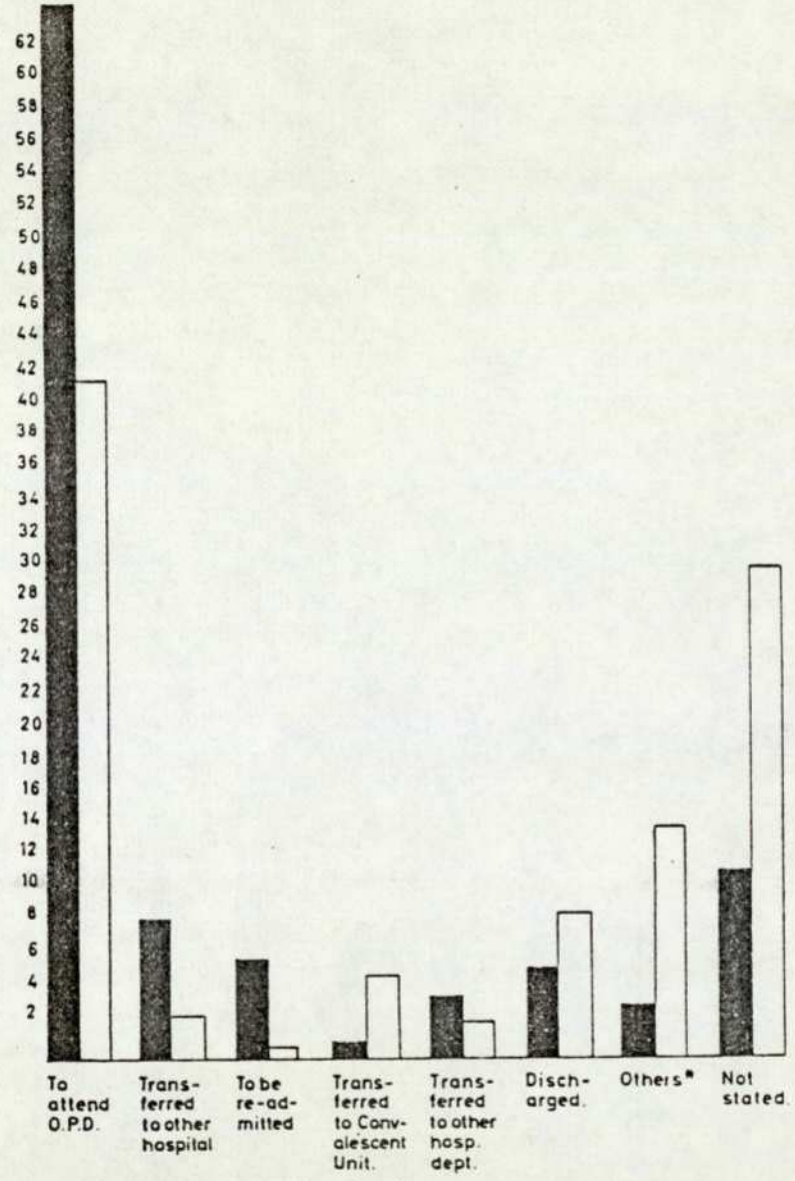
As the enquiry was limited to six selected hospitals and their surrounding local authority areas, no claim for a general application of the findings is made. The firm general recommendation arising from this report is that the staff of each hospital and each local authority and the general practitioners should review their activities in relation to the findings of this survey. Any further broad recommendations and suggestions must be considered in the light of local practices and circumstances to which they may or may not be directly relevant.

Discharged in-patients and current out-patients formed the two main groups of respondents and several of the findings and conclusions are common to both.

The survey findings highlighted some of the less desirable implications of out-patient attendances. These affected the patient because of long journeys, expenditure on fares, waiting time, loss of

FIGURE 4

Comparison of disposal pattern of discharged in-patients from London teaching hospital with other hospitals summated



Height of block = percentage of total patients
London teaching hospital (shaded block): total 120 patients
Other hospitals summated: total 812 patients
'Others' includes: self-discharged; died; handed over to police; combination mainly of Convalescent Unit and O.P.D.

income; they caused pressure and overcrowding in the out-patient departments, loss of working time. The out-patient study suggested that patients who had already attended a number of times were more likely to prefer the hospital to other places of care, showing in a measure of dependence; this could have been a preference for continuity of care and confidence in it. The pattern was perpetuated by the hospital medical staff who seemed reluctant to discharge or refer patients. Patients on their third or subsequent visit were often seen by different members of staff, perhaps by those in the lower ranks of the hospital medical hierarchy; one was left wondering whether these doctors found it easier and safer to request a re-attendance than to take the responsibility of initiating alternative procedures, or to seek authority to do so, where appropriate.

If Ministerial policy to reserve hospital facilities for those who really need them is to be effective, a profound change of attitudes is necessary; a statement which applies first to the hospital consultant. This survey was not the first or only source of evidence showing a reluctance on the part of many consultants to refer patients to community care; they seemed to be uncertain about the standard of care that can be provided outside hospital, particularly by the district nursing service. The faith many consultants had in their own ward sisters did not extend to their community counterparts the district nursing sisters, whose professional preparation was certainly not always recognised. One consultant who had lost his ward sister to the district nursing service was under the impression that she was the first trained pioneer! It seemed advisable to have a clearer discharge policy for out-patients enabling medical staff other than the consultant to take the initiative for discharge and referral.

If continuity of patient care were to be achieved, both from the

home to the hospital and from the hospital to the home, communications between the general practitioners and the hospital medical staff were seen to need considerable improvement. Reports sent to the general practitioner about patients who have been seen by hospital medical staff as in- or out- patients must be prompt. Delay in receiving hospital reports was one of the main grievances voiced by the general practitioners in this study. The reports must also be more informative. Full awareness of the weaknesses in the type of information about patients sent from the hospital to the general practitioner was shown by a Sub-Committee of the Standing Medical Advisory Committee.[38] This Committee recommended that: -

> 'in most cases the discharge letter must be followed as soon as possible by the full discharge summary but for some treatments, the discharge letter itself which should be sent at the time discharge is decided upon, will be sufficient'.

Although the Committee recognised that: -

> 'there are a number of items of information which should be known by the general practitioner, which might not occur to the hospital doctor completing the form, e.g., information given to the patient's relatives,'

they decided on a simple flexible form. The Committee suggested, however, that notes of guidance be included in any handbook issued to housemen. The Committee, in its report, commended the practice established by a number of hospitals of sending a notification to a general practitioner that one of his patients had been admitted to hospital. This appeared to be done by one of the three hospitals in whose areas the general practitioner enquiry was conducted, and was appreciated by the general practitioners concerned.

The communication between the hospital and district nursing staffs was also found to be either sparse or non-existent. Ward sisters and district nurses expressed concern about the lack of mutual contact but did little to improve it. In the two hospitals where deliberate efforts to establish better communications and more

personal contact had been made, benefits to both services, and to the patient were reported.

It was concluded by the investigator that ward sisters should be willing to enlist the help of the local authority nursing services for the continuing care and support of their patients. They should also be able to use these services to get to know more about their patients' social background and home circumstances, knowledge that is needed for the planning of the patient's discharge and after-care.

The medical and nursing administrators of the domiciliary services need to make it possible for their staff to respond to requests and facilitate this liaison. This was seen to be particularly important in areas where the attachment of local authority nursing staff to general medical practice has, for one reason or another, not been implemented.

Another factor militating against an extension of community care seemed to be the inadequacy of supportive services, particularly of the invaluable home help service.

The survey showed that there may well be need for help among patients who have not asked for it, either because they did not know they could be helped or they were unsure as to how and where to apply, a finding which was supported in a Scottish study 'Hospital and Community'.[39]

This gap in care is closely linked with one of the more obvious needs of patients which this study has exposed, an efficient follow-up service for patients who have had treatment or advice at the hospital. This service would be best undertaken by the district nurse who would be involved in the patient's care. There were ward sisters in all six survey hospitals who said that they usually had patients in their wards who could be discharged if their home conditions were suitable; only very rarely were these statements

based on information obtained from professional colleagues.

Most patients who attended the hospital for nursing treatments such as dressings, removal of sutures and injections, received this care in the wards or in the accident and emergency departments. They were not always seen by a doctor, and the reasons for recalling them to hospital were often simply 'the usual practice'. Sometimes the consultant insisted on their return, sometimes the ward sisters preferred to complete the care of their own patients. The extent to which the district nursing service assumed responsibility for these categories of hospital patients in the survey was negligible. It must not be concluded from this finding that patients returned to the hospital in large numbers for nursing care or that they were discharged without suitable arrangements for further nursing being made. The main reason for the minimal involvement was that patients did not seem to need much technical or practical nursing care: what they needed in abundance was moral support, advice and re-assurance.

In spite of the Ministry Circular 12/65[40]. the employment of SENs and ancillary nursing staff was still relatively limited. One of the survey areas included a county which had one of the country's highest proportions of SENs in the district nursing service. Without that county the number of SENs in the survey would have been very small indeed and a more realistic reflection of the national scene.

The analysis of work in this survey showed that some of the most highly qualified nurses were spending much time on tasks which could be delegated, leaving less time for the skilled professional advice that only they could give. It was pointed out that the triply qualified worker in the rural areas might be more effective if she were, at least sometimes accompanied by a nursing auxiliary; this would expedite the time-consuming practical care, affording the qualified nurse more opportunity to talk to the family, thus giving the patient

the best possible service. The proportion of auxiliaries in the district nursing service was minimal. This was partly because of the nature of their deployment. Some local authorities were reluctant to take the responsibility of sending untrained personnel into the homes of patients. If they were allowed to be helpers to the qualified nurse rather than substitutes for them, their usefulness might be further enhanced. Similarly, a more imaginative use of home helps such as attaching them to general practice teams or financing them as good neighbours might have been helpful.

Patients' anxieties and nursing needs do not disappear with night-fall; they often increase. Some general practitioners felt unable to accept responsibility for certain hospital patients unless a 24-hour home nursing service could be provided. The practicability and usefulness of such a service had proved itself in one of the survey areas. This survey set out to test two hypotheses: -

1. Patients are discharged from hospital without having the full domiciliary facilities made available to them.

2. Patients are requested to attend hospital as out-patients for treatment which could be given in their own homes, or perhaps at the general practitioner's surgery.

Did the findings support or refute these hypotheses?

With regard to the first hypothesis the answer depends on the interpretation of 'full domiciliary facilities'. If these facilities refer to services that can be provided within existing legislation, the hypothesis has been supported. Patients expressed needs of various kinds which had not been met, often because those who could meet them were unaware of their existence. More efficient communications supported by the local authority's care and after-care service would have gone some way toward identifying these needs and helping in many cases. On the other hand, discharged patients were

not found to have obvious serious practical nursing needs which had remained unmet by appropriate mandatory services, although simple nursing care burdens were often shouldered by members of the family.

The second hypothesis was also supported to some extent. There were some patients who attended hospital for treatment which could have been given elsewhere. These patients normally attended the ward or the accident department and the out-patient clinic was rarely involved. The system was usually based on habit and the consultant's preference. The individual needs and preferences of patients and the availability of alternative means of care did not seem to play an important part in the decisions which were made.

This report highlighted deficiencies in co-operation between hospital and domiciliary services.

District nursing and general practitioner sections

In order to test the two hypotheses which was the main purpose of the study it was also necessary to find out whether the community services in general and the district nursing service in particular could have coped with additional work currently undertaken by the hospital. For this reason, the study included a district nursing section and a general practitioner section.

The purpose of the district nursing section of the study was to discover: -

The structure of the district nursing staff and the nature of their duties.

The extent of contact between district nurses, other members of the health and welfare team and the hospital staff.

The types of patients being cared for by the district nursing service.

The district nurses' opinions about their own work and their views on the service as a whole.

The total population of the district nursing staff in those areas from which the hospitals drew most of their patients was invited to

participate.

A 96% response rate was achieved, non-response being due only to sickness and holiday. After careful briefing at group meetings by the investigator the district nurses completed a questionnaire asking for personal details, working arrangements, extent of contact with other workers and personal opinions. They also kept a work record for one week, recording between them 2,261 visits and 2,653 items of care or other tasks. Further analyses are shown in Annex 2. Pertinent to the district nurses' potential contribution are Tables 30 and 31 suggesting that some re-structuring and redeployment of district nursing staff might increase their potential. Table 32 supports the case for some formal working arrangement with general practitioners which seemed to increase contact with hospital staff. It is a pointer only, as the numbers and the differences are too small to reach significance.

Pertinent to the hypothesis was the finding that only 7% of the district nursing staff considered their workload too light enabling them to take on additional work. However, for 15% of their visits, on the basis of the nurses' own assessment, no professional expertise was needed.

If more patients are to be cared for in the community rather than the hospital it was considered necessary to ascertain the views of the general practitioners who would have to accept medical responsibility for these patients.

A one-in-ten random sample of all general practitioners who had patients in the survey, yielded 78 doctors of whom 73 were interviewed. The pre-determined topics covered in the interview were: -

Reports from the hospital.

Hospital versus home care.

District nursing service.

TABLE 30

Use of skills and knowledge in relation to employment and linkage

Utilisation of Skills	Full-time %	Part-time %	Fully seconded %	Partially attached %	Not linked %	Other and not Stated %	Total	
							Number	%
Always or nearly always	83	97	96	81	84	94	390	85
Occasionally	15	3	4	19	14	6	61	13
Hardly ever or never	2	-	-	-	2	-	7	2
Total (100%)	387	71	24	31	371	32	458*	100

*11 nurses did not answer this question.

TABLE 31

Number of district nurses' visits showing nurses' assessment of need for professional expertise, by patients' age groups

Patients' age groups	Full professional expertise needed	Some professional expertise needed	No professional expertise needed	Total
0-4	18	7	-	25
5-14	20	2	-	22
15-64	335	72	112	519
65-74	526	3	96	625
75-84	582	5	50	637
85 and over	200	11	48	259
Total	1,681	100	306	2,087*

*For 174 visits this information was not available.

TABLE 32

Contact with hospital staff

Frequency of contact within last month	Per cent. of nurses		
	Not linked	Fully seconded	Partially attached
None	67	54	73
1-2 times	21	29	21
3-5 times	8	-	6
6-10 times	1	13	-
11-15 times	-	4	-
16 or more	-	-	-
Daily	-	-	-

TABLE 33

Items of care given by district nursing staff during the survey period

Injection	827
Bath, Simple Toilet, Shampoo, Dressing and Undressing	541
Surgical dressing after surgery	180
Surgical dressing for ulcerated leg	333
*Skilled Nursing	342
Supervision and Advice	131
Urine Test, Colostomy, Bandaging and Appliances	79
Enema, Douche, Suppository	64
Rehabilitation	55
Visits with no reply or admittance	28
Instillation of drops and Syringing of ears	22
Temperature, Pulse, and Respiration rates	13
Household errands	11
Visits to doctor to discuss patients	9
Preparation for hospital admission	8
Removal of sutures	5
Cervical smear	3
Patient had died	2
Total	2,653

*General nursing described by the nurse as requiring professional skill and knowledge.

TABLE 34

Number of discharged in-patients by type of care received from district nursing staff in areas

Type of care	Areas						Total
	1	2	3	4	5	6	
Call only	-	-	6	-	-	1	7
Dressing	10	6	7	9	-	19	51
Washing, bathing, etc.	-	-	1	1	-	2	4
Injection	-	3	1	1	2	2	9
Removal of sutures	-	-	-	4	-	-	4
Other	3	-	1	3	-	3	10
Combination	6	-	-	6	-	-	12
Total number of patients having district nursing care	19	9	16	24	2	27	97
As % of discharged patients in each area	13.5	8.7	11.2	18.0	3.1	19.0	13.3

One of the main findings from this study was the gap in continuity of care often due to a lack of knowledge on the part of hospital medical staff about the type and standard of domiciliary care which could be provided.

The analysis of the district nurses' work shown in Tables 33 and 34 further suggested that the after-care of hospital patients, or, more particularly, the nursing care of surgical patients did not play a significant part in their work load.

It thus seemed that the relationship between district nurses and general practitioners and between district nurses and the hospital service had weaknesses which were considered to be professionally undesirable. Professional desirability was, however, based on a professional value judgment and not on demonstrated factual data. For this reason the next studies in the research programme were designed to examine in detail situations where closer relationship between the services existed.

As far as district nursing and general practice was concerned attachment schemes were beginning to increase sharply by the time this descriptive study was completed. There were, therefore, examples available which could be studied. A member of the staff of the Queen's Institute proceeded to undertake a descriptive study of seven practices to which district nurses had been attached.

It seemed that greater collaboration could be achieved resulting in a possible saving of hospital bed days for certain patients. The possibility of mounting an experimental scheme designed to discharge patients earlier than had been the prevailing practice was discussed with a senior surgical consultant. As, to the knowledge of the investigator, no ready made example of such a scheme existed the next stage in the research programme was designed as a quasi-experimental study.

CHAPTER 7

PROGRESSION TO A QUASI-EXPERIMENTAL STUDY

Background.

The decision to mount an experiment was made as a result of an informal discussion with a senior surgical consultant in the course of the previous research project. The consultant had expressed his concern about the never decreasing waiting list of patients requiring 'cold' surgery, such as stripping or ligation of varicose veins, haemorrhoidectomy and herniorraphy. The problems he encountered were typically those of a hospital in a popular seaside town, which attracts holiday visitors for summer activities and elderly people for retirement - both vulnerable groups. Surgical beds tended to be blocked by visitors in the summer and, in the winter, elderly residents needing hospital care outnumbered available beds, thus causing non-urgent treatments to be postponed, often for long periods.

Although the final decision to embark on the study was taken on the basis of this surgeon's concern and willingness to collaborate in an experimental study, the idea of and the need for such research had been generated from a variety of sources. Previous research in the extended programme had analysed district nursing work load and it had been shown that the number of post-surgical patients cared for by district nursing staff was minimal. (Hockey 1966)[1]. A study of District Nursing in Scotland (Carstairs 1966)[11] had produced similar findings. The idea was re-enforced by a variety of statements and articles relating to resource allocation and the expansion of community care.[28,41,42] Attempts to reduce waiting lists and to shorten the length of hospital stay after simple surgery were described in the medical press of the time.[43,44] In addition, the study described in Chapter 6 highlighted the lack of collaboration between the hospital and the domiciliary nursing services and the sparse knowledge about

the potential of the district nursing service which hospital medical staff appeared to have.

the aims of the proposed experiment were to demonstrate the potential contribution of the district nursing service to the care of patients discharged from hospital after surgical treatment, and, in particular, to increase the confidence of the surgeon in the seaside town hospital in the district nursing service, thereby helping to reduce his waiting list. The experiment was to consist of a specially implemented early discharge and after-care scheme for a specific group of patients.

The principles and problems of experimental research and the design and method of this specific quasi-experimental study form the substance of this chapter. Further findings of the study, especially those which provided the impetus for the last study in the research programme are presented in Annex 3.

Experimental design.

An experimental approach has been defined as 'a powerful design for testing hypotheses of causal relationships among variables....' (Treece and Treece 1977).[45.] The classical experimental research design is described briefly below if only to show how the approach used in this study deviated from it and why it is referred to as a quasi-experiment.

FIGURE 5

Classical experimental design
(Source: Treece & Treece, 1977)(page 154)

	Before	After
Control Group	1	3
Experimental Group	2	4

Ideally, all four cells should be used; two groups are identified and subjected to a test which is relevant to the experimental variable. This variable, the experimental factor, is then introduced for the experimental group, after which both groups are re-tested. Differences between the two groups, if any, are then identified and measured if possible. The two groups, experimental and control, should be as alike as possible, so that any established differences after the introduction of the experimental factor can be attributed to it with a measure of calculable confidence. Research theorists agree that such precise experimentation in the human and social setting is not always possible. It is appreciated, for example, that the precise matching of groups is extremely difficult to achieve and substitution of matching by random allocation is gaining popularity. Variations of the classical design are also beginning to gain credence; thus, it is possible to use just three, two or even one of the four cells in a number of possible combinations. For example, a group can be observed after the introduction of a specific change within it and then compared with the general population, which demonstrates the use of cell 4 only. The experimental approach used in this study consisted of the introduction of a combined experimental factor into a self-selected group of patients, the combined experimental factor being an attached district nursing sister linked with an early discharge scheme.

Experimental design in nursing research is beset with two main groups of problems. The first group is common to all experimental research in social rather than laboratory settings, the second is specific to nursing.

The first group of problems is related to the difficulty of holding a vast array of variables 'constant' in a diffuse and constantly changing social setting. In order to show the effect,

that is a causal relationship between the experimental factor and its impact, the experimental factor must first be isolated and clearly defined so that it can be observed. This condition raises three immediate difficulties: first, the isolation of the experimental factor, secondly, its introduction into a social setting and thirdly, the reproducability of the experiment.

The isolation of the experimental factor

The isolation of a single factor rather than a number of factors is remarkably difficult and was found to be almost impossible in the experiment under discussion. Not only was the experimental factor already a combination of early discharge and a specially appointed attached district nursing sister, but the term 'early discharge' embraces much more than a period of time. It can not be isolated from factors such as anticipation of discharge, fear of discharge, home conditions, quite apart from the range of personal and pathological attributes. Therefore, even if the latter variables of personal patient attributes could have been held constant, the concept of 'early discharge' represents a set of expectations which are neither tangible nor definitive.

The introduction of the experimental factor

By definition, a social setting implies the involvement of a group of people in the situation. The introduction of an experimental factor requires the agreement of the group to it which adds an element of artificiality to the experiment. The group, having given consent, can be expected to be positively motivated toward the experiment and may, therefore, albeit unwittingly, influence its normal course. In the experiment described this possibility can certainly not be ruled out. The surgeon, whose patients were discharged 'early' was keen to achieve a quicker throughput as were other members of the hospital staff. The community services represented by the Medical Officer

of Health and the Nursing Administrator were equally keen to prove the potential of their contribution. In addition, the Hawthorne effect of the experiment cannot be discounted. All the people involved realised that the study was being undertaken and that it might be published. They were aware of being 'under observation'.

The reproducability of the experiment

As alluded to earlier, the multiplicity of variables in a social setting raises problems for controlled experiments. It is hardly ever possible to hold social or human variables constant and for this reason randomisation of variables is often resorted to in an attempt to create valid experimental and control groups. In experiments affecting human welfare such randomisation is often modified or even negated on personal, ethical or medical grounds. Therefore, any replication of experiments may be complicated by subjective value judgments. There is yet another factor complicating replication which is social change itself, its constancy and rapidity. A time lag is inherent in any replication studies but this may introduce yet another variable. Moreover, neither the speed nor the direction of social change is identical for different social groups or for different geographical or social environments. Therefore, even if simultaneous replicated experimental studies were carried out in different parts of the country and in different types of areas the change factor could not be standardised. Yet, it is in replication of experiments that hope of establishing relationships of cause and effect lies. Any other research methods can lead to little more than the support or refutation of significant correlations; even these, due to variability in social settings, usually carry intolerably large albeit calculable margins of error.

The specific experiment of 'early discharge' discussed in this chapter is deliberately referred to as a quasi-experiment. It makes

no claim whatever on the status of a real experiment. No scientific control conditions were applied. Patients in the normal and the 'early discharge' groups were neither matched nor randomly allocated. They were patients who were given the option to be discharged earlier than would have normally been the case; they were a self selected and, consequently, a biased group. There is, therefore, no possibility of replication in this particular research design and no claim for any causal relationship between early discharge and patients' progress or satisfaction can be made. However, as is explained below, the self selected group was compared with the other group of patients on a number of variables and seemed to be in no way different other than that they were considered suitable for the scheme.

Reference was made above to the added difficulties of experimental research design in nursing. Reasons for this statement lie in the nature of nursing itself, especially its lack of complete autonomy. Mauksch[46] provides a useful analysis of nursing in highlighting the combination of functions which makes up the nurse's role. Apart from that part of nursing which is nurse initiated and nurse controlled nursing has a medically prescribed content and is also dependent on a number of other disciplines for its effective functioning. (Mauksch's work is referred to again in Chapter 13). Moreover, because of the continuity of nursing over 24 hours a day and seven days a week a number of individual nurses provide nursing, thereby introducing one of the most pertinent variables, their own personal differences in approach, their own personality, skill, motivation and other individual attributes.

In the domiciliary nursing services, this difficulty is decreased in one sense but increased in another. It is decreased in that the number of nurses involved in the care of any one patient may be less than in hospital. It is increased, in that the district nurse's social

relationship with the patient tends to be stronger and that, therefore, the differences between district nurses and their nursing care are less easily neutralised than the inter-nurse differences in the hospital setting. The differences between district nurses and the type of care they give were important considerations in the design of the national study and played a vital part in the decision to include nurses' preferences in the data collecting instrument described in Chapter 9.

Design and method of the quasi-experimental study.

The experiment consisted of the attachment of a district nursing sister to the surgical department of a busy general hospital. It was designed to demonstrate the potential use of the district nursing service for post-operative care. The district nursing sister spent one month on the ward, familiarising herself with the surgeon's preferred methods of after-care for specific surgical procedures, accompanying him on the ward round, establishing relationships with the hospital nursing staff and acquainting herself with the normal discharge routine of the hospital. As she had been a member of the district nursing staff of the local health authority surrounding the hospital, she was familiar with the available community services. The fact that this nursing sister had been on the district nursing staff and, therefore, potentially available to provide after-care for discharged patients is worthy of note. An arrangement of attachment had to be formally made in order to demonstrate the service; there had previously been no referrals of surgical patients by the hospital staff to the dictrict nursing service.

After one month, the central part of the experimental factor was introduced, which was an early discharge and formalised after-care scheme for suitable patients. Some patients were to be discharged earlier than would normally have been the case to be cared for by the

district nursing sister in their own home.

Suitability of patients for the experimental scheme was determined on the basis of specified criteria, which were: -

a) satisfactory post-operative progress, which included the patient's physical and mental condition,

b) availability of appropriate facilities in the patient's home,

c) the patient's preference.

The hospital secretary provided factual data about the patients in the ward; these included the patients' age, sex, type of surgery, date of admission and discharge. The factual data provided the means for comparisons between the patients in the special scheme and the other patients. The calculation of bed days saved through the early discharge scheme was also based on this set of base line data complemented by the consultant's assessment of the likely discharge dates of individual patients based on their individual condition. The calculation of saved days, referred to as 'early day' was crucial to the study as it formed the only reasonably objective item of information on which the scheme was assessed. Early days were, thus, based on the usual period of hospitalisation for the specific surgical procedure and the individual patient's assessment by the surgeon.

The period of the experimental scheme was six months, allowing 23 weeks for patient data being collected. Throughout that period, the district nursing sister kept a record of her work. For one random week she also produced an extremely detailed account of all her activities. (Annex 3).

She first saw all the patients in the ward when she accompanied the surgeon on his rounds; she was present on the occasion of the patients' discharge and after-care was discussed at that time. She

then visited the patients in their own homes either on the day of discharge or, more usually, the next day when she was able to assure herself that all necessary supportive care was available. She gave any nursing care that was needed, but, in any event, she visited most patients daily and sometimes twice daily. After their discharge from the district nurse's care the patients were asked to complete a simple postal questionnaire to be posted direct to the research base in London. A response rate of 84%, representing 106 replies, was achieved. The findings and conclusions from the quasi-experimental study in which it provided a basis for further work are given below. Further relevant data form Annex 3.

Table 35 shows the type and frequency of surgical procedures undertaken for the 126 patients in the experimental scheme.

As the scheme was intended to show if and how many 'bed days' could be saved by discharging patients earlier. Table 36 gives this information by the patients' age groups. It demonstrates that the scheme included patients of all age groups, children, as well as the very old. In Table 37, the nine, most frequently undertaken surgical procedures are related to the average length of stay for each of them and the average of 'early days' made possible through the early discharge scheme. By multiplying the average number of early days by the number of patients in each group one arrives at a total of 590 saved bed days, an average of 4.7 per patient. This apparent saving needed to be set against continued nursing care required after the patient's discharge. As shown in greater detail in Annex 3 the district nurse paid an average of 5.5 visits per patient. There is, therefore, a manpower implication for the domiciliary nursing services in such a scheme. It is, moreover, necessary to assess the general practitioners' reaction to such an innovation which, inevitably, increases their responsibility for post-operative patients and also to

TABLE 35

Type and frequency of surgical procedures undertaken

Type of surgical procedure	Frequency
Appendicectomy	25
Herniorrhaphy	17
Excision of cyst of breast	13
Excision of tumour	9
Cholecystectomy	7
Various surgical procedures for varicose veins	7
Mastectomy	6
Repair of anal fissure	6
Laparotomy	5
Incision of abscess	4
Preparation for and/or skin graft	3
Hiatus hernia (and vagotomy)	3
Excision of gland	3
Oophorectomy and appendicectomy	2
Biopsy	2
Repair of perforation	2
Accidental injury	2
Haemorrhoidectomy	)
Diathermy of polypus	)
Appendix abscess	)
Prostatectomy	) Once
Hydrocele	) only
Excision of scar	)
Breast abscess	)
Ovarian cyst and appendicectomy	)
Amputation of toe	)
Excision of fibrous nodule	)

obtain the views of patients. As far as the GPs were concerned, 38 of the 53 doctors responded to a postal questionnaire asking for their views, a response rate of 72%. Of the respondents, five doctors did not favour the scheme; it is, possible, however, that at least some of the non-respondents belonged to that group and the apparently favourable reception of the scheme by the GPs be interpreted with caution for that reason. The patients were also asked to help with a postal enquiry which yielded an 84% response rate. In view of

TABLE 36

Number of 'early' days in each age group

Age group	Number of 'early' days															Average number of 'early' days	Number of patients in group
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14		
0-14			1		2	1							1			5.4	5
15-20			6	3	4	3	2									3.6	18
21-30				2	3	3		3								4.9	11
31-40	1	1	4	3	4	3		4								3.8	20
41-50			1	6	6	4		6								4.6	23
51-60	1		1	5	5	3	4	3			1					4.7	23
61-70		1	1	2	2	1		3							1	5.2	11
71-80					3	1	3	1	1		1				1	6.4	11
81 and over					1		1	2								6.0	4

TABLE 37

Average length of hospital stay and number of 'early' days for nine most frequent surgical procedures.

Surgical procedure	Col. 1 Number of patients in group	Col. 2 Average length of stay (in days)	Col. 3 Average number of 'early' days	Col. 4 Assessed normal average stay (in days)
Appendicectomy	25	5.8	4.3	10.1
Excision of cyst of breast	13	2.3	4.0	6.3
Herniorrhaphy	17	7.2	5.4	12.6
Repair of anal fissure*	6	5.2 ✓	6.2	11.4
Cholecystectomy	7	11.8	3.6	15.4
Laparotomy	5	16.2	5.4	21.6
Treatment of varicose veins	7	3.1	6.0	9.1
Mastectomy	6	8.2	6.8 ++	15.0
Excision of tumour	9	2.7	4.2 ss	6.9

* This group includes one patient who had a 'laying open of anal sinus' as a day patient. His normal stay in hospital would have been four days.

✓ This includes one patient in hospital for 17 days. The average for the other five patients would be 2.8 days.

++ One patient had 14 'early' days. The average number of 'early' days for the other five patients would be 5.4

ss Two patients in this group had no 'early' day and should not have been included in the study. The average for the other seven would be 5.4 days.

the fact that the patients in the experimental scheme were self selected it was thought that they might wish to make their answers consistent with their decision, thereby, producing a distorted favourable overall response. For this reason they were given the opportunity to state their choice in a hypothetical situation, giving an answer to the question: -

> 'If you had to have another operation would you 'prefer to go to a convalescent home; 'prefer to go home and have a district nurse visit' or 'no preference'?

Table 38 shows the answers.

TABLE 38

Patients' future preference related to age group

Age group	Patient's preference			No response	Total
	Convalescent home	Own home with visits from district nurse	No preference		
0 - 14		1	1	3	5
15 - 20	1	11	1	5	18
21 - 30	1	7	2	1	11
31 - 40		16	3	1	20
41 - 50	1	16	2	4	23
51 - 60		18		5	23
61 - 70	2	8		1	11
71 - 80	1	9	1		11
81 and over	2	1		1	4
Total	8	87	10	21	126

It seemed, therefore, that an 'early discharge scheme' could save a substantial number of hospital bed days and that, on the whole, it seemed acceptable to general practitioners and to the patients themselves. Complex accounting procedures are necessary to calculate

the relative costs of hospital and of domiciliary care; for example, the number of patients who can be cared for in the two settings within a given period of time and the social and/or hidden costs often inherent in domiciliary care should be calculated. Such calculations were not performed as they were far beyond the investigator's competence.

On the basis of the findings of this quasi-experimental study, and in view of the alarming increase in the cost of a hospital bed,* extension of community care by earlier discharge of patients seemed to be a rational proposition. However, as alluded to above, the feasibility was seen to hinge to no small extent on available nursing manpower.

Implications for nursing of an early discharge policy are basically of two kinds: -

1. If patients are discharged from hospital almost as soon as they are past the constant care stage, the intensity of nursing in hospital both in terms of quantity and on quality will be increased.

2. If patients requiring a fair amount of skilled nursing care are discharged for home care, the intensity of nursing in the community both in terms of quantity and in quality will also be increased.

This indicates a need for more qualified personnel rationally deployed.

Recruits for the basic two year course preparing learners for enrolment had, in recent years, over-taken those for the more advanced three year course preparing learners for registration (Addendum 1). It was, therefore, a logical next step to examine carefully the work and deployment of the enrolled nurse vis-a-vis the registered nurse in the community nursing service. Chapter 8 describes the progression to such a study on a national scale.

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* At the time of the study the national average cost based on Hospital Costing Returns 1968/69 was £50 for an in-patient week in a General Hospital.

CHAPTER 8

PROGRESSION TO A NATIONAL STUDY

Design and method of the study

The previous studies undertaken as part of the long-term research programme were limited to specific areas and their findings could not be generalised to any other area in the country. The last study, published in 1972, as Use or Abuse[4]. was designed on a national basis giving the findings national applicability. The study was descriptive and designed to examine the contribution of enrolled nurses to the community nursing service. Its progression from the quasi-experimental approach of the previous study, reported in Chapter 7, lies in the complexity of the design and sampling method, the development of a recording instrument for district nurses' work (Chapter 9) and the potential use of the research findings. The subject of the study was an important issue at the time and the need for it was generated from and re-enforced by the investigator's previous work.

Pilot study

The pilot study was undertaken in four local authority areas, in all of which enrolled nurses were employed. Three of the areas were in England and one in Scotland. The English authorities included a small rural county, a relatively affluent borough in Greater London and a small industrial borough in the North. The Scottish local authority was a small industrial burgh situated between two of Scotland's main cities. The pilot areas were deliberately chosen to be as representative of local health authorities as possible, but, clearly there was a considerable limitation on this attempt imposed by the restriction on the number of pilot areas which it was possible to include.

Sources of information

It was considered important to obtain information from four main sources. These were: -

a. the state registered district nurses employed in the selected areas,

b. the state enrolled district nurses employed in the selected areas

c. the superintendents of the district nursing service in the selected areas

d. the general practitioners in the selected areas.

It was decided to collect the information from the district nurses by a personal interview using a semi-structured interviewing schedule. In order to obtain information about their work the nurses, registered and enrolled, were asked to keep a record of their activities using a blank note book.

Information from the superintendents of the district nursing service was obtained by a combination of interview and self-completed questionnaire. The method of data collection used for the general practitioners in the pilot study also consisted of a combination of interview and questionnaire. Some GPs were interviewed and others were asked to complete a postal questionnaire.

The response rate from all types of respondents in the pilot study was encouraging. Of the 50 nurses approached, 46 participated and of the remaining four potential respondents only one refused because she 'did not believe in research'; the other three nurses had inevitable reasons for non-response, which were sickness in the family, an exceptionally heavy work load due to the sickness of a colleague and sickness of the respondent herself just after commencement of the survey. The four superintendents of the district

nursing service in the selected pilot areas were eager to participate and showed a great deal of interest. A random sample of 217 general practitioners was drawn from the list provided by the Executive Council. Twnety general practitioners were asked for an interview and all agreed. A postal questionnaire was sent to the remaining 197 doctors and 157 were returned representing a response rate of 80%. The reason for interviewing some general practitioners and asking others to complete a postal questionnaire was primarily to discover whether the latter method, being cheaper and less time consuming, would yield a sufficiently high response rate for useful results. The response rate of 80% was considered to be satisfactory and determined the method of data collection for the main study.

The work records, in blank note books provided for the purpose, along with simple instructions regarding the type of information to be recorded, were kept by the 46 nurses for one working day. The nurses were allowed to choose the day themselves; it was thought that they would like to accept the investigator's suggestion to select a day which would best demonstrate the diversity of their duties. It was considered more important to capture the full range of a district nurse's work than to know what a typical day looked like. The 46 completed note books were used as basis for the design of the structured work record book, which, after further testing was used for the main study. It is described in detail in Chapter 9.

The design and method of the main study

The exploratory and pilot studies combined with consultations with professional medical and nursing personnel, with research workers in similar fields and a study of the literature on research methodology, paved the way for the main study design. It was decided to use local health authorities as basic units for the survey, as policy was determined at that level. The variability in the employment of enrolled nurses in the district nursing service was known and it was

this factor which indicated the need for a relatively large sample of local authorities to be studied.

A random sample of 50 local health authorities was drawn with a probability proportional to population after stratification by region and type of area. This method of sampling was arrived at after a great deal of thought. The advisability of selecting a sample with a probability proportional to the employment of enrolled nurses had been carefully considered. It was discarded as a suitable method because it would have biased the results in the direction of authorities with a positive policy regarding the employment of enrolled nurses. It was considered essential to obtain information from respondents with opposing view and policies. On the assumption that those local authorities with a larger population would need a proportionately larger staff complement of all levels of staff the sampling method indicated above was deemed more suitable. The method of stratification also demanded a series of difficult decisions. It could be argued that such a large sample did not require stratification at all; however, in view of the small numbers of local authorities in Scotland, Wales and Northern Ireland compared with England, they might have been missed and it seemed obvious that a study representative of the U.K. as a whole would have to include all constituent countries. In addition, it was considered relevant to ensure a reasonable scatter of geographical regions in England. The second stratification factor was the type of area, that is county, county borough or London borough. Professional experience, statistical information and the pilot work had indicated that the type of area played a considerable part in determining the mix of staff considered appropriate. For this reason it was decided to apply the double stratification, region and type of area.

The method of sampling with probability proportional to population is explained below and the resulting sample of local health authorities included in the survey is shown in Table 39.

The populations of all local health authorities were taken from the Registrar General's Estimates for 1968, the latest available. The populations were cumulated and the total divided by 50, which was the selected sample size. The resulting figure became the sampling interval. A random figure below that of the sampling interval was taken from a table of random numbers and was used to select the first of the areas to be included in the study. For the purpose of selection the sampling frame of local authorities had been prepared in alphabetical order with the population of each added to the previous one. After selection of the initial area, the sampling interval was added and the area whose cumulated population included the resulting figure became the second in the sample; the process was repeated for each of the strata and continued until the selected sample size was achieved. The sampling method ensured, by definition of the phrase 'with probability proportional to population', that the more highly populated areas had a greater chance of being included in the sample. If an area has a very high population, it is possible for it to be drawn twice; for this to happen the population must be higher than the sampling interval. In the sampling for this survey, three areas were drawn twice, which necessitated a further methodological decision. The area drawn twice could be treated as a single area and the area next on the list could be included to make up the sample size. Alternatively, the areas drawn twice could be treated as a double area with the number of respondents within it being doubled. The latter alternative was adopted resulting in the final number of 47 local health authorities in the sample, of which 44 were 'single' areas and three were 'double' areas.

TABLE 39

Study Areas

Random sample drawn with probability proportional to population after stratification by region and type of area.

Area	County	Region	Population RGs Annual Estimates 1968
Durham	-	North	823,370
Yorkshire N.Riding	-	"	323,970
Teesside C.B.	Yorkshire N.Riding	"	392,990
*Yorkshire W.Riding	-	Yorkshire and Humberside	1,774,270
Doncaster C.B.	Yorkshire W.Riding	"	84,250
Sheffield C.B.	"	"	531,800
Cheshire	-	North West	1,056,370
*Lancashire	-	"	2,428,040
Bootle C.B.	Lancashire	"	80,240
Manchester C.B.	"	"	602,790
≠Part of Derbyshire	-	East Midlands	613,210
Northamptonshire	-	"	321,120
Leicester C.B.	Leicestershire	"	280,340
Staffordshire	-	West Midlands	710,010
Warwickshire	-	"	582,530
West Bromwich C.B.	Staffordshire	"	172,350
Birmingham C.B.	Warwickshire	"	1,074,940
Cambridgeshire and Isle of Ely	-	East Anglia	301,470
Norwich C.B.	Norfolk	"	118,940
Buckinghamshire	-	South East	568,110
Essex	-	"	1,129,870
Hampshire	-	"	955,960
Kent	-	"	1,336,290
Oxfordshire	-	"	255,490
East Sussex	-	"	428,250
Southend-on-Sea C.B.	Essex	"	166,070
Bromley L.B.	Greater London	"	304,230
Enfield L.B.	"	"	267,830
Havering L.B.	"	"	252,290
Lambeth L.B.	"	"	329,250
Redbridge L.B.	"	"	246,090
Wandsworth	"	"	321,720
Oxford C.B.	Oxfordshire	"	110,050
≠Part of Dorset	-	South West	243,890
Somerset	-	"	572,960
Bristol C.B.	Gloucestershire	"	427,780
Glamorganshire	-	Wales I	742,920
Caernarvonshire	-	Wales II	120,770
		Total	£21,052,820

*These areas were drawn twice.

≠ All except Buxton M.B., Glossop M.B., New Mills, U.D., Whalley Bridge U.D.

≠ All except Poole M.B.

TABLE 39 (Continued)

Area	County	Region	Population RGs Annual Estimates 1968
Scotland			
Perth County	-	Northern	83,007
Fife County	-	East Central	220,749
Dundee City	Angus County	" "	182,340
Stirling Burgh	Stirling County	" "	28,439
Lanark County	-	West Central	313,180
*Glasgow City	Lanark County	" "	945,034
Selkirk County	-	Southern	20,160
		Total	1,792,909
Northern Ireland			
County Down	-	-	295,300
Belfast C.B.	-	-	390,700
		Total	686,000

*This area was drawn twice.

Total population of United Kingdom Registrar General's Annual Estimates 1968: 55,282,500

Total population of selected sample areas Registrar General's Annual Estimates 1968: 23,531,729

Percentage of population in selected sample areas: -

Total	42.6%
England and Wales	43.3%
Scotland and Northern Ireland	37.1%

Population within the study areas

Information within the local health authority areas selected for study was obtained from six sources, the four main sources mentioned in the pilot study and two additional sources. They were: -

1. Enrolled nurses working in any branch of the local authority nursing services.
2. Registered nurses working at least partly in the district nursing service.
3. Superintendents of the district nursing service, i.e., Chief or Principal Nursing Officers.
4. General practitioners.

The two additional sources were: -

5. Health visitors

6. Medical Officers of Health.

The total population of Nursing Administrators (3 above) and of Medical Officers of Health (6 above) were included in the study. Sampling methods were used for the other groups of respondents.

Sampling of nursing respondents

Enrolled nurses (1 above): It had been intended to include all enrolled nurses employed in any branch of the local authority nursing services. In the event, because of the limited time period available for the study, the number had to be restricted to a maximum of 30 in single areas and of 60 in double areas, randomly selected. In the majority of areas less than 30 enrolled nurses were employed and, there, the total population was included.

Registered nurses (2 above): A sample size of ten registered nurses in the single areas and twenty in the double areas was decided on. The sample was randomly chosen from a list of staff supplied by the local health authority and alphabetically ordered. Where the selected staff member was not available, a replacement was made by inviting the person next on the list to participate.

Health Visitors (5 above): A sample size of five health visitors in single areas and ten in double areas was decided on. The sample was randomly chosen and replacements, where necessary, were made in the same way as for registered nurses.

Sampling of general practitioners (4 above)

A simple random sample of 1 in 15 of the general practitioners in the survey areas was decided on. The task of drawing such a sample presented certain problems, which had suggested themselves in the pilot study, but seemed unsurmountable. They were encountered in full force in the main study.[47.]

Names had been taken from the lists of general practitioners provided by the Executive Councils in the study areas. Sampling from these lists was complicated by the fact that any one doctor would appear on all the Executive Council lists in whose areas his patients lived. Doctors practising near local authority boundaries were likely to have patients in two or even more neighbouring areas, several of which came within the purview of this study - no doubt a result of the large sample. By definition, a simple random sample is one where all members of the population have an equal chance of being selected. Therefore, in order to give all GPs an equal chance of being selected, it was necessary to create a sampling frame on which each doctor's name appeared once only. For this purpose an 'order of precedence' was devised among adjoining areas, one of them being randomly chosen as an area of precedence. All the GPs in that area were then listed alphabetically and their names were removed from the lists of neighbouring areas. This process was more time consuming than had been anticipated. Selected GPs received a postal questionnaire with a letter giving details of the project. The questionnaire attempted to elicit the GPs' view on the contribution of enrolled nurses to domiciliary care. In at least one previous study, Feeling the Pulse, it was found that GPs were often unaware of the qualifications held by district nursing staff and that the difference between registered and enrolled nurses was not always clear to them. For this reason the explanatory notes included factual notes about the two types of qualification, thus enabling the doctors to answer the questions from a common knowledge base (Annex 3).

A national postal strike severely hampered this part of the survey and resulted in a disappointingly low response rate. The doctors had been given a time limit within which to return the completed

questionnaire and, as they saw no way of complying with it, they did not respond at all. When the strike was over, a reminder letter was sent, extending the time limit, but some GPs had already destroyed the questionnaire, others indicated that they were too busy. In order to encourage the former group, duplicate questionnaires were sent and, in order to help the latter group these doctors were invited to answer just those questions in which they were particularly interested and felt most strongly about. Although, in this way, the overall response rate was greatly increased, from 48% to 62%, not all respondents answered the same questions and statistical analysis of the information was not possible. The doctors who did return a completed questionnaire were compared with the non-respondents on those items of information which could be gleaned from the official lists. These items included the size of practice, the number of principals in the practice and the number of Executive Council lists on which the name appeared. On none of the above variables was a significant difference between respondents and non-respondents discernible. Moreover, the type of practice represented by the GP respondents mirrored the national picture, a finding which gives a measure of credibility to the findings.

Medical and nursing administrators (6 and 3 above)

The design and method of data collection from medical and nursing administrators proved more difficult than anticipated.

For both groups of respondents the total population was included and all the information was sought by means of postal questionnaires.

As far as the Medical Officers of Health were concerned, three of them did not return the questionnaire at all and one questionnaire was returned partially completed by the Chief Nursing Officer, resulting in a 91% response rate. On the face of it, such a response rate seems satisfactory, but on careful perusal of the answers, it became obvious that the task of completing the questionnaire had been delegated either

partially or wholly to another officer, who was not always a doctor or a nurse. This experience demonstrates one of the known hazards of postal questionnaires, which is that it is impossible to rely on the source of information, which may not come from the target population at all.

In this survey, the intention had been to analyse medical and nursing corporate views and opinions in a comparative way. The plan had been to cumulate all 'medical' answers and all 'nursing' answers in order to show differences, if any, in the thinking of these two important groups of policy makers. In the event, for the reasons alluded to above, this type of analysis had to be abandoned. The problem regarding information from the nursing administrators lay in the changes within the local authority nursing services which were under way at the time of the survey. The recommendations of the Report 'Management Structure in the Local Authority Nursing Services'[48]. were being implemented and, in two of the study areas, there was a change from a district nursing service operating under the auspices of a voluntary committee as agent of the local authority, to direct local authority control. In one of the areas in particular, this change appeared to cause considerable trauma which showed itself in the responses received.

The change in the management structure made it difficult, in some areas, to identify the nurse responsible for policy making in each of the three local authority nursing services. As new appointments were being made, the name of the nursing administrator to whom to direct correspondence was not always known. Titles and designations differed widely over the 47 areas, as did the degree of accountability to the Medical Officer of Health. Moreover, where the recommendations of the Report on the Management Structure mentioned above, had been implemented, which meant that a Chief Nursing Officer with responsibility for the management of the three services had been

appointed, she was, theoretically, the correct respondent for the purpose of the study. However, where this officer had only held her position for a short time, she was not able to speak with authority on the policy from her new position. In those areas, where the Chief Nursing Officer had been appointed from another position inside the authority, she had been concerned with one or two of the services only and the service or services for which she assumed responsibility in her new role were still somewhat unfamiliar to her. Where the Chief Nursing Officer had been appointed from a position in another local authority she had the additional difficulty of applying her comments to the new setting.

The distribution of nursing administrators in the study areas is shown in Table 40.

TABLE 40

Distribution of Nursing Administrators

County Councils	Number of areas	Number of nursing administrators
One for all three services	23	23
One for each service	1	3
One for health visiting service	1	2
County Boroughs		
One for all three services	7	7
One for each service	3	9
One for district nursing service One for health visiting service Two for midwifery service (geographical division)	1	4
One for health visiting service One for district nursing and midwifery services	3	6
One for midwifery service One for district nursing and health visiting services	1	2
No nursing administrator	1	-
London Boroughs		
One for all three services	3	3
One for each service	2	6
One for district nursing and midwifery services One for health visiting service	1	2
Total	47	67

As can be seen from Table 40, 33 of the 47 local health authorities had appointed nursing officers with responsibility for the management of the three services, district nursing, midwifery and health visiting. Some had the title of Chief Nursing Officer, others Superintendent Nursing Officer, Chief Administrative Nursing Officer, or County Nursing Officer. Designations of the remaining nursing administrators included Principal Nursing Officer, Superintendent of Home Nurses and Midwives, Superintendent Health Visitor and others.

In 13 authorities, responsibility for the three services was shared between two or three nursing administrators accountable to the Medical Officer of Health. One small Scottish burgh had no nursing administrator designated as such. Senior members of the nursing staff had a case load as well as some administrative responsibilities and a medical officer controlled the nursing services with accountability to the Medical Officer of Health. The above administrative inconsistencies caused problems as far as the organisation and the analysis of the national survey were concerned and it is, for this reason, that they are described in some detail.

Nursing Respondents

The collection of information from the nursing respondents was two-fold. All registered and enrolled nurses as well as the health visitors in the sample were asked for a personal interview, for which a semi-structured interviewing schedule was used. In addition, those members of the staff who were employed in the district nursing service were requested to complete a purpose-designed work record book for a seven day period.

The design of the recording instrument, including its actual and potential use, forms the content of Chapter 9.

The national study resulted in the development of a major data base which has greater potential than that for which it was used. A major part of the information relating to the nurses in the study is described in Chapter 10 and that relating to their work in Chapter 11. A further use of the data is demonstrated in Annex 5.

CHAPTER 9

THE DESIGN AND USE OF A RECORDING INSTRUMENT FOR THE WORK OF DISTRICT NURSES.

The recording instrument had to achieve one over-riding aim, which was to combine maximum simplicity in completion for the nursing staff with the maximum amount of reliable information. It also had to be acceptable in terms of format, size and transportability. The information thought to be relevant for the study was related to:-

a. the distribution of the nurse's time over a seven day period and over the 24 hours of each day within that period,

b. the type of work undertaken, both in direct patient care and on other activities,

c. details of procedures undertaken for patients,

d. the place where patient care was undertaken,

e. the type of patients cared for, that is their sex, their age group, their mobility and the nature of their condition

f. nurses' preferences regarding certain aspects of patient care.

A work record book was designed which could be easily handled and fitted in the standard size of district nursing bag. Transportability was important as nurses were asked to record the information throughout the day rather than leaving it until the evening.

The nurses' reaction to the work record book suggested that the aim of achieving simplicity in completion had been achieved. The work was carefully recorded and had face validity. Whether content validity was achieved is not possible to assess. Simplicity is, obviously, a subjective term and simplicity for one person msy be experienced as difficulty by another. However, the testing of the work record book had included the nurses' views on the method of recording the information and they had indicated that it was considered to be a simple procedure to be followed. In fact, the total system of recording consisted of the insertion of times using the

24 hour clock and of ticks in appropriate columns. It became obvious during the testing period, that it was the use of the 24 hour clock which presented the greatest difficulty. This method of recording the time was, however, retained for two reasons. The first reason was that it was possible to use 24 hour time recording for computer processing without having to transcribe the recordings again which would have been excessively time consuming and would also have generated another potential source of human error. The second reason was that the 24 hour clock is being generally introduced into many aspects of life and it seemed reasonable to expect district nurses to familiarise themselves with it. Spot checks in the main study suggested that they had managed very well indeed. A detailed description of how the work record book was designed to collect the six items of information indicated above follows.

a. The distribution of the nurse's time over the week and over the 24 hour period on each day of the week.

The page on which this type of information was recorded is reproduced (page 143). As can be seen the nurse ticked the day of the week in the first instance; if it was her day off duty or if she was away from her nursing work for any other reason she was able to indicate this information by placing a tick in the appropriate box. If it was an ordinary working day she proceeded to record the work she undertook.

b. The type of work undertaken.

On the same page the nurse was able to record the full range of work undertaken. She had to indicate the time each activity began on the left side of a line and the time the activity ended on the right side of the line. Each line represented a discreet activity, which was indicated by a tick in the appropriate box. The activities were mutually exclusive which resulted in one tick per line. Where a

Daily TIME TABLE

Please tick in the box on the right the day of the week for which you are using this sheet.

Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
		✓				

If you are off for half or the whole of the day, please tick in the appropriate box below.

1. Day off ☐ 2. Half day off ☐ 3. Off sick ☐ 4. Holiday ☐

Other reason for off duty ☐ Please give reason .....

Time when each activity/ Off duty STARTED Hr. Min.	Tick below what you did between the time on the left side and the time on the right. Use a new line for each new activity.												Time when each activity/ Off Duty FINISHED Hr. Min.
	Travelling	Patient Care/ Contact Put Number of Patient		Call on Patient No reply	Professional Discussion Face to Face	Professional Discussion Telephone	Equipment	Clerical Work including workround	Meals	Off Duty On Call	Off Duty Free	Lecture. course etc.	Other	
24.00										✓				8-30
8-30						✓								8-40
8-40	✓													8-50
8-50		✓	1											9-10
9-10	✓													9-27
9-27		✓	2											10-03
10-03	✓													10-10
10-10				✓										10-20
10-20								✓						10-25
10-25	✓													10-35
10-35		✓	3											11-12
11-12	✓													11-15
11-15		✓	4											11-22
11-22								✓						11-45
11-45	✓													12-00
12-00					✓		✓							12-12
12-12	✓													12-20
12-20													✓	12-30
12-30	✓													12-40
12-40		✓	5											13-00
13-00									✓					13-50
13-50	✓													14-05
14-05							✓							14-15
14-15		✓	6											14-20
14-20		✓	7											14-30
14-30		✓	8											14-36
14-36	✓													15-00
15-00		✓	2											15-40
15-40	✓													15-53
15-53						✓								16-05
16-05											✓			18-00
18-00								✓			✓			18-25
18-25											✓			24-00

Estimated time spent on work record

patient contact was indicated, a patient number was placed beside it. The nurses had been asked to ensure that all their patients had a number; they were free to use any numbering system already in operation or, alternatively, to number their patients for the survey starting with patient number 1 as the first patient seen on Sunday morning. The patient number was unique to the patient and was retained to denote that patient throughout the survey week. The work record book contained sufficient pages for the nurse to use more than one page per day and, in no case, was the book inadequate for a full record of the week's work.

c. Details of the procedures undertaken for the patients.

The page on which this information was recorded is reproduced as page 145). In the actual work record book it faced the page on which the time distribution over the day was entered, thereby making it easy for the nurse to check that details of the procedure were entered for each patient number which appeared. A list of procedures was compiled from the nurses' unstructured diaries mentioned as part of the pilot study and also in consultation with nursing administrators and a volunteer group of practising district nurses. Again, a tick in the appropriate box was all that was needed to indicate the type of procedure undertaken for each patient; the procedures could not be rendered mutually exclusive as the many different combinations of procedures would have necessitated far too many boxes for recording purposes. It was considered easier to allow each individual procedure to be recorded separately.

d. The place where patient care was undertaken.

The bottom section of the same page on which the procedures were recorded made provision for the recording of the place where the patient received the care. It was deemed important to discover whether there was a difference between registered and enrolled nurses

Daily PROCEDURE SHEET

Please tick in the box on the right the day of the week for which you are using this sheet.

Sun.	Mon.	Tues.	Wed.	Thur.	Fri.	Sat.
		✓				

Each patient should be given a number in place of his or her name. This is to ensure confidentiality. Therefore please give each patient a number and use the same number for that patient each time he or she is seen during the week.

	DISTRICT NURSING/CLINIC WORK	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
	Technical procedures: Patients' numbers:	1	2	3	4	5	6	7	8	2							
	Injections: D.D.A. drugs excluding (Other hypodermic	✓															
	Immunisation. (Other intra-muscular						✓										
	(Other																
	Dressing: Post-operative																
	Ulcerated leg					✓											
	Other																
	Enema Rectal suppository/rectal washout/ manual removal									✓							
	Vaginal douche/pessary/suppository																
	Catheterisation/bladder washout																
	Vaccination Smallpox																
	Other vaccination/immunisation								✓								
	Treatment to eyes or ears				✓												
	Testing of vision																
	Audiometry																
	Cervical smear																
	Electrocardiogram																
	Taking blood sample																
	Taking blood pressure							✓									
	Taking throat swab																
	Breast palpation/other diagnostic procedure																
	Other technical procedure to patient																
	Renal dialysis - supervision																
	Testing of urine																
	Reading blood test																
1b.	Basic care:																
	Routine basic care or bed bath		✓														
	Bathing in big bath																
	Care of hair, nails, feet		✓														
	Assist with bedpan/commode/lavatory			✓													
	Taking T.P.R.																
	Rehabilitation exercises etc.			✓													
1c.	Other activities:																
	First visit in response to call for doctor																
	Assessing patients home conditions or needs																
	Talking to patient or relatives without undertaking any technical procedures including teaching/supervising patient or relatives.																
	Teaching/supervising patient or relatives		✓														
	Accompanying doctor or patient																
	Delivering/collecting equipment/ making arrangements																
	Preparing food for patient/including drinks					✓											
	Other activities or care																
	Wasted visits/no reply																
B.	ACTIVITIES AS QUALIFIED HEALTH VISITOR																
C.	ACTIVITIES AS QUALIFIED MIDWIFE																
D.	PLACE WHERE TREATMENT/CARE GIVEN:																
	Patient's home	✓	✓	✓	✓	✓				✓							
	G.P. Surgery																
	Health centre																
	Local Authority clinic						✓	✓	✓								
	Old people's / Welfare home (Local Authority)																
	Private hotel/nursing home																
	Residential Nurses' Home																
	Nurse's private home																
	Other																

USE NEXT PAGE IF NECESSARY

in their main working environment. At the time of the survey district nurses were beginning to treat some patients in the doctor's surgery or at a health centre. Some district nurses also treated patients in those residential homes where no qualified nurse was on the staff. Patients who attended the doctor's surgery or a health centre for treatment were obviously mobile and their care tended to be of a technical kind. Therefore, nurses who were working predominantly in such a setting looked after a totally different kind of patient group and undertook a different set of procedures for them from those nurses who cared for patients in their own homes or in residential institutions.

e. The kinds of patients being cared for:

The last three pages of the work record book made provision for the recording of patient data. Whilst in the other parts of the record book any one patient would appear as often as he was visited during the survey week, in this part of the book each patient appeared once only. The appropriate page is reproduced below, (page147). The patient's sex and the age group into which he fell were easily recorded by ticks in the appropriate boxes. The mobility and type of condition were less clear cut. Both these types of information were relevant for the study as they were considered key factors in reflecting a nurse's work load. Recognising the value of making data obtained from different studies comparable with each other, an attempt was made to use established nursing dependency categories to denote a patient's dependence on help. For two main reasons the attempt was abortive. First, the best known dependency scale designed by Barr[49.] was not wholly appropriate for patients cared for outside hospital. Secondly, the detailed recording necessary for Barr's relatively complex mobility scale would have countered the

PATIENTS' SHEET

PLEASE TICK whatever applies

Please put patient's number at the top of each column. (please consult your records)

Patients' Numbers→																					
SEX																					
Male																					
Female																					
AGE																					
Under 5																					
5 - 14																					
15 - 44																					
45 - 64																					
65 - 74																					
75+																					
MOBILITY More than one category may apply, e.g. a patient may be confined to bed for a heart condition but have unrestricted movement.																					
Bedfast and needing complete assistance with washing, toilet and feeding																					
Bedfast and needing some assistance with washing, toilet or feeding																					
Partially confined to bed																					
Movement restricted																					
Unrestricted movement																					
TYPE OF CONDITION* (see notes at bottom of page)																					
1. Short term																					
2. Long term																					
3. Frail/handicapped																					
4. Deteriorating/terminal																					
5. Discharged from hospital within last 7 days																					
6. Ante-natal																					
7. Maternity care																					
8. Supervision/advice only																					
9. Other																					

*NOTES ABOUT TYPE OF CONDITION

1. Short-term Patients suffering from disorders where total treatment/care is expected to be curative and take no longer than twelve weeks, e.g. course of antibiotics for pneumonia.

2. Long-term Patients suffering from disorders, where total treatment/care is expected to take longer than twelve weeks, either continually or intermittently e.g. diabetes mellitus, chronic bronchitis, multiple sclerosis.

3. Frail/handicapped Patients who need care/treatment because they are elderly, weak or have a physical or mental handicap e.g. blind, disabled, mentally retarded.

4. Deteriorating/terminal Patients who are getting noticeably weaker and whose death within a week would not be surprising.

5. Discharged from hospital within last 7 days Patients who have been hospital in-patients for any reasons whatever and discharged less than seven days before your first contact with them during the survey week.

6. Ante-natal Patients who need treatment/care for a reason related to pregnancy.

7. Maternity case Patients who need treatment/care for a reason related to child birth less than 10 days before your first contact with them during the survey week.

8. Supervision/Advice only Patients who were visited merely for the purpose of supervision and/or advice. They may not suffer from any known disorder.

9. Other Patients who do not come into any of the above categories. (Also please put their numbers and type of condition on the back of the book)

NOTE: IT IS PERFECTLY IN ORDER FOR A PATIENT TO COME INTO MORE THAN ONE CATEGORY

e.g. A patient may be:-

(a) Discharged from hospital within last 7 days (5)
(b) Mentally retarded (3)
(c) Ante-natal (6)

over-riding aim of maximum simplicity of the recording instrument. At the time of the design of the work record book a research team working under the direction of Professor Logan* was undertaking community studies. In consultation with members of that team a final list of mobility categories was arrived at. The categories were: -

i Bedfast and needing complete assistance with washing, toilet and feeding.

ii Bedfast and needing some assistance with washing, toilet or feeding.

iii Partially confined to bed.

iv Movement restricted.

v Unrestricted movement.

Respondents were told that these categories were not necessarily mutually exclusive; they were given instructions and examples.

Similarly to the mobility categories, it was not possible to find an established and validated set of categories to which types of conditions, encountered in district nursing practice, could be allocated. The possibility of using the conventional diagnostic groups from the International Classification of Diseases was seriously considered but abandoned for three main reasons. First, professional experience and the pilot study had suggested that district nursing staff were not always familiar with the patients' full medical diagnosis; this was especially true for relief staff who did not usually have access to the patients' records kept in the administrative office. Few district nurses had direct access to the patients' medical records Secondly, many patients, particularly in the older age groups are known to suffer from multiple pathology, the coding of which would

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* Professor of Medical Care, London School of Hygiene and Tropical Medicine.

have presented enormous problems. Thirdly, a patient's medical diagnosis may give little, if any, indication of the type of nursing care he requires.

Eight categories of type of condition were, therefore, defined for the purpose of the study. As can be seen on the reproduced page, definitions of the categories were provided for the nursing staff. The eight categories were: -

I Short term

II Long term

III Frail/handicapped

IV Deteriorating/terminal

V Discharged from hospital within seven days

VI Antenatal

VII Maternity care

VIII Supervision/advice only

IX Other ..... to provide for an unexpected eventuality not catered for in the eight categories.

The definitions of the categories proved essential. There is bound to be a considerable variability in terminology and in recording systems among respondents to a national survey. By providing the nursing respondents with an operational definition it was hoped to achieve a measure of commonality. The definitions were not easily arrived at and, during the testing stage, several respondents expressed disagreements with them. Amendments were made and re-tested but it was never possible to achieve complete agreement from everyone involved. In the main study respondents' criticisms were forestalled by telling them that they were operational definitions to be used merely for the recording of patients in the study. The main problem was encountered with the attempt to define 'terminal'. Hinton (1967)[50.] 'defined' a terminal condition as one where death is expected within six

weeks. Many other definitions were studied and explored and many nursing administrators and teachers of nurses were consulted. All the definitions offered, were of a prognostic nature and, therefore, considered inappropriate for two reasons. In the first place, some district nurses, especially those on relief duties, would not be in a position to commit themselves to a prognostic statement. Secondly, the researcher's personal experience as district nurse and district nurse teacher, had suggested that district nurses are not only unable but also unwilling to make a prognostic statement about the death of one of their patients. The definition was, therefore, carefully worded as 'death ..... would not be surprising' rather than something like 'death ..... is expected'.

Nurses' work preferences.

The nursing respondents were given an opportunity in the work record book to express three types of preferences. These were first, the type of patient they preferred to care for, secondly, the type of treatment or care they preferred to give and, thirdly, the place where they preferred to function, that is the patient's home, a surgery, health centre or other place. There were several reasons for including these questions in a study of work patterns. District nurses exercise some discretion in the care of their patients, apart from giving the medically prescribed part of treatment. It is possible, therefore, that nurses' preferences may in some way determine the working pattern. The further analysis in Annex 5 demonstrates a relationship between these variables. Moreover, the attempt to establish nurses' priorities was intended to discover whether the generalised nature of district nursing played a part in attracting so many nurses, registered and enrolled, to this service. Whereas a trained nurse in hospital is usually appointed to a certain type of ward or department as staff

nurse or as ward sister/charge nurse, the district nursing field tends to encompass a variety of general nursing. Specialisation affects not only the types of patients but to some extent also the types of procedures.

The questions about priorities relating to the place of work were included in order to find out how nursing staff, who had elected to nurse patients in their own homes rather than in an institutional setting, felt about undertaking part of their work in a clinic, health centre or GP surgery, a practice which was known to be on the increase at the time of the survey.

Preferences were expressed in ranking order, that is a category having first preference was given 1 and the others were ranked as 2,3,4 etc. Equal preferences were given equal ranking.

A subsidiary purpose of the inclusion of this question was to establish whether those nursing administrators who were reluctant to allow district nursing staff to undertake work at the GP surgery or health centre on the ground that the staff did not like it, were supported by research evidence.

The nature of the data was such that it was possible to analyse nurses' preferences in some detail. The number of respondents who gave each category of patients and each category of procedures first, second, third and other preference ratings was computed. Preferences imply comparisons and comparisons are relative rather than absolute. As the study aimed particularly to discover differences, if any, between registered and enrolled nurses it was necessary to devise an absolute base line common to both, against which preference variations could be measured. The concept of the 'hypothetical average' was developed and used for this purpose. Through the hypothetical average it was possible to demonstrate the 'hypothetical' picture of all nurses

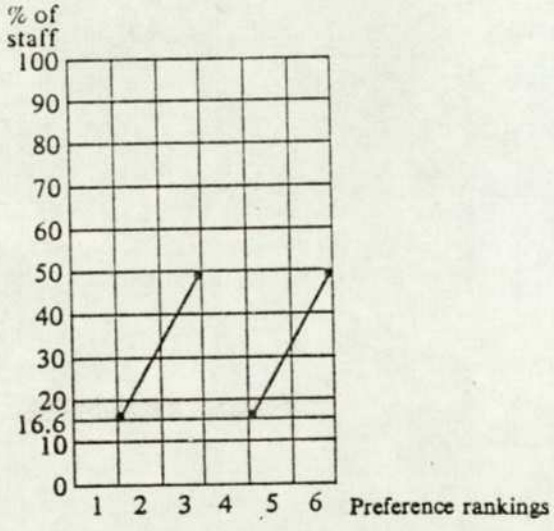
having their preferences distributed in the same way. Deviations from this picture could then be demonstrated. Details relating to the hypothetical average and the findings of the study are shown below.

Nurses' preferences measured against the the Hypothetical Average.

The hypothetical average was used as a base line common to both SENs and SRNs, against which preference variations could be measured. It was based on an assumption that the number of respondents was equally divided between the possible range of preferences. For example, of the six procedures which the nurses were asked to rank according to preference one-sixth would give each procedure first place.

FIGURE 6

Hypothetical average



The situation was not expected to arise in practice but was only used as a measurement tool. For simplicity of presentation, it was decided to cumulate the first three preferences in each category and to express them as percentage of the whole.

Figure 6 , presenting the hypothetical situation, shows the number of respondents equally divided among the six possible preference ratings; one sixth of the nurses (16.6%) are shown to give the item under consideration first preference ranking, a further 16.6%

are shown to give the item third preference. When these three preferences are cumulated, it results in 50% giving the item one of the first three preference rankings; the remaining 50% were equally divided into those who ranked the item as fourth, fifth and sixth preference.

Figure 7/ I shows the actual picture with regard to SENs' preference for dressings. Eighty-two per cent gave dressings as one of their first three preferences and for 18% dressings were one of the last three preferences. Figures 7/ II-VI show preference rankings of SENs for other procedures. As can be seen, the bath (v) was the least popular procedure, as the second line which shows the last three preferences, climbs above the first line which shows the number who gave the bath one of the first three preference ratings.

Figure 8 presents the same information for SRNs and the similarity of the two patterns can be easily seen. Like SENs, SRNs ranked 'dressing' and 'general nursing care' high and the bath low in preference.

Exactly the same procedure was adopted to show the preference ranking for specific types of patients. As there were only five possibilities in this instance, the first two preferences were cumulated instead of the first three.

Figure 9/ I-V show preference rankings for specific types of patients by SENs and Figure 10/ 1-V present the same information for SRNs. Again the patterns provided by the two grades of workers are remarkably similar. For both SENs and SRNs, the acutely ill and bedfast long term patients had most first or second preferance rankings, the mobile sick was of low preference although this was more pronounced for SRNs than for SENs Maybe nurses do not consider hygiene baths and care of mobile sick patients to fall within their appropriate work.

Figure 7

SENs' preferences regarding procedures

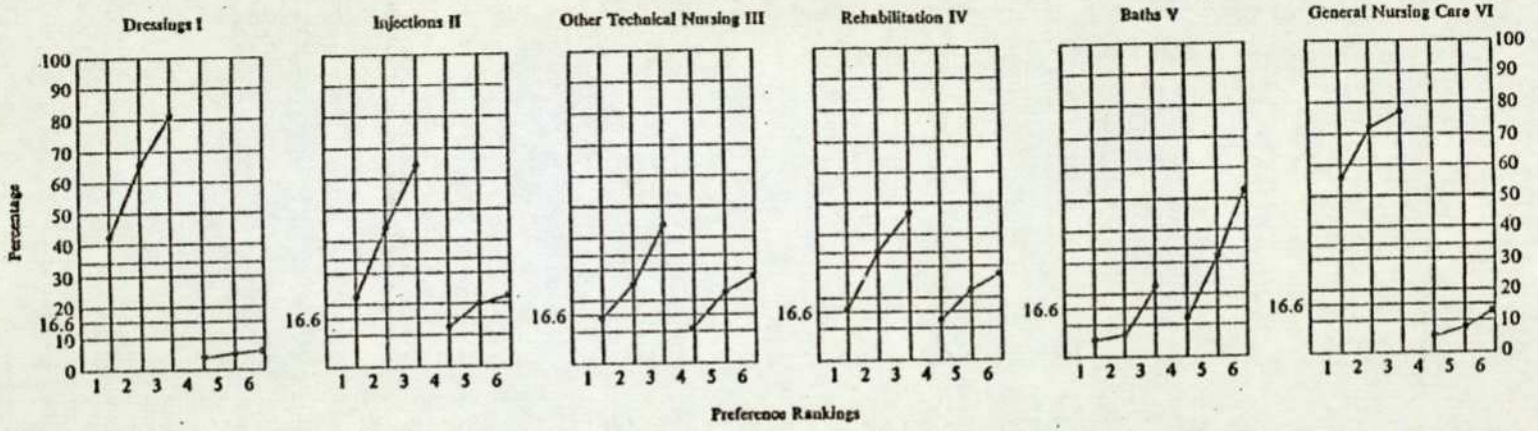


Figure 8

SRNs' preferences regarding procedures

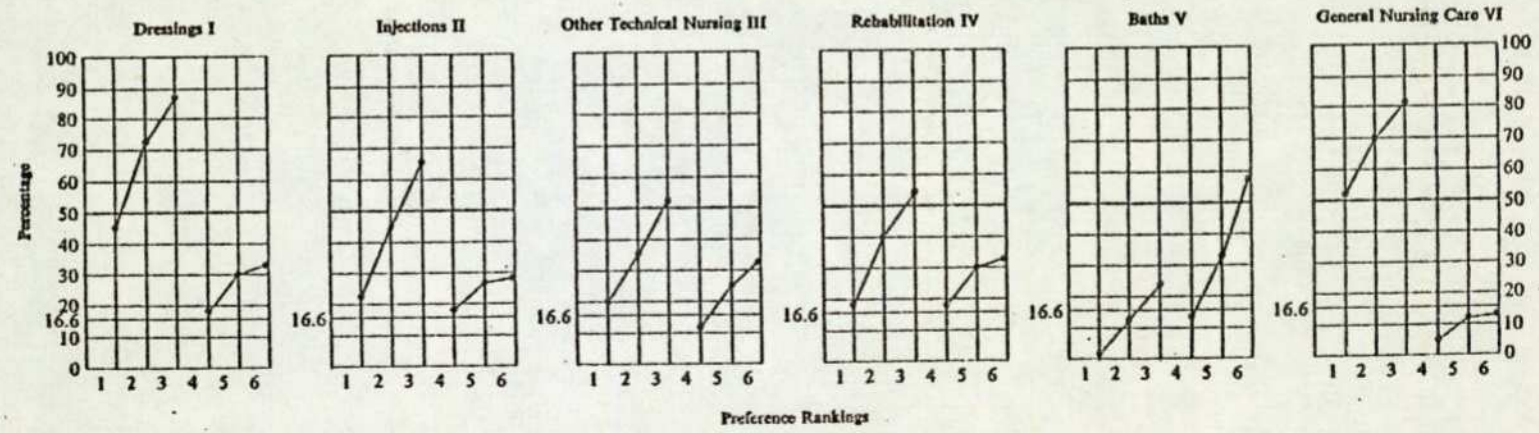


Figure 9

SENs preferences regarding types of patients

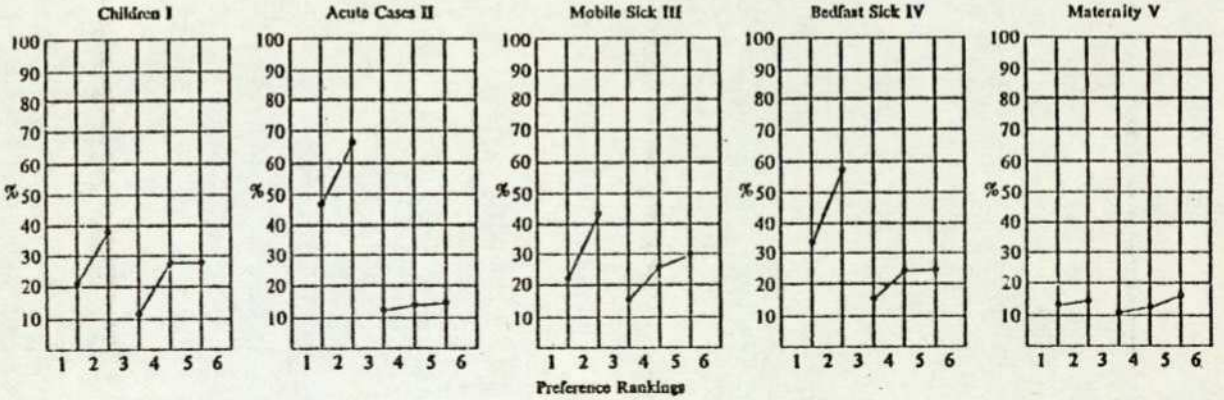
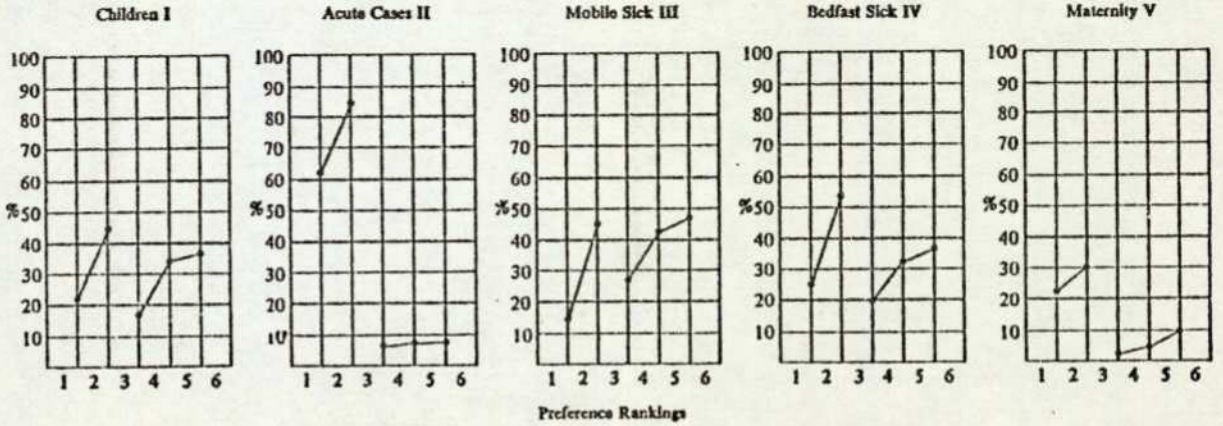


Figure 10

SRNs' preferences regarding types of patients



Murmurings of this came across in interviews but no systematic investigation of reasons underlying work or patient preferences was made. The point of nurses' preferences is discussed further in Chapter 13.

Actual and potential use of the Work Record Book.

A recording instrument which combines information about the nurse's time distribution and work preferences with information about patients and the place of their care can be seen to have a variety of uses.

As far as this study was concerned the work book was used merely for the purpose for which it had initially been designed, which was to assess differences, if any, between enrolled and registered nurses. The findings relating to these comparisons are presented in Chapter 11.

There are many potential uses of the recording instrument not only for research but for planning and management.

For research purposes the instrument has proved helpful because of its comparative ease of completion and because of its flexibility. Thus, it is possible to adjust or change all the headings within the book but preserve the principle of combining nurse data with patient data. For example, the first page, recording time distribution over a week and throughout the day, could be used for any person, simply by replacing the suggested activities by others which would be appropriate for the specific groups of workers. The method for identifying 'appropriate' activities used in this study could also be used in another setting, as it consisted merely of allowing members of the respective staff groups to record all their activities in an unstructured manner over a brief period of time; the activities identified in this way can then be used as suggested headings and tested. Already the investigator's permission for the use of the work book by several other researchers has been sought.

For management purposes, the linkage of patient data with type of care they received, the amount of time given to this care and the place where the care was given, has a predictive value. Statistical population forecasts provide information about the age and sex distribution of patients. From this type of information, linked with that obtained from the recording instrument, an assessment could be made of the likely type of care and its time involvement. (Annex 5). If the recording instrument could be used at regular intervals for monitoring purposes, trends in kinds of patients, in types of procedures undertaken for them and in moves from the patients' homes to clinics or vice versa could be identified. Recruitment of staff and professional preparation could then have a factual basis instead of persisting as separate activities unrelated to the needs of the population. Moreover, if it were acknowledged that nurses have work priorities which may and inevitably do, determine their working pattern, at least to some extent, deployment of staff to accommodate their priorities might be feasible. Not only might such deployment policy increase job satisfaction of staff, it might also achieve a more equitable and need-related distribution of nursing care resources.

In summary, in the design of this recording instrument, the investigator has attempted to make a three-fold contribution to nursing research: -

(a) the work record book is easy to use and makes provision for nursing categories of care.

(b) the concept of a hypothetical average provides a useful way of comparisons.

(c) the recognition of district nurses' preferences might have important implications for patient care which should be explored further.

CHAPTER 10

THE NURSES IN THE NATIONAL STUDY

The national study is described in greater detail than the preceding parts of the research programme for two reasons: -

1. The study formed the culmination of the extended programme and resulted in the development of a major data base.

2. The analysis was complex and unique in its linkage of nurses' attributes with their patients and with nursing activities.

Although information for the study was obtained from medical and nursing administrators and general practitioners, as well as district nurses and health visitors, only that relating to the field workers in contact with patients or clients is presented in this thesis.

The data were obtained from personal interview with the respondents which totalled 1,240. Because of the replacement method adopted, non-response was a negligible factor. The sampling method, described in Chapter 8, resulted in an over-representation of enrolled nurses which did not reflect the national distribution. The method was chosen to ensure a sufficient number of enrolled nurses for conclusions about this group of community nursing staff to be possible.

The interviewing schedule made provision for the recording of factual personal data which included sex, age, marital status, family commitments, country of birth, educational background, socio-economic group and professional qualifications. This section was followed by questions on career choice, work other than nursing, length of time in present post, preparation for their present work and attendance at refresher courses.*

As the study had as one of its main objectives to assess the suitability of work distribution between enrolled and registered

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*The interviewing schedule is available for consultation on request to the investigator (University of Edinburgh).

nurses, a list of nine hypothetical situations was designed. All groups of respondents, that is medical and nursing administrators, general practitioners and nurse field workers were asked to indicate whether, in their view, a registered or an enrolled nurse would be the most suitable person to deal with the situation. Situations were chosen rather than procedures as it is the investigator's contention that the level of skill required for a particular procedure is determined by the patient and his situation as well as the procedure. The situations are shown overleaf and the results relating to four of them are included in Chapter 12.

The respondents were also invited to express their views on the amount of responsibility they were given, their working conditions and desirable changes in the service. The findings are presented in Chapter 12, which deals with the dilemmas and conflicts as they were identified in the national study.

In the remaining part of this chapter the main findings relating to the personal data of nursing staff are shown.

List of Situations

1. Syringing the ears in surgery of a 70-year old patient with wax obstruction.

2. Dressing the ulcerated leg of a 60-year old woman in the home.

3. Injection of insulin to a well-controlled 80-year old diabetic in the home.

4. Injection of mersalyl to long-standing congestive cardiac failure of 70-year old man.

5. Giving daily care to a patient of 40 years with multiple sclerosis who is doubly incontinent.

6. Giving daily care to a patient of 70+ deteriorating after colostomy for ca. colon.

7. First home visit in response to telephone call to the surgery by relative reporting feverish cold and vomiting in child of 3 years.

8. In the surgery taking cervical smear in 30-year old woman with no symptoms.

9. In the surgery - routine immunisations.

10. Helping obese lady of 60 years with bath - no diagnosed disease.

11. Home visit to assess suitability of home prior to discharge of hemiplegic man of 68 after cerebral catastrophe.

12. Follow-up visit of - patient of 45 years after discharge from hospital following uneventful hysterectomy.

13. Follow-up visit of - child of 7 years after initial visit by GP.

14. Follow-up visit of - man of 75 years living alone on top floor and therefore housebound, having recovered from bronchitis and no longer in need of nursing.

Sex distribution

The sex distribution is shown in Table 41.

TABLE 41

Sex of nursing respondents

Type	Female	Male	Total
SENs	521	7	528
SRNs	453	18	471
HVs	241	-	241
Total	1,215	25	1,240

At the time of the survey it was not possible for male nurses to become health visitors in terms of the Statutory Instrument*, although negotiations concerning this matter were currently in progress.

The proportion of male enrolled nurses is lower than those of male registered nurses. It may be that men who for any reason cannot meet the demands of student nurse training choose an alternative career.

As male respondents contributed a mere 2% of the sample all further tables and analyses ignore sex differences.

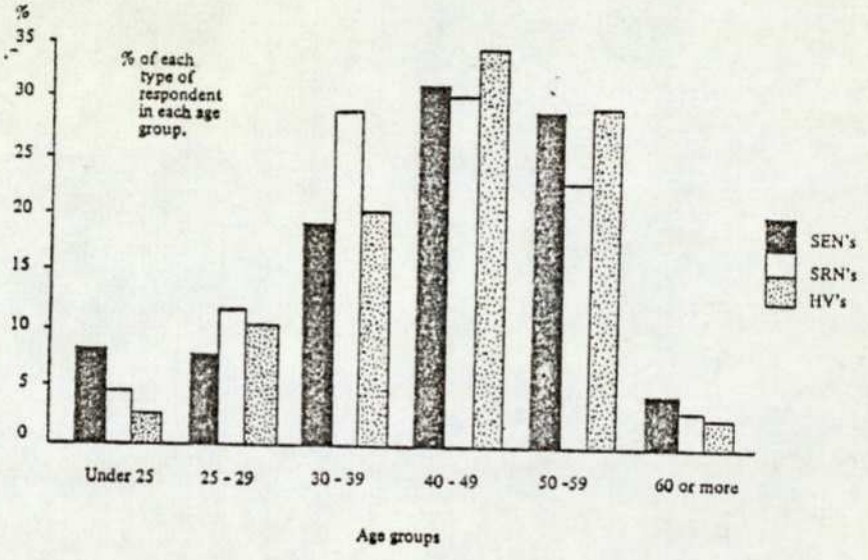
Age structure

Figure 11 shows the age structure of the three groups of staff. In all groups the largest proportion of staff was 40-49 years of age. Enrolled nurses were, however, different from the other types of staff in two respects. Nine per cent were under 25 years of age against 4% of registered nurses and 3% of health visitors. At the other end of the age scale, 32% enrolled nurses were over 50 years of age against

*Statutory Instrument 1948/1415 defines a health visitor as a 'woman'.

FIGURE 11

Age structure of Staff



25% registered nurses. Health visitors came close to the enrolled nurses in the older age group, 38% being over 50 years old.
In Figure 12 the SEN, SRN, and HV composition of each age group is presented.

As can be seen, the age structure of field workers in the local authority nursing services reflects maturity and, as is shown in Chapter 11, considerable experience.

Marital status

Table 42 gives a comparison of nursing respondents in relation to their marital status.

As can be seen from Table 42 a lower proportion of HVs were married than either SENs or SRNs.

The large proportion of married enrolled nurses would seem to support the frequently advanced statement that married women tend to train for the Roll because the training is shorter and less demanding.

TABLE 42.

Marital status of nursing staff

Marital status	SENs		SRNs		HVs	
	No.	%*	No.	%*	No.	%*
Single	111	21	116	25	129	53
Married	366	70	308	65	96	40
Widowed	29	5	29	6	11	5
Divorced/Separated	17	3	17	4	4	2
Not answered	5	1	1	-	1	-
Total	528	100	471	100	241	100

*Percentages are rounded.

Figure 13 suggests a change in the marriage pattern of local authority nursing staff; whereas the largest proportion of single respondents under the age of 25 were enrolled nurses, from that age

FIGURE 12

The SEN, SRN and HV composition of each age group

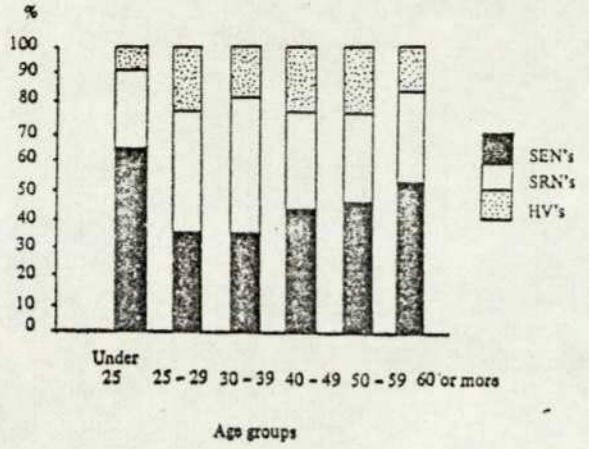
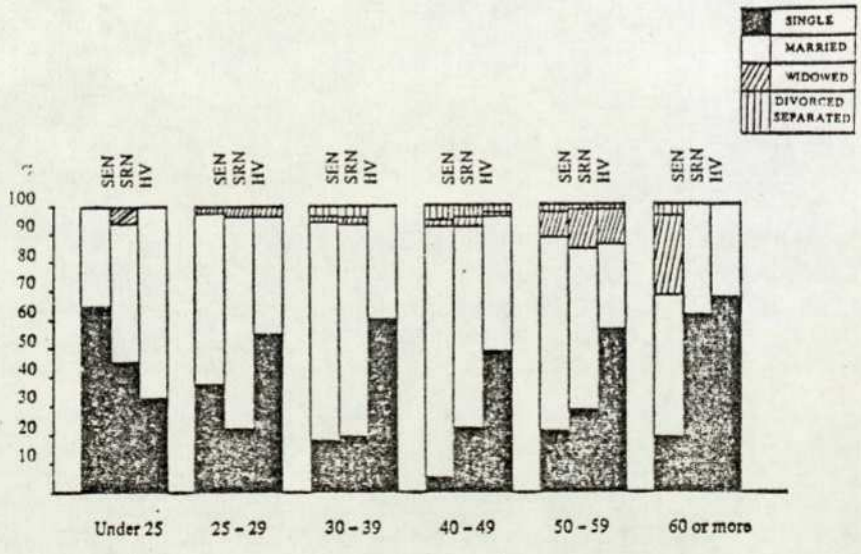


FIGURE 13

Percentage Distribution of marital state by age group



onwards they formed the smallest proportion of single respondents and health visitors took their place as a majority of the unmarried.

Family commitments

Table 13 presents family commitments in terms of children and other dependants living with the respondent.

The table suggests that the enrolled nurses were least involved with family commitments. Four per cent had children under five years of age in their care, whereas 9% registered nurses had such young children. Although the same proportion of health visitors as enrolled nurses had pre-school aged children in their care, health visitors had the greatest proportion of respondents with dependants sharing their home - 19% compared with 14% registered nurses and only 11% enrolled nurses.*

It is not surprising, therefore, that only just over 5% of enrolled nurses found it difficult to combine the care of their children with their job. One would have expected quite a number of registered nurses to have experienced problems, whereas, in fact, only just over 8% did so. It is remarkable that as many as 11% of health visitors stated that they found it difficult to combine their job with the care of their children. Part of the reason may lie in the fact that 92% of the health visitors worked full-time, whereas 89% of enrolled nurses and 81% registered nurses were employed on a full-time basis. Almost half the enrolled nurse part-timers had elected to work part-time because it was easier to combine it with family responsibilities. Most of the others expressed a willingness to take

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*Questions 'Have you any children under the age of fifteen in your care? If yes, are any of them under the age of five? How many?'
'Is there anybody such as an elderly or handicapped person who is dependent on you for physical care in any way? If yes, does this person live with you?'

full-time employment if it were offered to them. A much smaller proportion of the few part-time health visitors were willing to work more hours.

TABLE 43

Children and other dependants of nursing staff

Number of children under 15 years	SENs		SRNs		HVs	
	No.	%*	No.	%*	No.	%*
None	341	65	273	58	190	79
One	91	17	76	16	29	12
2-3	56	11	110	23	22	9
4-5	3	1	4	1	-	-
More	-	-	2)	1	-	-
Not answered	4	1	1)		-	-
Total number with children under 15 yrs.	150	28	192	41	51	21
Number of children under 5 years	SENs		SRNs		HVs	
	No.	%*	No.	%*	No.	%*
One	15	3	37	8	8	3
2-3	3	1	2	-	3	1
4-5	-	-	-	-	-	-
Not answered	1	-	3	1	2	1
Total number with children under 5 years	18	4	39	8	13	4
Other dependants	56	11	64	14	46	19

*Percentages are rounded.

The care of elderly or handicapped dependants combined with their work presented difficulties for just over 5% of all the staff. This proportion may well increase in line with current demographic trends, as staff providing nursing services are likely to have more members of their own families surviving to a greater age.

Country of birth

Table 44 presents the percentage distribution of countries of birth for the three groups of nursing respondents.

The last six categories are presented compositely as the numbers in each were small. It is worthy of note, however, that most of the 3% of enrolled nurses were born in the West Indies, whereas the largest proportion of the comparable groups of registered nurses and health visitors respectively, were in the last two categories, via. Europe and 'other'.

TABLE 44

Country of birth

Country	SEN	SRN	HV
	%*	%*	%*
England and Wales	60	50	35
Scotland	17	18	20
N. Ireland	7	13	19
Channel Isles	7	8	17
Eire	6	8	7
West Indies, Africa, South Africa, India/Pakistan, Europe, Other	3	3	2
Total number	100 n = 528	100 n = 471	100 n = 241

*Percentages are rounded.

In absolute numbers a total of 236 (19.2%) of all the nursing staff in the sample came from countries outside the United Kingdom. If one subtracts those from the Channel Islands and Eire it leaves a mere 39(3.2%) who were born in other lands. This is strikingly different from the hospital service where 30-40% are estimated to have come from overseas countries.[51].

Educational background

The respondents were asked at what age they left school and what type of school they attended for most of the time after the age of

14 years*. The answers are shown in Tables 45 and 46.

Table 45 is not surprising. It shows that two-thirds of the enrolled nurses left school at 15 or under, whereas just over one-third registered nurses and a quarter of the health visitors did so. At the other end of the scale, just over 14% enrolled nurses left school at 17 years or later, whereas 34% registered nurses and 45% health visitors remained at school to this age. It is possible that the late enrolled nurse school leavers might have undertaken training for the State Register had their domestic commitments permitted it. This point is discussed further in a later section of this chapter.

TABLE 45

School leaving age

School leaving age	SEN		SRN		HV	
	No.	%**	No.	%**	No.	%**
Under 14	5	1	1	-	1	0.5
14	170	32	82	17	22	10
15	173	33	101	21	41	6
16	103	20	128	27	65	27
17	53	10	109	23	73	30
18 and over	21	4	50	11	38	16
Not answered	3	-	0	0	1	0.5
Total	528 =	100	471 =	100	241 =	100

**Percentages are rounded.

Type of school

It is not easy to differentiate schools in such a way that the different levels of education they provide is immediately obvious; there was also inadequate probing in the interviews resulting in the recording of a large number of school types which are by no means mutually exclusive in character.

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*Respondents who left school at 14 years or earlier, were 60 years or more at the time of interview.

Table 46 shows the type of school attended by the respondents for most of the time after the age of 15 years.

Socio-economic groups

The Registrar General describes 17 socio-economic groups to which occupations are rather crudely allocated. In this study an attempt was made to obtain the socio-economic background and current position of the respondents through the occupation of fathers and husbands. Qualified nurses* fall into socio-economic group V and social class 2. The socio-economic grouping system is complex and in order to allocate persons to a social class a great deal of detailed information is needed; for example one has to know whether a person is employed,

TABLE 46

Type of school

Type of School	SEN		SRN		HV	
	No.	%**	No.	%**	No.	%**
Elementary	66	12	12	2	9	4
Comprehensive	14	3	17	4	15	6
Secondary Modern	115	22	93	20	22	9
Technical	16	3	25	5	10	4
Grammar	84	16	160	34	98	41
Direct grant	0	0	2	0	6	2
Private	16	3	32	7	14	6
Public	2	0	10	2	5	2
Convent	22	4	22	5	11	5
Commercial	15	3	5	1	1	0
Foreign	8	2	9	2	4	2
Other/not certain	21	4	38	8	14	6
Not answered/not applicable	149	28	46	10	32	13
Total	528	100	471	100	241	100

** Percentages are rounded

Some respondents included the period between their 14th and 15th birthday and some were unable to give precise information.

self-employed, an employee or manager and also the degree of skill

* 'Persons providing or training to provide nursing or midwifery care.

required for their work. Unfortunately the information obtained from the interviews with the nursing staff was not adequate for this purpose. Two points worthy of note did however emerge. First, the highest proportion of all respondents indicated that their fathers were skilled manual workers in socio-economic group 9 and secondly, of all married female respondents those with husbands in manual work were a markedly smaller group than those whose fathers were in this type of employment. This difference showed itself particularly in the group of health visitors; 23% of health visitors' fathers, but only 8% of health visitors' husbands were in manual employment.*

Over a quarter of enrolled nurses' husbands were 'employees engaged in manual occupations which require considerable and specific skills'. These, therefore, are men who will tend to migrate to areas where their specific skills are in demand. The implications of this for the recruitment of their wives are obvious and it is for this reason that the above data are included in this report in spite of their limitations.

Basic nurse education

Table 47 showing the number of years since basic nurse education was completed, highlights the greater number of recently qualified enrolled nurses than registered nurses in the community nursing services.

The decade during which the nursing respondents completed their basic training is worthy of attention (Table 18). The larger number of enrolled nurses who training in the '60s may be linked in two ways with the fact that post basic district nurse training for enrolled nurses became available during that period. This might have been an inducement to nurse recruits who for one reason or another did not

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* Caution in statistical interpretation is necessary because of the large proportion of single health visitors and because roughly 12% of all respondents did not give the information about husbands' or fathers' occupations.

TABLE 47

Number of years since completion of basic training

No. of years	SEN		SRN		HV	
	No.	%*	No.	%*	No.	%*
Less than 1	12	2	3	1	0	0
1 less than 2	23	4	5	1	2	1
2 less than 3	30	6	7	1	3	1
3 less than 4	38	7	11	2	7	3
4 less than 5	34	6	13	3	5	2
5 less than 10	116	22	51	11	25	10
10 less than 15	50	10	81	17	29	12
15 less than 20	43	8	94	20	41	17
20 or more	172	33	197	42	128	53
	10	2	9	2	1	0
Total	528	100	471	100	241	100

* Percentages are rounded.

TABLE 48

Decade of completion of basic training

Decade	SEN		SRN		HV	
	No.	%*	No.	%*	No.	%*
1910-19	0	0	0	0	0	0
1920-29	3	1	2	1	1	0
1930-39	13	2	43	9	33	14
1940-49	138	26	136	29	88	36
1950-59	83	16	180	38	69	29
1960-69	256	48	105	22	46	19
1970**	10	2	2	0	0	0
Inadequate answer	25	5	3	1	4	2
Total	528	100	471	100	241	100

*Percentages are rounded.

** The low figure of twelve respondents who trained in the 70s is explained by the timing of the enquiry which took place in the latter half of 1970.

train for the register. It may also be that post-basic training courses were begun because of the increasing number of enrolled nurses employed in the local authority nursing service. There may, of course, be no connection at all between the two phenomena. Another speculative interpretation might be gleaned from an attempt to relate the age structure of staff (Figure 11), their hospital experience (page 178) and the decade of basic training. This might lead one to deduce that enrolled nurses tend to change from hospital to community nursing sooner than registered nurses. Moreover, it is likely that the rise of enrolled nurses who trained in the '60s merely reflects the general increase in pupil nurse training (Addendum 1).

The number of respondents who apparently trained before this was possible, is difficult to explain; there could have been errors in coding or punching; it is also possible that nurses referred to a basic midwifery or other type of training which some enrolled nurses had taken. The Roll of Nurses was not established until 1943 (Addendum 2). Some enrolled nurses were enrolled by virtue of experience and some were qualified midwives.

Other professional nursing qualifications

Less than half (216 = 41%) enrolled nurses in the study had no other nursing qualification apart from their certificate of enrolment. The additional nursing qualifications held were mainly district nursing qualifications (41%) and full midwifery qualifications (18%). Twenty enrolled nurses were qualified Fever or Mental Nurses and a great variety of other certificates were mentioned by a small number of enrolled nurses.

As the Part I midwifery certificate used to be a necessary prerequisite qualification for health visiting it is not surprising that most health visitors held it. Just over 20% were fully qualified midwives and it is noteworthy that almost 10% had a mental

nursing qualification which would seem a most valuable asset. This qualification was also held by just over 5% of the state registered district nurses and this group also included a vast array of other nursing certificates, e.g., orthopaedic, thoracic, occupational health nursing etc. Less than a quarter of the registered nurses in the sample held no certificates apart from state registration.

Other qualifications

Of the enrolled nurse respondents 95 (18%) stated that they held qualifications apart from nursing ones. These included educational qualifications, viz. General Certificates of Education or Higher Schools Certificates held by 37 enrolled nurses. Four enrolled nurses stated to have GCEs at Advanced Level. One enrolled nurse held a degree in the Social Sciences. The other main qualifications mentioned were secretarial ones held by 31 enrolled nurse respondents. A higher proportion of registered nurses (34%) and health visitors (41%) had qualifications other than nursing; this is, of course, largely explained by the inclusion of educational certificates. Apart from these, secretarial qualifications and certificates in various arts and crafts outnumbered all others in both groups of staff. The other qualifications included beautician, hairdressing, children's nursing, mechanic.

Choice of profession and career patterns

It is neither easy nor reliable to re-construct the reasons for the selection of one's profession initially or for changes of work within one's career path. Events tend to become distorted over time and their chronological sequence might not be clearly remembered resulting in unreliable statements about causal relationships. These are weaknesses and limitations of many retrospective surveys; they cannot be eliminated but an awareness of them aids the interpretation of findings.

Reasons for nursing as a career

The motives for having taken up nursing in the first instance were, for the most part, positive ones for all groups. Thus, 374 (74%) enrolled nurses gave reasons such as 'always wanted to be a nurse', 'I like helping others', 'the work seemed interesting'. Negative reasons such as 'I couldn't be a doctor' or 'there aren't many jobs for women' were given by approximately 10% of enrolled nurses.

This pattern was almost identical for the registered nurse district nurses, but a slightly higher proportion of health visitors (14%) said that they became nurses either because they could not go in for medicine or because openings for women were restricted.

Enrolled nurses were asked why they elected to train as pupil, rather than student nurses (Table 49).

Reasons for enrolment

The enrolled nurses' reasons for having become enrolled rather than registered show that less than 4% deliberately made this choice because they wanted to be practical nurses. The most frequently given reasons, were first, inability to complete the three year training period and, secondly, attraction of the shorter training in the first instance. In view of the impending changes in nurse education this would seem an important finding which might point to experimentation within basic nursing education. In this study almost one quarter of the enrolled nurses became enrolled because they could not complete registered nurse training for one reason or another.

The negative reasons for enrolled nurse rather than registered nurse training are reflected in the respondents' answers to hypothetical questions about their reaction to a daughter's choice of nursing

career.* Although 81% stated that they would be pleased if their teenage daughter decided to become a nurse, no less than 83% would rather see their daughter as a registered than an enrolled nurse.

TABLE 49

Enrolled nurses' reasons for becoming pupil nurses

Unable to complete a three year course for domestic and other non-academic reasons	122
Failure to complete registered nurse training	
because of sickness	20
because of academic problems	117
Attraction of shorter training	141
Advised as being most suitable	20
Wanted something better than auxiliary work	26
No registered nurse training available	27
Did not train (enrolled through experience)	24
Prefer practical nursing	18
Other	17
Total	532**

** Some respondents gave more than one reason.

The most frequent reason for this, given by 143 enrolled nurses, implied the lack of a career prospect for enrolled nurses.

There is no doubt that the majority of enrolled nurses considered themselves underprivileged, although some clearly recognised that they did not have the ability to become registered nurses. A higher proportion of enrolled nurses than registered nurses or health visitors had left school earlier and it may be of interest to note that only 32% of enrolled nurses called themselves middle class, whereas 55% of the registered nurses did so. This corresponds closely with the occupations of their husbands or fathers.

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* Question 6: If you had a teenage daughter who had decided to become a nurse, would you be pleased or not?
Question 8: If you had a teenage daughter who decided to do nursing, would you prefer her to become a state registered nurse, a state enrolled nurse or an auxiliary?

Reasons for working outside hospital

The reasons given by enrolled nurses for having chosen to work outside hospital although completely unstructured at interview, fell into clear categories, presented in Table 50.

It became obvious from the preliminary work in preparation for the study that many nurses though stating that they themselves enjoyed their work, had reservations when asked whether they would advise a friend with suitable basic qualifications to seek employment in the same branch of the service as their own. Such a question was, therefore, incorporated in the final interviewing schedule. Just over

TABLE 50

Reasons for working outside hospital

Reasons	Number of SENs
Domestic convenience	179
Interest, variety, initiative	128
Ability to give more care to patients	47
Friends in local authority nursing	60
Wanted change	115
Dislike of hospital	47
Other	26
Total	602*

* Some respondents gave more than one reason.

60% enrolled nurses, 59% registered nurses and 42% health visitors said that they would advise a friend to do similar work. It seems, therefore, that once enrolled nurses had come to terms with being enrolled instead of registered, roughly two-thirds of them were content to work in the local authority services.

Length of time in post

Table 51 shows the length of time the three groups of staff had been in their present post and in local authority employment.

TABLE 51

Length of time in local authority nursing service and in present post

Length of time in present job					
Percentage of:	Less than 1 yr.	1 yr. less than 2 yrs.	2 yrs. less than 4 yrs.	4 yrs. less than 10 yrs.	20 years plus
	%	%	%	%	%
SENs	21	16	24	22	17
SRNs	15	11	19	28	27
HVs	12	13	17	26	31
All staff	16	13	20	25	25
Length of time in local authority employment*					
Percentage of:	Less than 1 yr.	1 yr. less than 2 yrs.	2 yrs. less than 4 yrs.	4 yrs. less than 10 yrs.	20 years plus
	%	%	%	%	%
SENs	16	13	23	25	23
SRNs	9	11	15	27	41
HVs	5	5	9	23	59
All staff	10	10	16	25	41

*It must be remembered that some respondents worked in the domiciliary services before these became the responsibility of local authorities; in two of the research areas the district nursing service was still delegated to voluntary agencies at the time of the survey.

From Table 51 a striking though perhaps not unexpected pattern can be discerned. This possibly reflects on the one hand the enrolled nurses' comparatively later appearance in local authority nursing and on the other, a great stability of field workers in the local authority nursing services.

Health visitors had the smallest proportion of newcomers to their current job, only 5% had been in local authority service for less than a year. They also had the highest proportion of people who had been in their jobs and in local authority employment for 20 years or more.

This suggests that although health visitors may be difficult to recruit in the first instance they tend to remain in the service.

The age structure of the 198 members of staff who had been in their present post for less than one year shows that over half were 30-49 years old. In the group of enrolled nurses alone the proportion was two-thirds. Health visitors had the smallest proportion of this age group in posts for such a short period. The findings suggest that enrolled nurses particularly come back into nursing when their family responsibilities are less urgent. This type of nursing personnel would seem, therefore, to provide a valuable source for recruitment into the domiciliary nursing service.

It is difficult to make valid comparisons in stability between enrolled nurses and registered nurses in the district nursing field. On the one hand, the older ones tend to be midwives or enrolled by virtue of their experience and this group is rapidly dwindling. On the other hand, as mentioned earlier, employment of enrolled nurses in district nursing and particularly in the health visiting service is a comparatively recent practice, and it is not surprising, therefore, to find that a smaller proportion had been in posts for 20 years or more.

Breaks in service

A considerable number of respondents had had breaks of three months or more since they started in the local authority nursing service.

Table 52 presents the details of the breaks in service.

Most registered nurses and health visitors had their last break between five and ten years ago, most of the enrolled nurses were last away for at least three months, less than a year ago.

For both enrolled nurses and registered nurses the last break was most often of less than a year's duration whereas health visitors tended

TABLE 52

Breaks in Service

	Number of breaks							
	One		Two		Three		Four or more	
	No.	%	No.	%	No.	%	No.	%
SENs	77	15	11	2	2	0.4	0	0
SRNs	114	24	32	7	4	0.9	1	0.2
HVs	82	34	13	5	4	2.2	3	1
Total staff	273	22	56	5	10	0.8	4	0.3

to have breaks of five to ten years. In all groups pregnancy was the most frequent reason for breaks in service. Other main reasons were illness and domestic commitments. Only 22 respondents altogether had last broken their local authority service to work in hospital.

Hospital experience

Discussion about status parity between hospital ward sisters and registered district nurses had been in progress for many years.

This study shows that 437 (93%) registered nurses had worked in hospital after their registration, about a third of them for five to ten years. Of these, 43% had been staff nurses only, but 137 (31%) had held ward sisters' posts and twelve had been in higher ranking nursing administration.

The career opportunities for enrolled nurses are restricted and the most responsible official position held by 34 enrolled nurses was that of a 'Senior Enrolled Nurse'. Almost five times that number stated, however, that they had been in charge of wards or departments 'when there was no registered nurse available', and 37 claimed the position of a staff nurse. It was somewhat surprising to find that health visitors had held their most responsible hospital positions for shorter periods than either registered nurses or enrolled nurses; this may be linked with their more frequent changes before coming into

health visiting. Thirty per cent of them had been in their most responsible post for less than one year and 7% for five years or more. The corresponding figures for registered nurses were 20% who had been in their most responsible post for less than one year and 9% five years or more. Twenty five per cent enrolled nurses had held their most responsible position for less than one year and 15% for five years or more. For the three types of workers the period of four years seemed to be significant in terms of a change of job. Those who stayed in hospital longer than four years after qualification stayed much longer, and those who held their most responsible post for more than four years tended to hold it for ten years or more. There were fewer changes between five and ten years than within the first five years or after the tenth year. Two hundred and thirty seven (19%) of all nursing respondents had been employed as nurses in places other than hospital or the local authority services within the last twenty years. The two most frequently mentioned nursing posts were first private nursing and secondly occupational health nursing. Slightly more health visitors had been in HM Forces than in occupational health. One enrolled nurse and four registered nurses had been privately employed in general medical practice.

The professional experience, both in hospital, in the local authority and elsewhere, represented by the nursing staff in this study is obviously considerable.

This point is referred to again in Chapter 11, where the work of the district nursing staff is discussed.

Jobs other than nursing

Because of the gap between school leaving age and minimum age for entry into nursing, an understandably large proportion (over 80%) of all nursing respondents had done work other than nursing for more than

three months. This included clerical work, work in shops, factory and domestic work, teaching, children's nursing, war service and agricultural work. Clerical work was the most common in all groups, followed by work in shops, mostly as assistants. More of the enrolled nurses (10%) had done factory work than registered nurses (5%) or health visitors (2%). Of the 13 nurses who had done agricultural work, five were men. Enrolled nurses were different from the other two groups in that over half (53%) of them had done work other than nursing for four years or more whereas 40% registered nurses and 32% health visitors had worked for such a long period in non-nursing jobs.

Thoughts about career change

Recruitment must be concerned not only with enlisting personnel to a particular job in the first instance, but also with retention of staff. For the planning of nursing services and manpower needs, it is important to know whether existing staff are contemplating changes in their own career.

Two questions about this were included in the interview. First, respondents were asked whether they had thought of going back to hospital nursing and secondly whether they had thought of leaving nursing altogether in the future.

It seems that the thoughts about their future career which the nursing respondents had were not consistent with their actions in this respect. Table 51 showed the remarkable stability of local authority nursing staff; basing one's statements on past career paths rather than tentative thoughts about the future one would not expect almost a quarter of the district nursing staff to be contemplating a return to hospital work. The relatively smaller percentage of health visitors thinking about a return to hospital reflects their statements that they had been out of nursing too long to go back to hospital. This is

consistent with the higher percentage of health visitors than other groups who thought about leaving nursing. It seems that those health visitors who want a change feel they must leave the nursing profession altogether (Table 53).

TABLE 53

Nurses' thoughts about career changes

Thoughts of:	SENs		SRNs		HVs	
	No.	%	No.	%	No.	%
Going back into hospital	128	24	115	24	38	16
Leaving nursing altogether	46	9	61	13	43	18

Unfortunately not all respondents gave reasons for their thoughts about career changes although they had been invited to do so.

Preparation for the work currently undertaken

District nursing is the only branch of local authority nursing for which a specific training was not a requirement for licence to practise at the time of the survey. Table 54 shows the number of enrolled nurses and registered nurses who had undertaken a specific training for work in the community, other than a statutory health visitor training course.

TABLE 54

Staff with training for work in the community

	Numbers of staff with specific training	
	SENs	SRNs
In-service training - no certificate	13	14
Integrated Course	4	4
Post basic Nat. Cert.	26	82
Post basic Q.I.D.N.	165	229
In training	13	7
Total	221 (42%)	336 (73%)

Respondents' views on preparation

Three hundred and nine (93%) of the registered nurses who completed a course of training said that they had found this helpful. They felt it had given them knowledge about district procedures (39%), social services (48%) and roughly 30% of respondents mentioned psychological aspects, such as appreciation of how to make relationships with people, as having been a helpful part of their training. Health education and sociological aspects of community care were also mentioned as helpful training content.

The registered nurses who had not taken a specific course of training (135 = 27%) for work in the community were exactly equally divided about the desirability of such training. Most of these who thought a course would be helpful gave as the reasons that they would learn district procedures and social services.

As Table 54 shows a much smaller proportion 42% (221) of enrolled nurses than registered nurses had been specially prepared for work in the community, leaving a sizeable number 58% (307) who had not been thus prepared. Comments made by enrolled nurses on helpful training content followed almost the same pattern as those made by registered nurses in that the highest proportion (38%) had appreciated district procedures. However, whereas almost half the registered nurses had considered knowledge of social services particularly helpful only 20% enrolled nurses mentioned this aspect of their training. As 62% enrolled nurses against 34% registered nurses said that social services were an aspect of their work they would like to know more about, one must conclude that their training had either been inadequate for the work they were undertaking or that their responsibilities involved a greater knowledge than enrolled nurses were normally expected to need. Understandably, a large proportion of enrolled nurses (175 = 57%) who had not a specific course to prepare them for work outside hospital

thought that such a course of preparation would be helpful. Two hundred health visitors considered their training helpful, whereas four considered it not helpful. The remaining health visitors gave qualified answers.

Unfortunately a study such as this may expose discrepancies but it cannot answer the crucial question whether personnel ought to be prepared for a specific job or whether they should be given a job which matches their preparation for it. In the district nursing field this is a particularly complex problem while district nurse training is neither a requirement nor uniform.

Of the seven respondents who appeared to be employed for health visiting duties without having taken the health visitor training course, four of them thought a course could be helpful and one made her answer dependent on the type of course.

Refresher Courses

The fact that refresher courses for staff other than practising midwives are not compulsory is reflected in the number who had attended such courses. The number varied widely as between enrolled nurses, registered nurses and health visitors, as shown in Table 55.

TABLE 55

Refresher Courses

Attended a refresher course at any time:	Types of staff					
	SEN		SRN		HV	
	No.	%	No.	%	No.	%
Yes	196	37	268	57	168	70
No	317	60	198	42	62	26
Just qualified	9	2	2)		10	4
Other, e.g. in training	3)		2)	1	1	0
No adequate answer	3)	1	1)		0	0
Total	528	100	471	100	241	100

In Chapter 11 the work undertaken by the district nursing staff is described and discussed.

CHAPTER 11.

THE WORK UNDERTAKEN BY THE DISTRICT NURSING STAFF

The data presented in this chapter were obtained from the work record book described in Chapter 9 and from personal interviews with registered and enrolled district nurses.

Those members of the district nursing service who had been respondents in a personal interview were asked to complete a record of their work for a seven day period, which was 28th March - 3rd April, 1971. Health visitors were not included in this part of the study. A total of 1,060 work records were sent out and of these 772 were completed, a response rate of 72.8%. Reasons for non-response are shown in Table 56.

TABLE 56

Reasons for non-response in completion of work record.

	No.	%
Sick	42	3.9
Work not appropriate	16	1.5
Retired	7	0.7
On course/lecture/study day	6	0.6
Holidays	44	4.2
No reply/no explanation	71	6.6
Left service of local authority	41	3.9
Returned partially completed	2	0.3
Reported as having been posted to Q.I. - not received*	29	2.7
Other, including no time illness at home information unsuitably recorded	30	2.8
		27.2

* As stated earlier the postal strike disrupted this part of the survey.

The simplicity of completion of the work record by respondents paralleled the complexity of coding it. It took an average of $3\frac{1}{2}$ hours to code of completed document, the information recorded by some

respondents amounting to as many as eighty 80 column cards. Statistical advice* to code only every other record book in its entirety was taken. This decision resulted in work records of 352 members of the district nursing staff being available for analysis unintentionally; they were divided almost equally between enrolled and registered nurses, 178 of the former and 174 of the latter.

The analysis falls into three main sections related to the design of the work record. The first section deals with the distribution of whole and half days off duty and the structure of the respondents' day. The second section consists of an analysis of the nurses' activities and the third section shows the types of patients cared for.

Table 57 shows the distribution of whole and half days off duty during the seven day period for full time staff.

TABLE 57

Distribution of whole and half days off duty
(Off duty includes all periods off work for whatever reason)

	SEN				SRN			
	Whole day off		Half day off		Whole day off		Half day off	
	No.	%	No.	%	No.	%	No.	%
Sunday	56	28	41	51	48	27	32	33
Monday	18	9	-	-	12	7	4	4
Tuesday	17	9	4	5	6	3	9	9
Wednesday	20	10	-	-	9	5	2	2
Thursday	11	6	6	7	11	6	-	-
Friday	40	20	9	11	41	23	22	23
Saturday	36	18	21	26	53	29	28	29
Total	198*	100	81	100	180*	100	97	100

* The total number of non-working days exceeds the total number of nurses because some had more than one day off during the week. The same applies to their half days. This excess is greater than the figures suggest as 21 SENs and 14 SRNs did not record any free day during the week. Part time staff are not included.

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* The Advisory Panel for the study included a Statistician from the Department of Health and Social Security, (Use or Abuse, p. V11)

Not all the days and half days off work were normal off duty periods. Six per cent of the whole days off were due to sickness, 3% were lecture or study days and just over 1% were days off work for other reasons, such as caring for a sick relative. Some respondents did not distinguish clearly between normal weekly days off and days off as part of annual leave. However, staff who had more than four days' leave during the week were excluded from the analysis in order to approximate the norm. Unfortunately a considerable number of staff had such leave; no doubt this was due, at least in part, to the choice of week which included the end of the holiday year; this tends to be a period when staff try to complete their annual leave entitlement. Findings show that of a possible 1,246 enrolled nurse working days 1,008 were actual working days. Similarly, of a possible 1,218 registered nurse working days, 990 days of work were recorded.

This amounts to roughly 81% and may be a useful guide to staffing requirements.

It can also be seen from Table 57 that weekends were the most frequent non-working days with Sunday as a legitimate day off for 26% enrolled nurses and 23% registered nurses. This was followed by Saturday and Friday and the same pattern applied to enrolled nurses and registered nurses and to half-days off duty. Another point worthy of mention is the fact that days off for sickness and for other reasons were noticeably more often recorded before or after a leisure day than as an isolated day. This finding appeared to be in line with other studies on absenteeism in nursing and other fields.[52,53].

The nurses' day

The activity headings included working time as well as leisure periods and Figures 14a and 14b show the distribution of working and

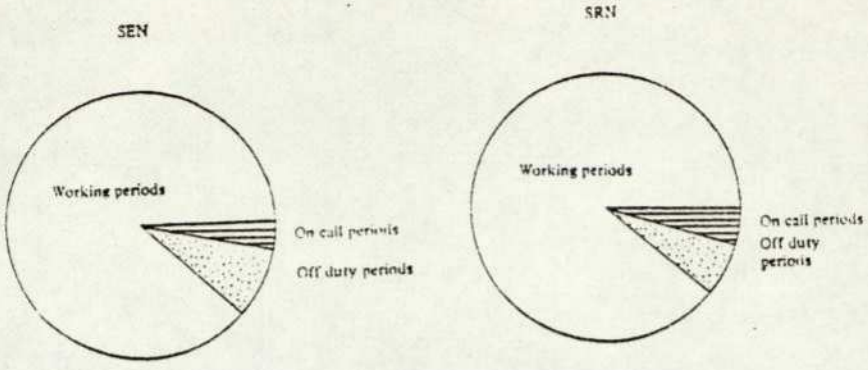


FIGURE 14a . **Structure of the Nurse's Day**
Frequency of off duty periods, on call periods and working periods.

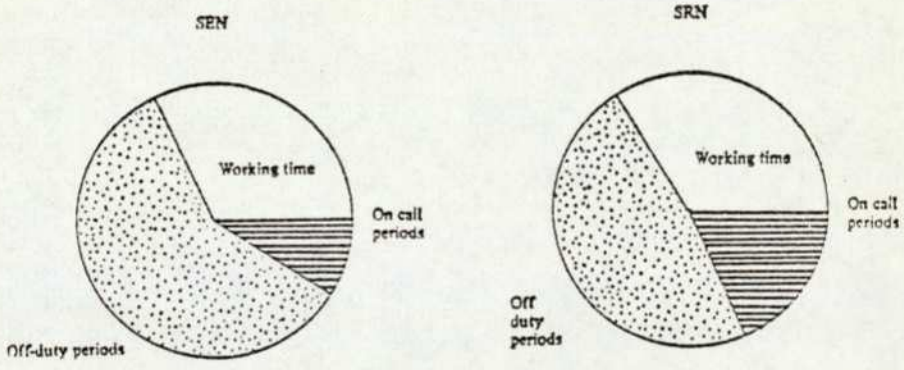


FIGURE 14b **Structure of the Nurse's Day**
Duration of off duty periods, on call periods and working time.
The circle represents 24 hours.

leisure time for enrolled nurses and registered nurses. They also include the periods during which nurses were officially off duty but on call. In the interpretation of the Figures it must be noted that they represent the mean average of the seven day period calculated from full-time enrolled nurses and registered nurses. Not any one actual day may have conformed exactly to this pattern. For example, it would be rare for a nurse to be on call every day of the week. An average time of 4 hours 30 minutes could have resulted from two 12 hour periods, one $3\frac{1}{2}$ hour period and two 7 hour periods, or a wide range of other permutations.

'On call' periods

The complaint often voiced by members of the district nursing staff that they spend many hours 'on call' although they are rarely called out to patients was supported by the findings of this study. As Figures 14a and 14b show, both types of district nursing staff had periods of being off duty but 'on call' during the survey week. The registered district nurses had an average of seven such periods during the week, enrolled nurses an average of three. This difference is likely to be related to the respective functions undertaken by the two types of staff. The arrangement for a district nurse to be 'on call' although theoretically off duty is designed to meet the need of an emergency call with which an enrolled nurse may not be allowed or able to deal.

The duration of such periods fluctuated widely from one hour to 48 hours but there was no difference between enrolled nurses and registered nurses. The longer periods were rarer for both types of staff and roughly 3% of both recorded instances of being 'on call' for longer than 24 hours at a stretch. If nurses had been called to patients whilst 'on call' the periods would have been broken by the activities of 'travelling' and patient care/contact. The

majority of such periods were six to ten hours for both types of staff. One might have expected weekends to be peak times for 'on call' periods but this was found not to be so. They were fairly evenly distributed throughout the week but slightly less frequent on Saturdays and Sundays. Enrolled nurses and registered nurses had most 'on call' periods on Monday but this could have occurred by chance.

Structure of the working day

In Figures 15a and b the average working day for enrolled nurses and registered nurses is divided into the main activities of travelling, patient care/contact, clerical work and professional contacts with other people, showing their frequency and their duration.

As can be seen, registered nurses recorded more journeys than enrolled nurses but this did not appear to result in a reduction of patient care/contacts. For both activities, travelling and patient care, registered nurses recorded a significantly greater frequency than enrolled nurses. The frequency with which these times occurred was inversely correlated with their duration, which is, of course, understandable. If a nurse had to visit more patients she had to travel more often and, provided the length of the total working day remains roughly the same, she has less time for each individual patient. Figures 15a and b demonstrate this. In the interpretation of these differences it is important to bear in mind that of the patients cared for during the survey week 4% attended a clinic, doctor's surgery or health centre. This made it possible for more patients to be seen in a shorter time. Eleven per cent registered nurses recorded clinic sessions against 3% enrolled nurses, a difference unlikely to have occurred by chance.

The same markings for the identification of activities are used in Figures a and b. However, whereas in Figures 14a and 15a

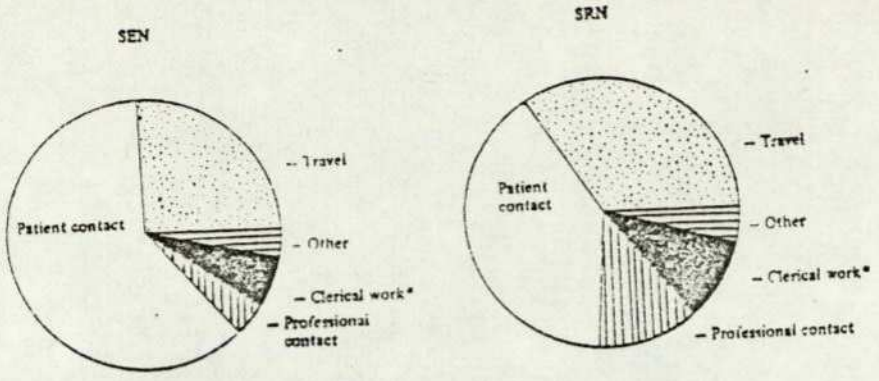


FIGURE 15a **Structure of the Nurse's working day**
Frequency of main activities.
The circle represents the total working period.

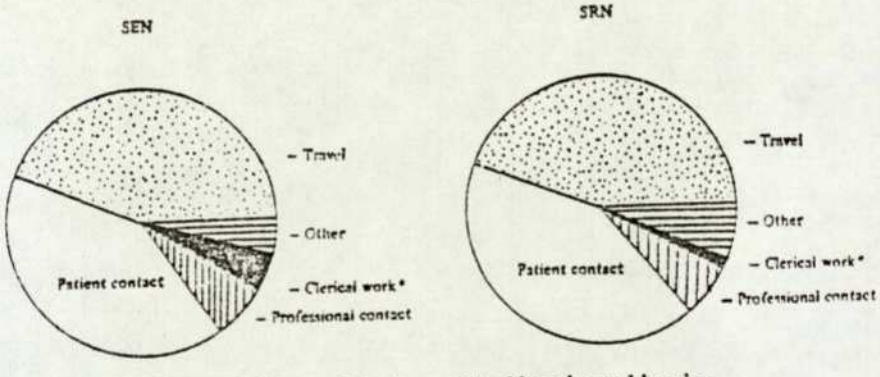


FIGURE 15b **Structure of the Nurse's working day**
Duration of main activities.

* Clerical work includes record keeping for this survey.

the segments denonte the frequency of the activities, it is their duration which is demonstrated in Figures 14b and 15b. The length of the hypothetical average full-time working day was 7 hours 40 minutes for enrolled nurses and 8 hours 10 minutes for registered nurses. There were marked variations for both types of nurse ranging from 5 hours 10 minutes to 9 hours 50 minutes. It is likely that regional differences as well as differences by type of area could be pinpointed if the analysis on these lines were pursued.

Other activities which showed marked differences between the enrolled nurse and the registered nurse as far as frequency is concerned were: -

Calls	-	no reply
Discussion	-	telephone
Off duty	-	on call

These differences are not unexpected. Registered nurses are more likely to pay visits to new patients or occasional supervisory visits. These visits tend not to be pre-arranged and it is possible, therefore, that access to the patient cannot be gained either because the patient is bedfast and alone or because he is not at home. As it is common practice for district nurses to visit such patients there is usually some arrangement made at the first visit to secure future access. Visits by enrolled nurses are more often to those patients who have regular pre-arranged visits and, therefore, the unsuccessful call, that is when there is 'no reply' is not a frequent occurrence.

Although registered nurses had more telephone discussions about patients than enrolled nurses their face to face discussions were not markedly reduced, suggesting that registered nurses have more frequent professional contact with colleagues. This may be due to greater awareness on the part of the registered nurse of the need and benefit of contact or just to the easier availability of telephone

facilities for the registered nurse who, on the whole, had accommodation at the doctor's practice more often than the enrolled nurse. It is also possible, and indeed likely, that many enrolled nurses were not encouraged to make their own professional contacts and that necessary discussion about patients were channelled through registered nurses. (Chapter 12).

A further explanation may be that enrolled nurses were less likely to visit patients whose medical or social condition necessitated urgent professional discussion on their behalf.

Patient care/contact periods

Of the 56,585 activities which were analysed in relation to their type, frequency and duration; the two most frequent were travelling and patient care/contact.

The activity recorded as patient care/contact was considered to be the most relevant for detailed presentation and discussion; it included any time with a patient or client, whether in the patient's home, at a clinic, health centre or elsewhere.

The total number of patient care/contact periods recorded by all nurses were 20,614. Of these, 9,952 were recorded by enrolled nurses, i.e., 48%, the remaining 52% were recorded by registered nurses.

Figure 16 shows the frequency of patient contact periods for each day of the week. It is expressed as a percentage of the total.

The total number of patient contacts for enrolled nurses were 9,952 and for registered nurses 10,662 and the graph overleaf (Figure 17) illustrates the distribution of these over the seven day period.

As can be seen from Figure 16 , troughs in frequency of patient contact periods occurred on Saturday and Sunday with a slight peak on Monday and fairly even distribution throughout the remaining oart of the week. From the data obtained and the way the computer

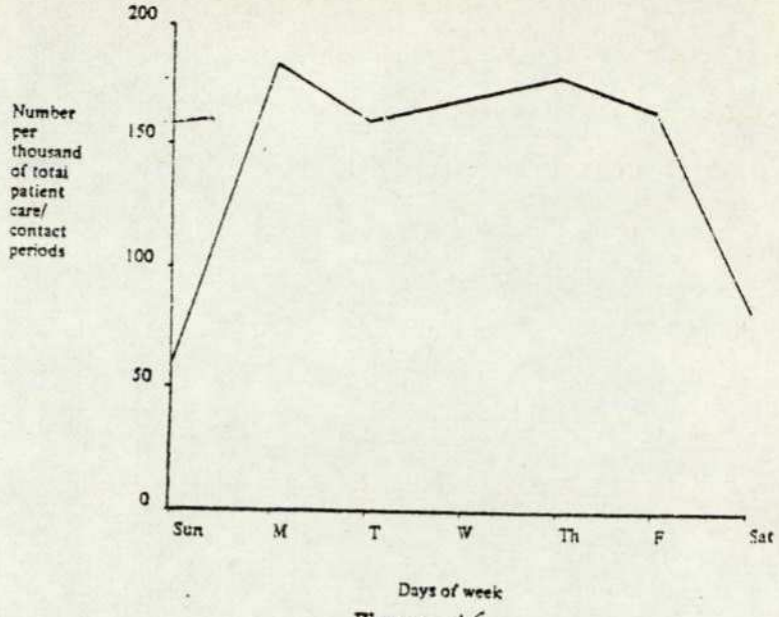


Figure 16

Frequency of commenced patient care/contact periods during survey week.

Figure —shown for all nurses.

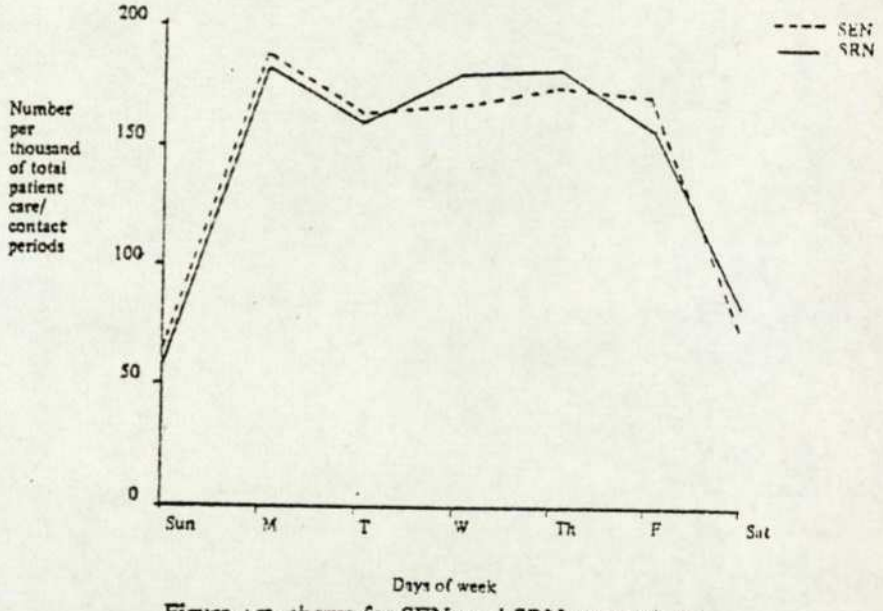


Figure 17–shown for SENs and SRNs respectively.

programme was designed it is not possible to show the frequency of activities in progress at a certain period of the day but rather the frequency of activities commenced at hourly intervals during the 24 hour period.

Figure 18 shows the frequency with which patient care/contact periods commenced during the three five-hour sections of each day, i.e., 0800 - 1300 hours

1301 - 1800 hours

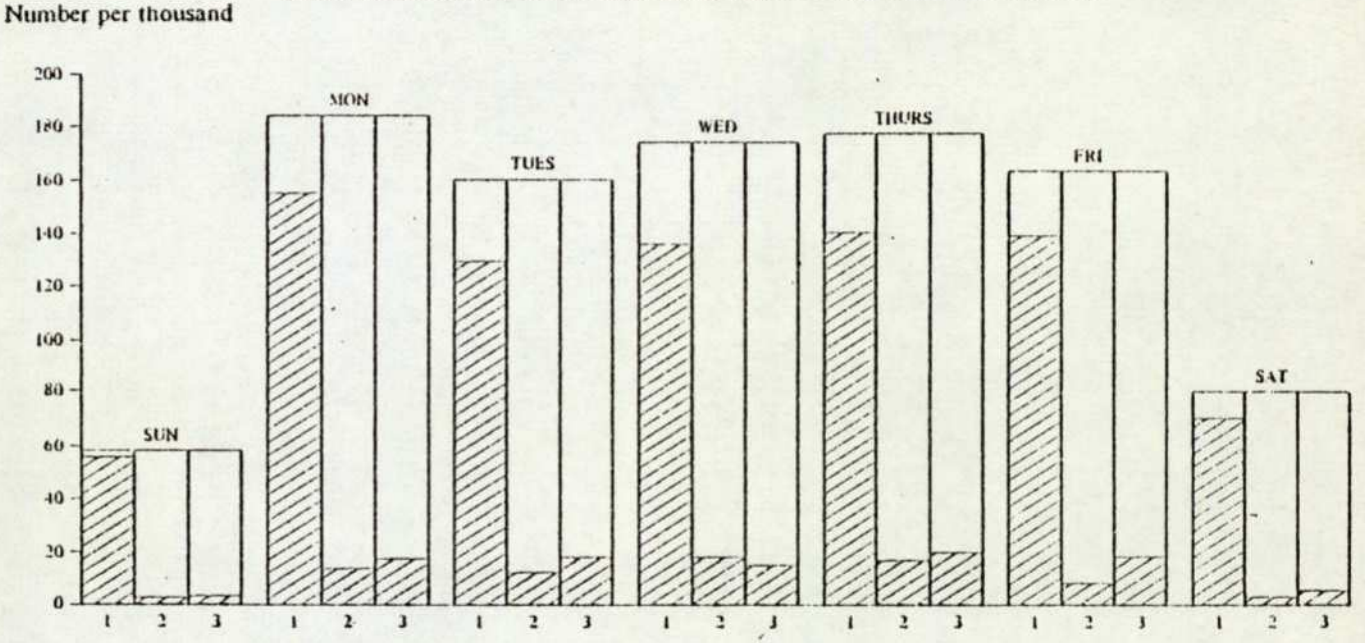
1801 - 2300 hours.

The night hours have been omitted as the district nursing activity during the night is minimal. The Figure is again constructed on the basis of the total number, in this case 20,611 being 100%. The total for each day is shown on the top of each day's block and each block is longitudinally divided into the three equal sections representing the three five hour periods. The shaded parts in each five hour section show the proportion of the day's patient contact periods which commenced then.

Figure 18 demonstrates the greatest frequency in the morning of each day, whether the day was generally busy or not. Eighty-three per cent of all contact periods commenced during the morning hours of each day. A similar pattern for both types of workers can be discerned although, on the whole, registered nurses saw more patients in the evening period of the day than enrolled nurses (Table 58), which is almost entirely due to their different functions taking these over all. There were several study areas where enrolled nurses were not allowed to give late night sedation and, clearly, many of the evening visits were paid for this purpose. Also, as referred to above, where nurses were 'on call' and likely to be called out to answer emergency calls they tended to be registered nurses rather than enrolled nurses.

Figure 18

Patient care/contact periods commenced during three time intervals of each day.



Periods in day:—
1 = 08.00–13.00 hrs.
2 = 13.01–18.00 hrs.
3 = 18.01–23.00 hrs.

Shaded areas represent number of patient care/contact periods commenced.

Table 58 Number and percentage of patient-nurse contacts commenced during three time periods of each day

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
SEN		*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
08.00–13.00	1	596	97	1,641	88	1,314	82	1,330	80	1,434	82	1,389	82	671	88
13.01–18.00	2	12	2	168	9	160	10	200	12	210	12	68	4	46	6
18.01–23.00	3	6	1	56	3	128	8	133	8	105	6	237	14	46	6
	Total	615	100	1,865	100	1,603	100	1,663	100	1,749	100	1,694	100	763	100
SRN															
08.00–13.00	1	560	95	1,598	82	1,353	80	1,488	78	1,465	76	1,461	86	808	90
13.01–18.00	2	12	2	97	5	101	6	191	10	154	8	102	6	36	4
18.01–23.00	3	18	3	253	13	237	14	229	12	308	16	136	8	54	6
	Total	589	100	1,949	100	1,691	100	1,908	100	1,928	100	1,699	100	893	100
All nurses															
08.00–13.00	1	1,156	96	3,239	85	2,667	81	2,818	79	2,899	79	2,850	84	1,479	89
13.01–18.00	2	24	2	265	7	261	8	391	11	364	10	170	5	82	5
18.01–23.00	3	24	2	309	8	365	11	362	10	413	11	373	11	100	6
	Total	1,204	100	3,813	100	3,293	100	3,571	100	3,676	100	3,393	100	1,661	100

As it is the frequency and not the duration of patient care/contact periods which is shown in Figure 18 the blank portion of the columns indicate that no such periods commenced at those times and not that no patients were seen. The excess of the blank portion during the afternoon and evening periods of each day is explained in part by the type of work often undertaken at those times. Visits to patients whose care is more time consuming tend to be arranged for the afternoon and because these visits take longer, less of them are undertaken. Clinic sessions are often arranged in the evening and because they are continuous without interdispersed travelling they are recorded as 'one' patient care/contact period.

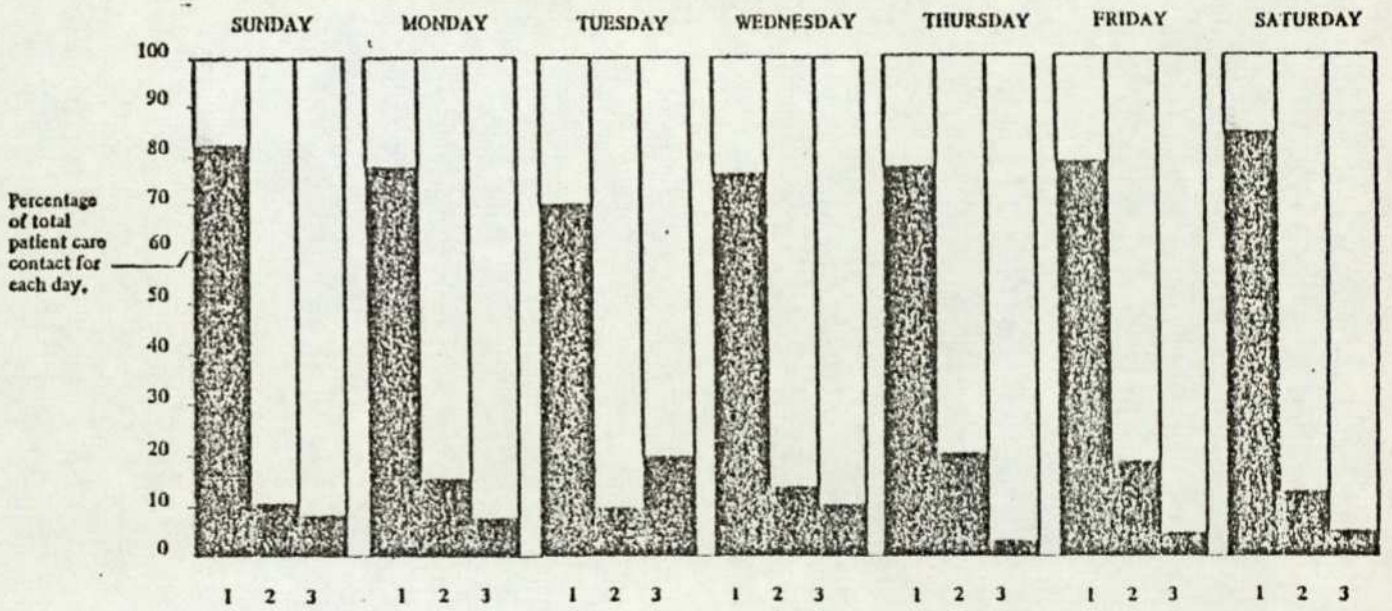
Frequency of all nurses' activities.

In Table 59 the frequency of all activities pursued as part of 'work' is shown for enrolled nurses and registered nurses.

Figure 19 illustrates the duration of patient care/contact periods during the same three five-hour periods. The difference between Figure 18 and Figure 19 reflects peaks and troughs in patient care more clearly than either of the two Figures considered in isolation. As can be seen, the duration of patient care/contact periods - the shaded areas in each column - are considerably less than their frequency in the morning section of the day. When more patients are seen during a given period less time is spent on their actual care. During the other two five-four sections of the day the duration of patient care/contact exceeded their frequency but there remained a sizeable part of the afternoon and evening when no patient care/contact took place. This does not necessarily denote inactivity on the part of the nurse as the length of the working day shows. Care of equipment, clerical work and communication with other professional workers and services on behalf of patients, tended to happen in the afternoon or evening hours and all these are important and necessary activities. Nevertheless,

Figure 19

Duration of patient care/contact during three time intervals



the irregular distribution of patient care/contact periods, the pronounced peaks and troughs, deserve further study.

TABLE 59

Frequency of activity in relation to the type of nurse

Activity*	Type of Nurse					
	SENs		SRNs		All Nurses	
	No.	%	No.	%	No.	%
Travel ≠	10,761	43	11,229	42	21,990	42
Patient care/contact	9,952	40	10,662	40	20,614	40
Call - no reply	119	1	133	1	252	1
Discussion - face to face	809	3	740	3	1,549	3
Discussion - telephone	801	3	888	3	1,689	3
Equipment	428	2	375	1	803	2
Clerical work	1,070	4	1,092	4	2,162	4
Off duty - on call	878	3	1,255	5	2,133	4
Combination of these	309	1	273	1	582	1

* Meals free - off duty and activities recorded as 'other' are not included.

≠ 'Travel' included all travelling irrespective of the distance between the respondent's home and work area.

If the nurse arranges her work in such a way that all patients requiring urgent care are seen in the morning these patients appear to get a relatively small proportion of the nurse's time. As a considerable part of the evening patient care/contact periods was accounted for by clinic sessions this portion of the nurse's time was given to ambulant patients and more of these patients were seen by registered nurses than by enrolled nurses. The afternoon patient care/contact periods occupied a mere fraction of the five hours 13.00 - 18.00 hours, a part of the day during which most meal times and other activities were recorded.

One is almost bound to conclude, therefore, that in the domiciliary care of patients there are definite troughs during the afternoon and evening hours and, especially at weekends and that the morning peaks represent rushed visits to a large number of patients rather than

extended periods of care. This conclusion applies to the care given by both registered and enrolled nurses although, as commented earlier, patient care/contact periods were, on the whole, longer for enrolled nurses than for registered nurses. Bearing in mind that some enrolled nurses did not look after bed-fast patients at all but had their activities confined to baths of frail/elderly patients and the cleaning or preparation of equipment, the need to examine the quality of domiciliary nursing care and the deployment of skilled nursing manpower in relation to it becomes more urgent.

Duration of activities.

The frequency and duration of 'on call' periods has already been commented on and reference has also been made of the inverse correlation between frequency and duration of travelling and patient care/contact.

An analysis was undertaken of the duration of all individual activities comparing enrolled nurses with registered nurses. A higher proportion of activities recorded by enrolled nurses took twenty minutes or more than those recorded by registered nurses. Taking activities as a whole, the difference could have easily occurred by chance during the survey period; however, for specific activities the difference was more clearly discernible and likely to be an inherent characteristic in the work pattern of the two types of respondents. The specific activities on which enrolled nurses spent different lengths of time to registered nurses were first 'equipment' on which they spent more time, secondly 'telephone discussions' for which less time was recorded and thirdly 'patient care/contact' for which enrolled nurses gave more time than registered nurses - in that order of magnitude in the difference. As activities recorded as 'equipment' included cleaning, replenishing and assembling of equipment, it is not possible to distinguish between these. From

comments made in the course of interviews, however, it can be assumed that considerable time was spent on cleaning of equipment and on its preparation for use by either doctors, health visitors or registered nurses. The longer telephone conversations made by registered nurses might understandably be linked with the complexity of their responsibilities. Whereas an enrolled nurse might merely notify a doctor or other worker of a problem the registered nurse might take further action including more telephoning. The content of the telephone conversations is not known and the above interpretation is, therefore, mainly speculation with some support from verbal statements made by nursing staff and administrators. The third activity for which enrolled nurses took more time than registered nurses is patient care/contact. This difference is due almost entirely to the difference in the types of patients attended by enrolled nurses and the kind of care these patients were given. Enrolled nurses cared for a significantly higher proportion of frail elderly bedfast patients than registered nurses and they also recorded a significantly higher proportion of baths and general nursing care. Therefore, not only could the type of patients they visited most often not be hurried on account of their age and limited mobility, but also the procedure they undertook most often, was inherently time consuming.

Patients cared for during the survey week.

As explained in the description of the purpose designed work record book (Chapter 9) the nurse respondents were asked to give details of the patients they cared for during the week. Details were requested under four headings, viz. the patient's sex, age group, mobility and type of condition.

A total number of 11,283 patients were recorded and classified under the above headings.

Sex distribution and age structure of patients.

Table 60 shows the sex distribution and Table 61 the age structure of patients seen by enrolled nurses and registered nurses respectively.

TABLE 60

Sex distribution of patients

Type of Nurse	Sex of patients					
	Female		Male		Total	
	No.	%	No.	%	No.	%
SEN	4,441	81	1,012	19	5,453	100
SRN	3,886	67	1,910	33	5,796	100
Total	8,327	74	2,922	26	11,249*	100

* For 34 patients, 26 seen by SENs and eight by SRNs, the sex had not been recorded and it was not possible to deduce it from the type of condition or care given.

The sex distribution of patients is relevant to a study of the enrolled nurse. The considerable excess of female over male patients has been shown in a variety of studies and the finding is in line with demographic trends and female longevity.

The findings show that female patients tended to be less mobile and to have more long term and deteriorating conditions. Based on the training syllabus of enrolled nurses and on the findings of this study, female patients are more likely to be cared for by enrolled nurses than registered nurses. If the number of female patients requiring care outside hospital continues to rise even only in the same proportions as general need for care outside hospital, and if the type of care female patients require continues to follow the current pattern, then enrolled nurses, as trained under the current syllabus, would seem to be needed in increasing numbers.

For reasons stated above, as for example female longevity, sex and age of patients are inter-related. As can be seen from Table 61

Table 61 Age structure of patients

Type of nurse	Under 5		5–14		15–44		45–64		65–74		75 and over		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
SEN	104	2	105	2	716	13	941	17	1,646	30	1,967	36	5,479	100
SRN	332	6	124	2	992	17	1,036	18	1,560	27	1,760	30	5,804	100
Total	436	4	229	2	1,708	15	1,977	18	3,206	28	3,727	33	11,283	100

Table 62 Mobility of patients

Type of nurse	Categories of mobility*													
	i		ii		iii		iv		v		N.A.†			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
SEN	462	8	464	8	778	14	1,846	34	1,899	35	30	1	5,479	100
SRN	278	5	356	6	691	12	1,851	32	2,597	45	31	1	5,804	100
Total	740	7	820	7	1,469	13	3,697	33	4,496	40	61	1	11,283	100

* Categories were rendered mutually exclusive by using the recording denoting the least mobility in each instance of a patient having been allocated to more than one category.

† For 61 patients the information was not available.

in all age groups up to 64 years, enrolled nurses cared for fewer patients than registered nurses, whereas in the older age groups, i.e., from 65 years onward this was reversed and enrolled nurses cared for more older people than registered nurses.

The more time-consuming care of older people was mentioned above, therefore, the excess in terms of numbers of older patients reflects a mere fraction of the excess in terms of time which their care demands. Sex differences in children and young people are unimportant in this context as they do not bear any relationship to the type of care given. From the age of 45 onward female patients exceeded male patients. Of the 8,910 patients in the older age groups, 7,650 (86%) were women.

In Table 62 an attempt is made to show differences in the degree of mobility of patients cared for by enrolled nurses and registered nurses respectively.

It is evident from Table 62 that enrolled nurses tended to care for patients with greater restrictions in mobility. Their patients in categories i, ii and iii exceeded patients in those categories cared for by registered nurses to the extent of 379. Yet, the total number of patients recorded by enrolled nurses was 325 less than those recorded by registered nurses. The difference is explained partly by the nature of care required by the more restricted patients. By definition they were dependent on help to meet their basic needs, help which was more likely to be considered suitable for an enrolled nurse rather than a registered nurse. To some extent, the difference is also a result of the greater number of clinic sessions recorded by registered nurses than by enrolled nurses, where ambulant patients in category V were treated.

As shown in Table 63 the types of patients cared for by enrolled nurses and registered nurses respectively from the point of view of the patient's condition were remarkably similar. As expected and consistent with data presented earlier, enrolled nurses cared for more long term and frail/handicapped patients (Categories II and III) than registered nurses. In view of the fact that the total number of patients enrolled nurses cared for was lower than the number recorded by registered nurses (Table 61) the proportionate difference is greater than it appears.

TABLE 63

Patients' type of condition

Type of condition	Type of nurse					
Categories	SEN		SRN		Total	
	No.	%	No.	%	No.	%
I	1,017	15	1,292	18	2,309	17
II	3,167	47	3,088	44	6,255	45
III	1,219	18	1,124	16	2,343	17
IV	330	5	325	5	655	5
V	195	3	200	3	395	3
VI	164	2	284	4	448	3
VII	164	2	112	2	276	2
VIII	156	2	338	5	494	4
IX	308	5	273	4	581	4
Total	6,720*	100	7,036*	100	13,756*	100

* Some patients came into more than one category

The main categories to which enrolled nurses allocated less patients than registered nurses were ante-natal patients (Category VI) and patients who were seen for supervision/advice only Category VIII). This last difference is the greatest in magnitude and unlikely to have occurred by chance during the survey week; this is not at all unexpected, being in line with current thinking on community nursing teams. Registered nurses are, on the basis of their basic educational programme,

better qualified to give supervision and to advise than enrolled nurses whose basic training is of a more practical nature. As discussed in Chapter 12, a considerable number of enrolled nurses said that their patients were being visited by registered nurses either for initial assessment and advice or for supervisory purposes throughout the patient's care.

Types and frequency of nursing activities/procedures.

The data made it possible to compare the nursing activities of enrolled and registered nurses. The list of activities in the work record book had been evolved through exploratory and field work. All procedures which had been recorded more than once either by the same nurse, or once by more nurses than one, were included in the list of 42 procedures or activities.

Below, each activity or procedure is given a number to facilitate further reference.

List of activities/procedures

Activity Number

Technical procedures:

1	Injections - D.D.A. drugs
2	Injections - Other hypodermic
3	Injections - Other intramuscular
4	Injections - Other
5	Dressings - Post-operative
6	Dressings - Ulcerated leg
7	Dressings - Other
8	Enema - Rectal suppository/rectal washout/manual removal
9	Vaginal - Douche/pessary/suppository
10	Catheterisation/bladder/washout
11	Vaccination - Smallpox
12	Vaccination - Other vaccination/immunisation
13	Treatment to eyes or ears
14	Testing of vision
15	Audiometry
16	Cervical smear
17	Electrocardiogram
18	Taking blood sample
19	Taking blood pressure
20	Taking throat swab
21/	

Activity Number

Technical procedures:

21	Breast palpation/other diagnostic procedure
22	Other technical procedure to patient
23	Renal dialysis - supervision
24	Testing of urine
25	Reading blood test

Basic nursing activities:

26	Routine basic care or bed bath
27	Bathing in big bath
28	Care of hair, nails, feet
29	Assist with bedpan/commode/lavatory
30	Taking T.P.R.
31	Rehabilitation exercises etc.

Other activities:

32	First visit in response to call for doctor
33	Assessing patient's home conditions or needs
34	Talking to patient or relative without undertaking any technical procedures including teaching/ supervising patient or relatives
35	Teaching/supervising patient or relatives
36	Accompanying doctor or patient
37	Delivering/collecting equipment/making arrangements
38	Preparing food for patient/including drinks
39	Other activities or care
40	Wasted visits/no reply
41	Activities as qualified health visitor
42	Activities as qualified midwife.

As far as possible the 42 activities were grouped into technical procedures, 1 - 25, basic nursing procedures, 26 - 31 and other activities such as teaching or supervising patients or relatives or preparing food. All these activities entailed the nurse being in the patient's proximinity either in his own home or at a clinic, surgery or health centre. All the patients were given numbers, which they retained throughout the survey period, to be used instead of their names. The type of treatment or care was recorded on each occasion the patient was seen and it was of course possible for several procedures to be undertaken on any such occasion.

TABLE 64

Type and frequency of technical activities/procedures

Activity Number	Frequency of activity		
	SEN	SRN	Total
1	47	103	150
2	492	733	1225
3	712	981	1693
4	83	69	152
5	346	470	816
6	596	507	1103
7	635	628	1263
8	138	165	303
9	31	60	91
10	25	61	86
11	7	11	18
12	45	82	127
13	139	173	312
14	35	5	40
15	37	10	47
16	2	36	38
17	2	5	7
18	23	62	85
19	110	178	288
20	3	2	5
21	62	40	102
22	81	47	128
23	4	15	19
24	263	304	567
25	4	9	13
Total technical procedures	3,922	4,756	8,678

Table 64 shows the type and frequency of activity or procedure undertaken during the patient care/contact periods discussed in this chapter. Activities undertaken by respondents in their capacity of midwives or health visitors were recorded separately and are not included.

As can be seen from Table 64 and as mentioned earlier, there was no one technical procedure not undertaken by any enrolled nurse. Two-thirds of the procedures were more frequently recorded by registered nurses than enrolled nurses, the exceptions being:

Activity Number

4	Injections - Other
6	Dressings - Ulcerated leg
7	Dressings - Other
14	Testing of vision
15	Audiometry
20	Taking throat swab
21	Breast palpation/other diagnostic procedure
22	Other technical procedure to patient

Of these eight procedures at least four (14,15,20,21) were performed by enrolled nurses in their capacity as clinic nurses*

Table 65 gives the same information for the basic nursing and other activities.

TABLE 65

Type and frequency of basic nursing and other activities

Activity Number	SEN	SRN	Total
26)	1965	1708	3673
27) Basic	221	173	394
28) Nursing	920	693	1613
29) Care	709	534	1243
30)	392	326	718
31)	481	380	861
32	69	129	198
33	63	111	174
34	428	457	885
35	342	489	831
36	41	86	127
37	116	152	268
38	163	111	274
39	235	247	482
40	67	72	139
Total	6,212	5,668	11,880

Table 65 shows the excess of basic nursing activities undertaken by enrolled nurses over registered nurses. When these six activities (26 - 31) are taken together the difference between the two types of workers was unlikely to have occurred by chance more often than once in a thousand instances. The first difference between

* Nurses with clinic responsibilities only were not included in the study.

enrolled nurses and registered nurses in the frequency of activity 32 - first visit to patients - was also unlikely to have occurred by chance more often than once in a thousand instances. Differences regarding the frequency of activities 33, 35, 36 were significant at the 1 in 100 level; differences in the frequency of activities 34, 37, 39 and 40 were not statistically significant at that level and could have occurred by chance more often than once in a hundred instances.

The most frequent recorded procedures for both enrolled nurses and registered nurses were basic nursing ones. For enrolled nurses they were followed by dressings, for registered nurses injections took second place in frequency.

The variety of procedures recorded by all nurses reflects work within general medical practice; activities 11 - 20 were most often undertaken in the G.P. surgery.

The number of post-operative dressings suggests some effects of earlier discharge policies; two thirds of these were undertaken by nurses in 18 of the 47 study areas. Registered nurses only were responsible for post-operative dressings in four of the 18 areas; in the other 14 areas such dressings were recorded by both enrolled nurses and registered nurses.

The activities and procedures were recorded for each day of the week and it was possible, therefore, to analyse which activities were omitted on Saturday and Sunday of the survey week - the troughs described above. All activities except the injection of dangerous drugs (activity No. 1) and the very few instances of supervision of renal dialysis were recorded less often on Sunday than on any other day of the week. It is common practice for district nursing staff to reduce week-end visiting as far as possible. Many patients have less frequent than daily visits, and it is reasonable to space these in such a manner that the week-end or at least Sunday can be avoided.

Some patients have daily or more frequent visits. During the survey week 12% of the total number of patients were visited every day from Monday to Friday inclusive and a quarter of these had more than one visit on at least one of the five days. A further 4% had visits at least once every day of the week including Saturday and Sunday. These visits were almost entirely for the purpose of an injection, basic nursing care or dressings. These three procedures were also those which were most often performed on Sunday. Basic care, followed by injections and dressings - formed the most frequently recorded Sunday work for both enrolled nurses and registered nurses.

There was, however, a marked reduction in all of these especially on Sunday.

Both, enrolled nurses and registered nurses, recorded approximately half as many hypodermic injections* on Sunday as on Monday.
(Enrolled nurses - 47%; Registered nurses - 51%).

Both, enrolled nurses and registered nurses, recorded less than half the number of post-operative and other dressings** on Sunday than on Monday.
(Enrolled nurses - 44%; Registered nurses - 40%).

Both, enrolled nurses and registered nurses, recorded approximately one-third as many basic nursing activities*** on Sunday as on Monday.
(Enrolled nurses - 36%; Registered nurses - 34%).

* Injections of D.D.A. drugs are not included.
** Dressings of ulcerated legs are not included.
*** Visits for the purpose of a 'big bath' rather than a 'bed bath' are not included.

The data relating to the nurse's weekend activity are included because they illustrate that the two groups of workers tended to work in a parallel rather than a complementary way; they did not seem to stand in for each other at the weekend.

Place of treatment or care.

The practice of district nursing staff giving care or treatment in places other than the patients' homes was increasing at the time of the study and has continued ever since.

Table 66 presents an analysis of the place of treatment given to patients in the survey week.

TABLE 66

Place of treatment/care

	Activities/procedures			
	SEN		SRN	
	No.	%	No.	%
Patient's home	9,452	90	9,498	86
GP surgery	403	4	708	6
Health Centre	65	1	136	1
LA clinic	107	1	302	3
Old people's/welfare home	104	1	59	1
Private hotel/nursing home	7	-	39	)
Residential Nurses' home	-	-	5	1)
Nurses' private home	7	-	12	)
Combination	263	2	204	2
Other	149	1	38	-
Total activities/ procedures*	10,557	100	11,001	100

* All activities are included, even those undertaken by combined workers as midwives or health visitors.

Table 66 shows that enrolled nurses in the survey performed less procedures in the GP surgery than registered nurses; the most frequently recorded items were: -

Activities as qualified midwife	52
Taking blood pressure	51
Testing urine	51
Dressing ulcerated leg	37
Vaccination (other than smallpox)	32

The most frequently recorded procedures by registered nurses in the GP surgery were: -

Taking blood pressure	97
Taking blood specimen	90
Testing urine	90
Activities as qualified midwife	87
Immunisation	80
Vaccination (other than smallpox)	67
Other injections (not DDA drugs)	46
Dressings - not post-operative not ulcerated leg	43

Other procedures were recorded less than 30 times.

The only important difference in work at the GP surgery between the two groups was in vaccinations and immunisations which means that in areas where local authority staff are not permitted to undertake these procedures, differences would tend to disappear. The type of work undertaken at health centres or local authority clinics showed a rather different pattern. Enrolled nurses were even less involved in work at these centres. As Table 66 shows they recorded 172 procedures against 438 recorded by registered nurses. Although dressings, other than post-operative or ulcerated leg dressings, topped the list in frequency of procedures performed by enrolled nurses - they were recorded only 25 times. Activities as qualified health visitors were the most frequently recorded by registered nurses at health centres or local authority clinics, followed by taking of blood pressure and immunisations.

The excess of enrolled nurses' activities in Old People's Welfare homes is worthy of note; most of the work was basic nursing care and injections. The pattern was set almost entirely by the staff in one English county. This county not only employed the largest number of enrolled nurses, but also had a policy of district nursing staff undertaking care in its Old People's Welfare Homes. Differences of opinion about the desirability of district nursing staff giving care in places other than the patients' own homes have been commented on above.

In this study an attempt was made to obtain some information about the types of patients who were visited by district nursing staff in their homes and those who attended a clinic, surgery or health centre for their treatment. Table 67 presents an analysis of patients who received home visits for purposes other than basic nursing care.

As Table 61 shows, fully mobile and comparatively young patients receive treatment other than basic nursing care in their homes. In most cases this treatment was an injection or a dressing. Reasons why such patients could not be treated at a central place were not explored in this study, but might be investigated further.

TABLE 67

Analysis of patients who had home visits for purposes other than basic nursing care.

Patients' mobility	Patients' sex			Patients' Age Groups					Total
Category*	F.	M.	N.A	Under 5	5-14	15-44	45-64	65 and over	
I	192	70	6	68	34	16	19	131	268
II	312	52	6	26	11	8	74	251	370
III	622	106	-	10	87	128	51	452	728
IV	821	178	2	6	3	149	123	720	1001
V	628	996	5	24	9	31	567	998	1629
N.A.	15	13	2	11	-	6	5	8	30
Total	2590	1415	21	145	144	338	839	2560	4026 /

* For the definition of categories I - V see Chapter 9.

/ Many of these 4,026 patients had more than one home visit during the survey week. A detailed analysis was not carried out.

An increase of clinic sessions for ambulant patients may not only be an economy in district nurses' time but may also be in the interest of patients. It may be a positive step toward their rehabilitation and it may also be more convenient for some patients not to have to wait in their homes for a district nursing visit, the time of which could not easily be arranged with certainty.

Further research to show the reaction of all members of the caring team, including the patient and his relatives, is needed.

The details relating to the nurses in the national study and to the work they were found to undertake are presented in order to suggest the potential which such a data base has. Some of the further analysis which was carried out is described in Annex 5 but the scope is very much greater.

It would be possible, for example, to relate each nurse variable to the structure of her working day, the work she undertook and the patients she cared for. In view of the relative autonomy of the district nursing service further discussed in Chapter 13, such analysis might be relevant to management. District Nursing Administrators are committed to the provision of a service which will meet, as far as possible, the nursing needs of the community. In his study 'District Nursing - An Example of Front line Organisation', Jupp[7], draws attention to the relative freedom a district nurse practitioner has in the way the policy commitment is carried out in practice. Further analyses of the data might show differences between married and single nurses, between men and women, between those who have had special professional preparation and those who only have the minimum qualification in the way they organise their work and the length and frequency of their visits. The work preferences, the patient preferences and the preferences regarding the place where care is given deserve to be explored in much greater detail and related to the nurses' personal attributes. One such example of further analysis, which might have considerable significance for the district nursing service is given in Addendum 4. It is mentioned at this point, merely to explain the volume of detailed data in Chapters 10 and 11.

CHAPTER 12

FINDINGS FROM THE NATIONAL STUDY IDENTIFYING DILEMMA AND CONFLICT

The quasi-experimental study had suggested that the community nursing services might ease the pressure on the hospital facilities. The national study, with its emphasis on enrolled nurses had, therefore, been initiated primarily to identify actual and potential resources in the community nursing services.

Official statistics, both national and local, provide quantitative data about the employment and deployment of staff. They do not indicate how staff perceive their duties, their responsibility, their working conditions and their views on how the service they provide might be improved.

The findings presented in this chapter were intended to fill this gap, at least in part. The health visitor respondents are deliberately included in this section as their perception of the district nursing contribution is relevant; moreover, some enrolled nurses in the national study were interchangeable between the district nursing and health visiting work force.

Nurses' views about their work and the extent of their responsibility.

Ninety-eight per cent of the respondents said that they enjoyed their work and there was little difference between the three groups of staff.

They did, however, have thoughtful comments to make about the type of work they were doing and the amount of their responsibility. No less than 71% SENs, 88% SRNs and 65% HVs considered that some of their normal duties though enjoyed could be undertaken by someone less qualified. The main duties which district nursing staff included were basic nursing care and baths; taken together, they were mentioned 110 times. Those most frequently mentioned by health visitors were geriatric visits, routine clinic duties and

school medical examinations, together referred to 114 times.

In addition, a sizeable number of all respondents would have considered it more appropriate for someone not necessarily less, but differently, qualified to take over some of their normal duties. This group included 53 SENs, 91 SRNs and 59 HVs (16.5% of the total sample). Clerical work was the single item mentioned by the largest number (32) of health visitors as being more suitable for (clinic) clerks; physiotherapy reached the top position in the district nursing field, as being considered work that ought to be done by qualified physiotherapists; it was mentioned by 62 district nurses (6.3%), SRNs and SENs taken together. Other duties in this category included the care of feet which was thought to be more suitable for chiropodists and some technical procedures* which nurses would rather were done by technicians. None of these other duties were mentioned by more than 20 respondents. It was thought that the nurses' views about their work might be influenced, at least in part, by the organisational pattern depending especially on whether they were attached to general medical practice or not.

The percentages of 'attached' SRN and HV respondents were almost identical, 39% and 38% respectively; 31% of SEN respondents were attached. This is consistent with the information on attached staff given by GPs in that SENs are less often attached to general medical practice than SRNs or HVs. SENs appear to have more opportunity to work closely with GPs as privately employed practice nurses than as local authority staff members. This is further accentuated by the contact, or lack of it, that even 'attached' SENs had with the general practitioners; a matter that is discussed further when the amount of professional contact with other workers is shown.

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*Examples: 'taking blood specimens', 'reading haemoglobins', 'testing vital capacity', 'keeping an eye on oxygen cylinders at home'.

The respondents were asked identical questions to the GPs about attachment schemes; first, whether they thought attachment schemes were a good idea or not and secondly, whether they thought that attachment schemes benefited the patient in any way.

In order to get answers based on experience rather than hearsay both questions were confined to those respondents who were working in attachment schemes.

The overwhelming majority of all three groups of staff - 80% SENs and 90% SRNs and HVs answered the first question in the affirmative, i.e., they thought attachment schemes were a good idea. Their reasons, though unstructured at interview, fell into fairly clear categories ranked below in order of their frequency.

TABLE 68

Reasons for favouring attachment

	SENs	SRNs	HVs
Contact and discussion with GP	1	1	1
Feeling of being a member of a team	2	5	3
Access to patients' notes	3	2	2
Provides liaison between patient and doctor	4	3	4
GPs more co-operative	5	5	6
Greater variety of work	6	3	4

Equal ranking order indicates that equal percentages of respondents gave these reasons.

Although the largest proportion in each group gave contact and discussion with the GP as their first reason, there was a marked difference between SENs and the other two groups, 65% SENs against 78% SRNs and 84% HVs. This was because for many SENs attachment to general medical practice did not improve their personal contact with the GP. Many of the SEN respondents said that although they were counted as being 'attached' this did not involve a closer direct working relationship with the GP, it being more usual for the GP to communicate through the SRN rather than directly with the SEN. This

is in some measure supported by the respondents' answers to questions about contact with the GP presented later.

Those respondents who considered that attachment was not a good idea gave reasons in the following ranking order:-

TABLE 69

Reasons for not favouring attachment

	SENs	SRNs	HVs
Excessive travelling	4	1	1
Surgery work - waste of time	3	2	-
Nurse doing doctor's work	2	2	-
Several nurses in one area	5	-	-
Qualified answers, implying			
(a) if organisation is good	1	5	2
or			
(b) if team gets on	-	2	-

Equal ranking order indicates that equal percentages of respondents gave this reason.

The nursing staff who were not attached to general medical practice were fairly evenly divided into those who would and those who would not prefer to have such a working arrangement. There were slightly more SENs and SRNs in the second group, slightly more health visitors in the first, i.e., they would have preferred to be working in an attachment scheme. Reasons advanced by those who would have preferred to be attached were similar to those given by attached respondents who liked the arrangement. In all three groups of staff the majority would have preferred attachment because they thought it would increase their contact with the GP and other members of the practice team. Reasons why respondents preferred not to be attached again mirrored those advanced by attached respondents in support of their statement that attachment was not a good idea.

A larger proportion of attached SENs than others were dissatisfied with the amount of responsibility they were given; it was either too much or too little or it fluctuated. As the proportion of SENs in

attachment schemes was small this finding cannot be given much weight. More specific comments by staff about the degree of their responsibility are presented later in this chapter.

The preliminary study had suggested that some nurses were reluctant to work in attachment schemes because of the additional travelling and, as shown above, this was a reason advanced by some respondents in the main study. It was felt that this might be due to inadequate transport facilities, particularly for SENs.

A slightly smaller proportion of SENs than others had the use of private motorised transport - 76% SENs against 89% SRNs and 81% HVs and answers suggested that this was part but not the whole reason why attachment schemes were not favoured by one-fifth of the SENs. More generous private motorised transport concessions would have helped some but not all SENs to accept attachments more readily, as half of those without such transport preferred not to drive. Some SENs would have been more keen on attachment if they felt themselves better integrated as members of the team and if their work were more clearly and rationally defined. The fact that some SENs in attachment schemes were occupied mainly with the preparation and cleaning of equipment or bathing frail elderly patients, whereas others were doing 'first visits' for the doctor and taking full responsibility for all kinds of patients, shows uncertainty and ambiguity.

The SENs, SRNs and HVs were asked if there was anything at all that would make their work easier or more enjoyable. The question was unstructured apart from final prompting on telephone, transport and housing.

On the whole, enrolled nurses seemed either more satisfied with their present lot than other groups or were more reticent in voicing their opinions. It could be that the aspirations of the enrolled nurses were supressed.

Fifty-two per cent SENs said there was nothing at all that would increase the ease or enjoyment of their work. This answer was given by 23% SRNs and 15% HVs.

The nursing respondents were asked if they thought a 24 hour district nursing service was needed or not. Their answers are shown in Table 70.

TABLE 70

Nurses' views on need for night nursing service

A 24-hour service is:	SENs		SRNs		HVs	
	No.	%	No.	%	No.	%
Needed	284	53	214	45	135	56
Not needed	178	34	210	45	72	30
Qualified answer	36	7	34	7	12	5
Don't know	16	3	8	2	6	2
Not answered	14	3	4	1	16	7
Total	528	100	471	100	241	100

The qualified answers were similar for all groups of staff and fell into four categories; some respondents felt that such a service was needed in rural areas only, others considered that the need was mainly in urban areas. Roughly a third of the qualified answers indicated the need for night sitters rather than qualified nurses and the fourth group felt that a 24 hour nursing service might be needed, but could only be provided by a separate night nursing staff.

Those in favour of a 24-hour district nursing service most often stated that it was needed for the chronic sick, terminally ill and elderly people. Proportionately more SENs and SRNs than HVs thought that such a service was needed to help relatives, a higher proportion of HVs that it was needed for emergency purposes.

Reasons advanced in support of the answer that a 24-hour district nursing service was not needed were:

Insufficient demand Need met by relatives or others	Mentioned most often by SENs.
GP's place to do night visits Insufficient demand Patients needing 24-hour care should be in hospital	Mentioned most often by SRNs.
Need met by relatives and others Patients needing 24-hour care should be in hospital	Mentioned most often by HVs.

Very few - a total of 14 - respondents felt that such a service would be abused by the public.

Some of the registered nurses who considered that GPs should do night visits had been asked by GPs to answer night calls. There was considerable objection to this, summed up in one nurse's comment:-

> 'It's not fair on patients or on us. Patients want to see their doctor if they are ill in the night. More often than not we can't do much anyway and the GP has to get up after all. It just spoils two people's nights instead of one.'

The majority of all nursing respondents, 79% SENs, 78% SRNs and 82% HVs considered the amount of responsibility given was 'just right'. Thirty five respondents (3%) felt that they carried too much responsibility and a much greater number (165 = 13%) that they were given too little responsibility. Of the first 35 respondents the proportion of SRNs exceeded the other two groups marginally but as the total number is so small no importance can be attached to the difference. The second group consisted of 76 SENs, 66 SRNs and 23 HVs. In addition, there were some qualified answers implying a fluctuating measure of responsibility which was particularly marked in the answers given by SENs. Comments were made such as: -

> 'When there's no one else I have to do anything and sometimes I feel unsure.'

or

> 'When all the others are on duty I do most baths and things.'

Interviewers were aware of a feeling of uneasiness on the part of

their respondents when this question* was asked. One interviewer wrote: -

> 'It is clear from many comments that they (the respondents) thought the question implied criticism of their local authority and they were reluctant to venture any complaint.'

Similar observations were recorded by other members of the interviewing team. If their observations were justified, the large number of 'satisfied' respondents may give a false picture. This type of bias may of course be inherent in many answers; it is mentioned here because it was this question which alerted several interviewers sufficiently to draw attention to it.

Respondents were asked to give reasons for any feelings of too much or too little responsibility and to give examples of specific instances when in their opinion the measure of responsibility did not match their competence.

Close supervision and restrictions on the range of permitted procedures were most often quoted as resulting in too little responsibility. This was so for SENs, SRNs and HVs although the kind of supervision and restrictions differed. For SENs close supervision, understandably, most often meant supervision by SRNs. Seventy-four per cent (393) said that they had close contact with an SRN and for 241 SENs this contact took the form of work allocation by the SRN to the SEN. This allocation happened daily for 189 SENs, weekly for 42. Eleven SENs had only their new patients allocated to them and 18 had their work allocated on an irregular basis. Only 135 (26%) SENs had their own case load, that is they gave continued care to a certain number of patients, most others (67%) were given a list of work to be done but they took little or no part in the planning and organisation of patient care. In contrast to them were the 143

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* QUESTION: 'What about the amount of responsibility you are given? Do you think you are given too much or too little, or do you think it is about right?'

(28%) SENs who stated that they had no close contact with an SRN and that they took full responsibility for their patients' nursing care. The group, admittedly a small one (6%), who gave qualified answers to the question about contact with SRNs appeared to be the most frustrated. Without exception their answers implied that they had close supervision by an SRN if she was there but were left to their own devices when she was off duty for one reason or another. Several descriptive verbatim comments were recorded by the interviewers, best summed up by one who said: -

> 'When it suits them we can do anything, when it doesn't we are suddenly not properly trained.'

Enrolled nurses' unhappiness about their fluctuating responsibilities has already been referred to. An attempt was made in the analysis to discover whether there was a link between the nurses' experience and the responsibility they carried. There appeared to be no relationship as far as length of time in local authority service was concerned. Seventy five per cent of SENs who had been in such service for five years or more had a daily work allocation and 7% had their own case load. Of the new SEN entrants to local authority nursing, i.e., those who had done this work for less than two years, 67% had their work allocated daily and 8% had their own case load. It could be that this latter group had enjoyed a wider basic training which could account for the greater independence afforded them. This possibility was not explored.

Other methods by which SENs considered themselves supervised were visits by SRNs to their patients at regular intervals and in case of any change in the treatment or suggested regime. Sixty-two per cent said that an SRN always made decisions about frequency of visits when these were not determined by medical prescription and the SRN also decided on final withdrawal of nursing support. Some SENs

(approximately one/tenth) were in agreement with such arrangements expressed in terms like: -

'I think it's quite right for someone better qualified to have the final say.'

or

'Let's face it, she (SRN with district nurse training) has had special training for this. It's sensible for her to take the responsibility.'

Several SENs, approximately one/sixth, felt that there was unnecessary duplication of visits and that they were, in most cases, competent to make decisions themselves.

These feelings were voiced in comments such as: -

'For the most part I feel quite able to cope and in any case I can always ask if I'm unsure. There's no point in us both going in.'

or

'Surely the SRN in her three months or whatever of district nurse training can't have learnt as much as I have in six years of experience.'

SRNs who felt that they had too little responsibility and too much supervision were most often those who had not taken a specific training to prepare them for district nursing and who worked in close contact with staff who had taken such training. In one area, SRNs without district nurse training were called 'nurse' whilst those with such training enjoyed the title of 'sister'. In other areas this distinction in title applied to SENs and SRNs respectively.

Health Visitors appeared to be supervised either by GPs or, more frequently, by nursing administrators. The supervision was closely linked with the restriction on procedures and some HVs said, or implied, that they were supervised by their superiors in case the GP asked them to do work the LHA did not permit them to do. Vaccinations and immunisations were mentioned most often in this context. Sixty-one per cent HVs said that they were not allowed to vaccinate and 35 that they were not allowed to carry out

immunisation.*

Of the SRNs, just over half appeared to have no restrictions on procedures they were permitted to undertake. The most frequently mentioned 'forbidden' procedure was taking blood specimens, mentioned by 53 (11%) SRNs. This was followed by vaccinations (38 = 8%), treatments to eyes and ears, especially ear syringing (6%), first visits to patients (6%) and cervical smears (4%).

Vaccination was the most frequently mentioned forbidden procedure for SENs (83 = 16%), followed by first visits to patients (72 = 14%). Small numbers of SENs mentioned a wide variety of procedures they were not permitted to carry out. These included treatment to ears and eyes, insertion of pessaries, giving DDA drugs, intramuscular injections, catheterisation and others. Very few procedures seemed to be authorised for all SENs in the survey.

Only 83 (7%) of all the staff were given written information about the procedures they were not allowed to undertake. Forty-two per cent said that they were told about the restrictions and 26% just 'assumed' them. A sizeable proportion of all types of staff did not know whether there were procedures they were not allowed to undertake; SENs constituted the largest percentage of these (32%). SENs also had the largest percentage of qualified answers to the question about restrictions on procedures - 25% against 12% SRNs and eight per cent HVs. Fluctuation in the type of work entrusted to SENs emerged again in this context. Comments were recorded such as: -

'I am only allowed to give morphia when the SRN is off'

or

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* The work of privately-employed practice nurses was not studied in this survey. Four health visitors all in different areas said that the GPs nurses did the vaccinations and immunisations because the local authority would not allow their staff to undertake these procedures. One HV at least found this rationale hard to grasp: 'The doctor's nurse is an SEN, just qualified - I've been at it for 12 years.'

'The SRN I am working with now did her training here. While she was a student I had to do everything. Now she tells me that I mustn't give Jectofer.'

In Chapter 11 the procedures actually undertaken for patients by SENs and SRNs during the survey week are shown. As can be seen not one of the coded procedures was exclusive to SRNs. Thus, whilst few procedures were permitted for all SENs, none was forbidden for all.

Because of the confusion regarding the legal implications of changing nursing functions, the Royal College of Nursing has produced a statement on the duties and position of the nurse.[55]

An analysis of work pattern in relation to the possession of a district nursing qualification suggests that little or no weight was attached to it. Of SENs with a district nursing qualification, 78% had a daily work allocation, whereas 70% of those who did not hold a district nursing certificate had their own case load. This finding must, of course, be interpreted in the light of the small number of SENs who had taken district nurse training.

Nurses' preferences.

As explained in Chapter 9 the nursing respondents who completed a work record were given the opportunity to state three types of preferences. These were, first, the type of patient they preferred to care for,* secondly, the type of treatment or care* they preferred to give and thirdly, the place where they preferred to function, i.e., in the patient's home, at a GP surgery, health centre, etc.

Preferences were expressed in ranking order, i.e., a category having the first preference was given 1 and others were ranked as 2,3,4 etc. Equal preferences were given equal ranking.

The reason for including these questions was twofold:

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* These preferences were taken from 'Home Nursing in Scotland' by kind permission of the author.

First, it was an attempt to discover whether the generalised nature of district nursing might play a part in attracting so many trained nurses, both SENs and SRNs. Whereas a trained nurse in hospital is usually appointed to a certain type of ward or department as staff nurse or ward sister/charge nurse, the district nursing field is currently not specialised. Specialisation affects not only types of patients but to some extent also types of procedures.

Secondly, it was hoped to find out how nursing staff, who had chosen to work outside hospital, mainly in the homes of their patients, felt about undertaking part of their work in a GP surgery, health centre, or other central premises, a practice known to be increasing with the growth of attachment schemes.

The patients were divided into five categories to be ranked in order of preference. The type of work was divided into six categories.

First and last preferences of work type are shown in Table 71 and of patient type in Table 72.

As can be seen from Table 71 just over half of both SENs and SRNs gave regular general nursing care their highest preference rating, followed closely by dressings. Injections and other technical procedures were much less popular. The low ranking of rehabilitation may be influenced by nurses' views, already referred to, that they do not consider themselves suitably qualified to undertake this type of work. For both SENs and SRNs the weekly bath was low on the priority list, it was least liked by around 30% of all district nurses. In Annex 5 further reference to this is made.

TABLE 71

Work type preference*

FIRST work preference as proportion of nursing staff / FIRST choices	SEN %	SRN %	LAST work preference as proportion of nursing staff LAST choices	SEN %	SRN %
1. Regular general nursing care	54	52	1. Weekly bath	26	31
2. Dressings	39	50	2. Other technical nursing	6	7
3. Injections	22	23	3. Rehabilitation	4	3
4. Rehabilitation	15	18	4. Injections	)	2
5. Other technical nursing	13	22	5. Regular general nursing care	) 2	)) 1
6. Weekly bath	5	5	6. Dressings	) -	)

TABLE 72

Patient type preferences /

FIRST choices	SEN %	SRN %	LAST choices	SEN %	SRN %
1. Acute	47	63	1. Maternity	4	6
2. Chronic sick, bedfast	33	25	2. Acute	2	-
3. Chronic sick, mobile	26	20	3. Children	1	2
4. Children	22	20	4. Chronic sick, mobile	2	4
5. Maternity	12	22	5. Chronic sick, bedfast	-	1

* Vera Carstairs (1966) found similar preferences.

/ Percentages in the tables exceed 100% because some nurses gave equal rankings.

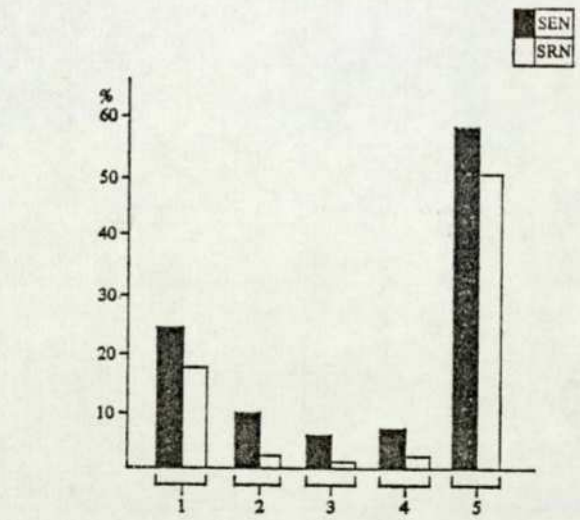
Table 72 shows that acutely ill patients were first priority for SENs and SRNs alike and among both types of staff, maternity patients topped the list of the 'least liked'. The answers referring to maternity patients and to children must be viewed against the background of Figure 20 which illustrates the small number of such patients cared for by district nursing staff.

Figure 20 shows the percentage of SENs and SRNs who said that they never or rarely nursed certain types of patients.

It demonstrates that district nurses generally nurse few maternity patients and few children. This is more marked in the work of SENs than SRNs. Twelve per cent of SENs rarely or never cared for acute patients and even 3% of the SRNs recorded this.

FIGURE 20

Percentages of SENs and SRNs who said that they never or rarely nursed certain types of patients



Key to categories:

1. Children
2. Acute cases
3. Chronic sick, mobile
4. Chronic sick, bedfast
5. Maternity

The 8% of SENs who indicated that they rarely or never cared for chronic sick, bedfast patients were surprising; a closer examination of the data revealed that almost 70% of them came from five areas where SENs were almost entirely used for weekly baths of ambulant

patients, hypodermic injections, colostomy dressings, dressings of ulcerated legs and preparation of equipment for use by other workers.

The above data were obtained from the subsidiary section of the record book which gave respondents the opportunity to state preferences of work and to indicate what type of patients they rarely or never had an opportunity to nurse. From Figure 20 it seems that work undertaken during the survey week was fairly representative and in line with usual practice.

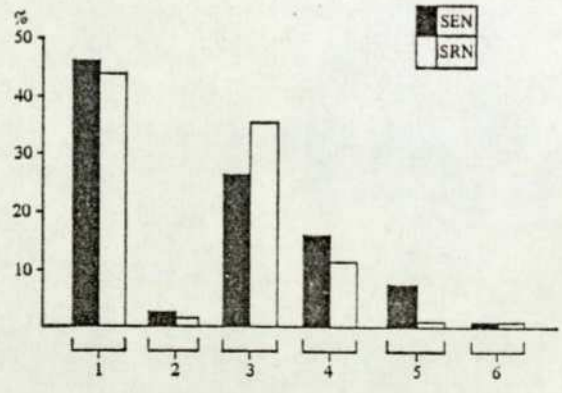
Where district nurses are attached to general medical practice they may give care at the surgery or in a health centre instead of working entirely in the homes of their patients. In some areas this care consists of a district nurse assisting the GP with vaccinations, immunisations, cervical cytology or similar preventive or diagnostic procedures; in other areas or practices district nursing staff are responsible for their own treatment sessions for ambulant patients. Some have even greater freedom and autonomy and make themselves available to patients for advice and consultation specific to nursing care. For example, in one practice the district nurse held regular sessions for teaching of nursing procedures and invited those relatives or friends who cared for practice patients to consult her on nursing problems.

Administrators of district nursing services have always tended to be divided in their opinions about the advisability of such extension of district nursing activity. Many contended that the service was intended to provide home nursing only and some local health authorities considered it illegal to use district nursing staff for work outside the patients' homes. Other authorities interpreted legislation (NHS Act 1946) in a wider sense and maintained that whilst they were committed to provide a home nursing service they were not forbidden to provide more than this.

The Health Services and Public Health Act 1968 regularised the arrangement whereby district nursing staff could provide care in places other than the patient's home. The Government report on Group Practice Organisation[54] endorsed it. In spite of this, reluctance on the part of some administrators persisted, either on the grounds that their staff establishment was not adequate or that their nursing staff were unhappy about this added dimension of their work. Whether this reluctance in encouraging or allowing staff to work at the doctor's surgery is wise or not it may well have a part to play in the direct employment of nurses by general practitioners. This study did not include an analysis of work undertaken by such privately employed staff. It did, however, provide information about numbers and qualifications of such staff which suggested that in some practices SENs were employed to help doctors with technical procedures which SRNs employed by the local authority were not permitted to undertake.

FIGURE 21.

Nurses' preference as to place of work.



Key to categories:

1. Only or mainly in patient's own home
2. Only or mainly at a clinic/surgery/health centre
3. About equal amounts in patient's home and at clinic/surgery/health centre
4. No preference
5. Undecided
6. Some other place, not mentioned above

An attempt was made to find out whether the administrators' argument that district nursing staff preferred to confine their activities to the patient's home was supported by the staff.

In Figure 21 the nurses' preferences as to place of work are presented.

Figure 21 shows that the largest proportion of SENs and SRNs prefer to work in the patients' own homes. This may be partly because of habit or because work at a clinic/surgery or health centre may entail new procedures with which a nurse is not familiar. It is also likely that it was work in the patient's home which attracted the respondents to district nursing in the first instance. Their reasons for working outside hospital (Chapter 10) tend to support this supposition.

Among the group (27% SENs and 36% SRNs) who preferred to work about equal amounts in the patients' homes and at clinic/surgery/ health centre - category 3 - there was a sizeable proportion of approximately one-third SENs who were not allowed to exercise this preference; they were roughly equally divided into those who were not allowed to work in the surgery at all and those who were only allowed to visit patients in their homes in exceptional circumstances. There was an even higher proportion of SRNs, almost half, who were unable to combine work at the surgery with work in the patient's home, which they would have preferred. This group seemed to be divided according to district nursing qualifications. Those with district nurse training tended to work almost entirely in patients' homes and those without, almost entirely as surgery or clinic nurses.* Although this kind of arrangement can be defended on rational grounds in that district

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* Further analysis of this information is referred to in Annex 5. It suggests that where district nurses have a choice it is reflected in their work pattern.

nurse training gives skills necessary for 'home nursing', the actual procedures in surgery nursing tend to be the more technical and carry an image of sophisticated expertise.

Nursing administrators were not unaware of the dilemma. It was difficult for most to define a rationally defensible policy on the deployment of SENs and SRNs either of whom might or might not have had special preparation for district nursing. Their dilemma was due in no small measure to the variation in demand for nursing support by general practitioners. One CNO who had clearly given the problem a very great deal of thought said: -

> ' It seems sensible to keep the nurse without district nurse training mainly in the surgery where she has little or no responsibility for the social aspects of care, adaptation of nursing and teaching of the family, none of which she has learned. But then you get a doctor who will ask her to do anything because she is to hand, including first visits when he is busy. I wish all this untidy mess with SENs, SRNs, district trained people and practice nurses could be cleared up. I can't see any way out of it other than giving them all the same basic training but - I think even then we'll have problems.'

Professional contact

Team work has become a commonplace term in community care. Professional contact between the members of a team would seem to be an essential pre-requisite. For this reason a number of questions on the extent and type of professional contact were included in the questionnaire.

Answers were, on the whole, encouraging and show considerable contact between the various members of the nursing staff and between nurses and GPs. Eighty-six per cent SRNs, 71% health visitors and 63% SENs had had professional contact with GPs in the week before the interview. Twenty-four per cent of 'attached' SENs had daily or even more frequent contact with the GP, a further 10% were in contact every two to seven days; the remainder reported contact weekly, monthly or 'when necessary'. Sixty-one per cent of SRNs

and 56% HVs reported regular contact with the GP. For two-thirds of SRNs this was said to be daily or more frequent contact, but only one-third of the HVs saw the GP to whom they were attached as frequently as that. It seems that the attached SRN district nurse benefits most from attachment as far as regular contact with the GP is concerned. Of the SENs who had not been in contact with a GP within this period, almost a quarter were in attachment schemes. This supports the statements made by SENs, already commented on, that for them attachment to general medical practice does not always increase their direct contact with GPs. They consider themselves attached 'by proxy' as one SEN succinctly put the position. Another SEN pointed out that for her attachment provided all the disadvantages and none of the advantages and this seemed to describe the position of several of her colleagues.

It was not surprising, therefore, to find that a greater proportion of SENs (31%) than of other respondents considered that they had too little contact with GPs. The position is not likely to be improved while policy makers in some areas (Chapter 17[4].) consider that direct contact between SEN and GP 'is not necessary' if a registered nurse is available.

Contact with hospital staff was less frequent than contact with GPs but more frequent than previous studies in this field have shown.[1,2,13.] Twenty-two per cent of SRNs but only 11% SENs said that they had been in contact with hospital staff within the last week before the interview; this was mainly with ward sisters for SRNs and mainly with other nursing personnel for SENs. A greater proportion (40% of health visitors had been in such recent contact with hospital staff, mainly with medical social workers. Very few respondents had communicated professionally with hospital medical staff. The method of contact used by SENs was most often face to face and by SRNs and HVs the

telephone. Contact by letter and messages conveyed through patients or relatives were forms of contact used by very small numbers of respondents.

SENs had more contact with home helps than any other type of worker. This may be due to the kind of patient both SENs and home helps tend to visit regularly, the elderly and long term sick or disabled.

Enrolled or Registered?*

This descriptive study of the SEN in the local authority nursing services was designed, at least in part, to compare SENs with other groups of local authority nursing staff in various respects. Basic attributes, such as age, marital state, educational background, etc., of SENs, SRNs and HVs are presented in Chapter 10.

The preceding chapter focused on the work patterns of SENs and SRNs and highlighted similarities as well as differences. Analysis of the work showed that there was not a single procedure which no enrolled nurse recorded.

One of the most outstanding though not most unexpected findings is the fluctuating responsibility given to enrolled nurses and the considerable variation in their deployment. As stated in Chapter 8 it was the knowledge of these variations which led to the study in the first place and which necessitated the large sample of study areas. In the district nursing service the boundary between SENs and SRNs was thought to be blurred and the findings of the study showed this to be true. It must be emphasised again that in some areas distinctions between SENs and SRNs were clearly defined; the

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* Questions were worded slightly differently for the different types of respondents in order to elicit information about differences in their respective spheres of work. For SENs and SRNs the question was: 'As far as the work you are doing is concerned, what would you say was the main difference between an enrolled and a registered nurse?'

blurring is accentuated by the national character of the study including so many authorities with different policies and practices. It is quite impossible to make a nationally applicable statement about the respective functions of enrolled or registered district nurses.

All respondents, SENs, SRNs, HVs, CNOs, PNOs, GPs and MOsH were asked to state differences, as they saw them between SENs and SRNs.* Approximately 40% of all 1,772 respondents said that there was no difference. Almost half the SENs (252) and almost a quarter (113) of the SRNs gave this answer. Several of the interviewers commented that many SENs expressed surprise at the question as if it had never occurred to them that the actual work they did was expected to be different. From the recorded verbatim comments it seemed evident that several SENs were emphatic that they did exactly the same work as their registered colleagues; the term 'precisely the same' was used repeatedly in this context. Many answers were inadequate in relation to the question as they mentioned differences in status, pay and holidays rather than in work. Where differences in work were mentioned they referred most often to existing working patterns and policies which created differences rather than to inherent differences in knowledge or competence. Policy differences occurred at two levels, administrative and procedural. Administrative differences most frequently mentioned by both SENs and SRNs were that the registered nurse was in charge of the district and that she supervised and allocated the work. As a result of this, so both types of respondents contended, the SRN made more professional contacts and spent more time 'on the telephone'. Both these

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* Questions were worded slightly differently for the different types of respondents in order to elicit information about differences in their respective spheres of work. For SENs and SRNs the question was: 'As far as the work you are doing is concerned, what would you say was the main difference between an enrolled and a registered nurse?'

statements were borne out by the work analyses in Chapter 11.

Procedural differences are as shown in Table 73.

TABLE 73.

Procedural differences between SENs and SRNs.

	SEN		SRN	
	No.	%	No.	%
Dangerous drugs given by SRN.	46	17	54	15
First visits to new patients by SRN.	48	18	22	0
Specified procedures forbidden to SENs.	83	30	74	21

Inconsistencies and fluctuations were again mentioned by many SENs implying that they were required to do precisely the same work as SRNs when there were insufficient SRNs on the staff but were told that they were not qualified to undertake certain procedures when there were no staffing problems. A typical remark: -

> 'Surely I can either give an intramuscular injection or I can't. If I can't I shouldn't ever be told to give one; as it happens I can but sometimes I mustn't.'

Very few health visitors (30%) answered the question about differences between SENs and SRNs as most considered it to be inapplicable to them. The answers were vague and unhelpful such as:

> 'I suppose the SEN is more practical.'

or

> 'I don't think there's a lot of difference in what they're doing.'

The medical and nursing administrators' answers related almost entirely to the differences they were themselves creating. Only three respondents in this group, all nursing officers, said that there was no difference and one of these added:

'I suppose we ought to make a difference but it wouldn't be honest to say we do.'

The differences mentioned by the nursing administrators were almost identical with those pointed out by the nurses themselves.

For example: -

'We don't allow enrolled nurses to go to new patients.'

'The SRN gives the work out and supervises.'

'We don't let SENs give dangerous drugs.'

Several administrators, especially MOsH, mentioned the legal aspects and the danger of a local authority being sued if anything happened to a patient treated by an SEN. No specific legislation was quoted; on the contrary, a number of nursing officers said that they did not know which law was involved but that the authority did not want to take any chances. The implication of such a statement is that SENs are less competent than SRNs to undertake specific procedures although not a single nursing officer expressed this.

General practitioners had a variety of ideas and observations on the differences between SENs and SRNs.* Approximately a third of those who answered this question - 526 - implied that they were not aware of any differences in the work being done.

Comments included: -

'I don't think any except that one is the boss'

'None, except that the SRNs are younger'

'Very little difference in general practice'

Because of the diversity of answers to an unstructured question it was not possible to quantify the information except in the crudest terms.

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* QUESTION: As far as the work in your practice is concerned what would you say was the main difference between an enrolled and a registered nurse?

Approximately a further third of the GP respondents expressed a keen awareness of differences in knowledge and competence. Their views were expressed in answers such as: -

> 'SENs are not experienced and often do not know the names and doses of simple drugs.'
>
> 'SRNs infintely more useful with a much wider potential range of duties and more able to take responsibility.'
>
> 'I can expect an SRN to deal with more acute illness and make an assessment of nursing progress. SENs are good for routine things.'

or a very similar point: -

> 'SRNs are able to take responsibility and make decisions. SENs can take the donkey work off SRNs.'

The remaining GPs tended to relate their comments to individuals rather than groups of differently qualified people. Answers in this group included: -

> 'The SEN who looks after our patients is every bit as good as an SRN.'
>
> 'It depends on the person. District work needs most of all a kindly heart - titles and things don't matter.'
>
> 'Our SRN gets a bit fed up at times and I think an SEN would be better.'

It was thought that it might be possible to obtain better information on a delineation of functions if respondents were asked to indicate on a list the most suitable worker to deal with a variety of specific situations. Respondents in personal interviews were handed the list so that they could see the alternatives and give some thought to their choices.

Fourteen situations requiring different types of levels of skills were selected on the basis of preliminary enquiries. Fictitious situations were created rather than procedures listed as it is the situation rather than the procedure which in the domiciliary care field tends to determine the level of skill required. Answers given by the nursing administrators are shown in Table 74.

TABLE 74

CNOs' or PNOs' answers on most suitable worker in 14 situations

Visits and/or procedures	*Most suitable for SEN*	*Most suitable for SRN*	*Equally suitable for SEN or SRN*	*Most suitable for doctor*	*Most suitable for nursing auxiliary*	*Someone else or combination. Please specify*		*Comments or qualifications*
						HV	*Rel*	
1. Syringing the ears in surgery of a 70-year-old patient with wax obstruction	9	36	13	22		1		1
2. Dressing the ulcerated leg of a 60-year-old woman in the home	45	10	36	1			1	
3. Injection of insulin to a well-controlled 80-year-old diabetic in the home	39	15	27	—			10	4
4. Injection of mersalyl to long-standing congestive cardiac failure of 70-year-old man	30	37	21	1				
5. Giving daily care to a patient of 40 years with multiple sclerosis who is doubly incontinent	45	13	34	—	6			
6. Giving daily care to a patient of 70+ deteriorating after colostomy for ca. colon	24	39	31	—	1			
7. First home visit in response to telephone call to the surgery by relative reporting feverish cold and vomiting in child of 3 years	—	24	—	60		9		
8. In the surgery taking cervical smear in 30-year-old woman with no symptoms	6	37	9	34			1	
9. In the surgery—routine immunisations	7	43	9	33		13		
10. Helping obese lady of 60 years with bath—no diagnosed disease	19	—	7	—	61			
11. Home visit to assess suitability of home prior to discharge of hemiplegic man of 68 after cerebral catastrophe	6	62	9			17		
12. Follow-up visit of—patient of 45 years after discharge from hospital following uneventful hysterectomy	10	36	19	13		13		
13. Follow-up visit of—child of 7 years after initial visit by GP	3	48	13	9	1	13		
14. Follow-up visit of—man of 75 years living alone on top floor and therefore housebound, having recovered from bronchitis and no longer in need of nursing	6	18	3		6	42	1	9

Table [75] shows the answers given by GPs to four of the 14 situations. The four situations involve different skills.

The 'first home visit' which demands skill of assessment or diagnosis was overwhelmingly felt to be the concern of the general practitioner: the same applied, although to a lesser degree, to the 'syringing of ears'. For the 'follow-up visit', the focus of opinion shifted from the doctor to the SRN. A majority of doctors felt that this procedure was most suitable for the SRN and of those who did not, 108 thought that such a visit came within the scope of the doctor. The SEN was clearly not considered suitable to play a significant part in either of these two situations.

At what level of skill a procedure or situation passes to or from any nurse's competence is still uncertain. Two hundred and twenty four doctors thought that 'the dressing of an ulcerated leg' was equally suitable for SENs and SRNs, more doctors (163 as opposed to 127) thought it most suitable for an SRN.

The results from this part of the study show some of the opinions of doctors concerning the role of the SEN. If anything, when faced with a 'concrete situation', their conception of the SENs' 'place' seemed more narrow than when they answered the more generally formulated questions. The only situation where the SEN as the most suitable worker had a clear majority from general practitioners was the bath of an obese lady of 60 with no diagnosed disease. Most other respondents selected an auxiliary or relative to deal with this situation, only 37 doctors did so; one GP mentioned a hydraulic lift operator, another thought that no one should have to do this and the patient ought to reduce before she is lifted into a bath.

Table 76 shows the percentage of each professional group who considered either an SEN or an SRN to be the most suitable person to deal with five of the 14 specific situations. Although there is a

Table 75

GP answers on most suitable worker in four situations

Visits and/or procedures	*Most suitable for SEN*	*Most suitable for SRN*	*Equally suitable for SEN or SRN*	*Most suitable for doctor*	*Most suitable for nursing auxiliary*	*HV**	*Relative**	*Other*
	Number of GPs							
1. Syringing the ears in surgery of a 70 yr. man patient with wax obstruction	38	186	89	243	2	0	0	0
2. Dressing of an ulcerated leg for a 60 yr. old woman in the home	127	163	224	11	12	0	1	2
3. First home visit in response to telephone call to the surgery by relative reporting feverish cold and vomiting in child of 3 yrs	4	78	3	459	0	2	0	0
4. Follow-up visit of: A patient of 45 yrs after discharge from hospital following uneventful hysterectomy	81	212	91	108	11	27	1	2

* Neither HV nor relative were given as suggested persons. Where an HV or a relative was indicated they were specifically mentioned by respondents in the category of 'someone else or combination'.

Table 76

Percentage of each professional group who felt that SENs or SRNs were the most suitable persons to deal with selected situations*

Situation	*Professional groups*											
	MOH Total 44		*CNO/PNO Total 67*		*GP Total 526*		*SEN Total 528*		*SRN Total 471*		*HV Total 241*	
	SEN	*SRN*	*SEN*	*SRN*	*SEN*	*SRN*	*SEN*	*SRN*	*SEN*	*SRN*	*SEN*	*SRN*
	%	%	%	%	%	%	%	%	%	%	%	%
Syringing the ears in the surgery of 70-year-old man with a wax obstruction	5	77	9	36	7	33	5	18	2	45	7	42
Dressing ulcerated leg of 60-year-old woman in home	54	17	45	10	24	31	41	2	33	26	5	84
First home visit in response to telephone call to surgery by relative reporting feverish cold and vomiting in 3-year-old child	2	24	—	24	1	14	4	24	—	35	1	23
Follow up visit to 45-year-old patient after discharge from hospital following uneventful hysterectomy	2	66	10	36	15	40	22	23	7	52	13	32
Helping obese lady of 60 with bath—no diagnosed disease	12	3	5	—	68	8	10	—	12	—	21	24

* The percentages do not add up to 100 because other answers to the questions are not included.

certain measure of relative agreement there is also conflict of opinion. For example, whilst 10% of the nursing officers considered the dressing of an ulcerated leg to be the most suitable for an SRN and 45% for an SEN, only 24% of the GPs thought of an SEN as the most suitable person to do this. The differences in opinion concerning the bath of an obese lady have already been referred to. The division of opinion can be easily discerned particularly in their choice between enrolled and registered nurses or in certain situations such as cervical cytology, routine immunisation or syringing of ears in their choice between registered nurses or general practitioners. The findings suggested that the actual or the perceived delineation of functions was by no means clear cut.

The dilemma lies in the possibility of inappropriate deployment of staff and in the sparse evidence of utilisation of experience or preferences. The conflict shows itself in inconsistency of deployment and lack of agreement between members of the health care professions on their respective contributions.

Some of the issues raised in this chapter are further discussed in Chapter 13 and in the concluding section.

CHAPTER 13

THEORETICAL ISSUES

This chapter is divided into three parts. Section I, the introductory section, states the position of nursing research in relation to theoretical issues. It raises the problem, which nursing shares with other applied social sciences, of lacking theories peculiar to its discipline, capable of guiding research endeavour in the conventionally acceptable manner.

In Section II methodological problems are discussed, especially the relationships between theory, empirical findings and policy. The investigator's approach used in the research programme is defended in this section.

Section III highlights those results of the research programme which, in the opinion of the investigator, require an explanation. They concern: -

a. the structure of the district nursing service,

b. teamwork,

c. the work pattern of district nurses.

Selected elements of social and nursing theories are offered as having the necessary explanatory potential.

Section I. Introduction.

Nursing embraces a variety of disciplines, each with its own set of theoretical propositions. The body of knowledge which a professional nurse applies, represents a composite science which is unique in the qualitative and the quantitative mix of the underlying disciplines of which it is composed (Hockey 1978)[56]. Figure 22 presents this notion conceptually. It can be seen that anatomy, physiology, sociology, psychology and a wide range of other sciences (not included in the figure which demonstrates the principle and not the details of the mix) merge to form a unique constellation called nursing. Medicine

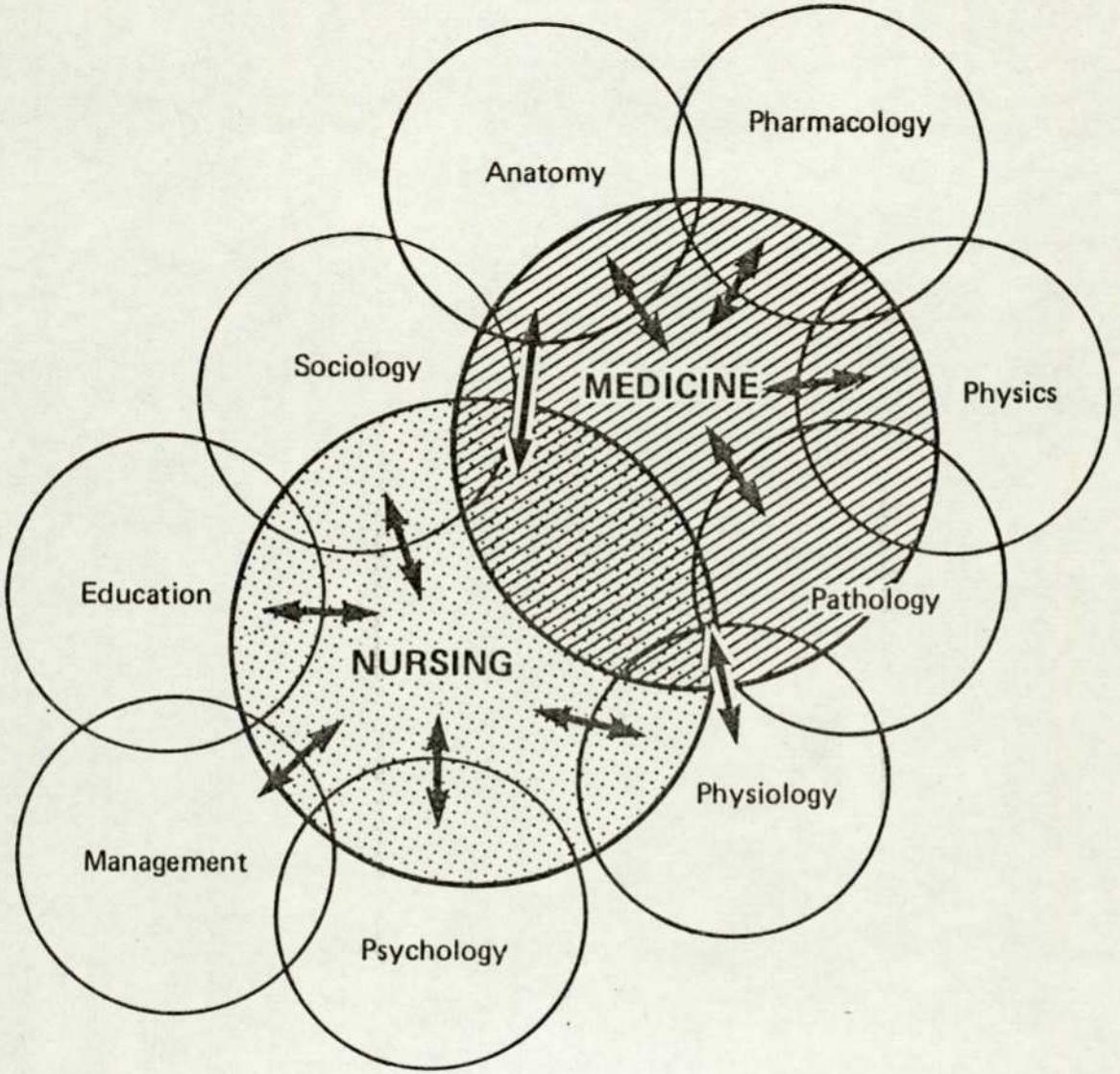


Figure 22 The figure does not claim to illustrate all elements in nursing or medicine. It is intended to suggest the unique constellations which make up nursing and medicine with areas of overlap and of independence.

and other applied sciences are similar in structure, the difference lying in the selection and the quantitative ordering of their underlying sciences. Figure 22 shows the relationship between medical and nursing science with some overlap and some independence in both. District nursing is a specialised type of nursing which superimposes specific sociological, administrative and other relevant knowledge on the composite discipline and science of general nursing. It is understandable, defensible and constructive for a study of nursing to be approached through any of its underlying disciplines. In nursing research, the selection of a relevant theoretical framework to guide empirical investigation has generated much debate and literature, referred to below. Nurses, with an academic background, who are more likely than other nurses to undertake research, have either selected research problems which were particularly suited to their academic discipline or, less often, they have attempted to study a practical nursing problem from their specific academic perspective. Examples of the former would be studies of the role or socialisation of nurses by nurse-sociologists.

Examples of the latter are the studies by Hayward (1975)[57.] and Boore (1978)[58.] respectively. Whereas Hayward, as a nurse-psychologist identified and measured psychologically determined patient outcomes in response to the stress of surgery, Boore, as a nurse-biologist focused her attention on physiologically determined patient outcomes in response to such stress. Both researchers made a valuable contribution to nursing and helped to increase the knowledge base of nursing science from their respective academic stances. However, nurses are searching for nursing theory, a search which is intensified by the move of nursing into higher education, the emergence of academic degrees in nursing itself and the establishment of Academic Chairs in Nursing Studies.

In the United States, nurses have applied themselves to the development of theories of nursing for some years. (e.g. Wald and Leonard, 1964[59], Putnam 1965[60], Dickoff and James 1968[61]). In Britain, though of more recent origin, the literature is proliferating rapidly. McFarlane (1970[62]) proposed a theoretical approach to the study of nursing, Inman (1975[63]) saw a need for a theory of nursing which, in her view, required a philosophical approach to nursing concepts in the first instance. Chapman (1976[64]) said: -

> 'Most nursing activity does not have a theoretical basis and it is difficult for nurses to isolate a body of knowledge specific to their role'.

The Association of Integrated and Degree Courses in Nursing devoted its 1976 Annual Open Conference to the theme: - 'Developing a Theory of Nursing'[65] of which proceedings were made available on application.

In a European context, the European Nursing Adviser to the World Health Organisation said: -

> 'What nursing needs is a theory of nursing'.[66]

Harrisson(1977[67]) in her study of Families in Stress, developed a model of care which has the necessary explanatory and predictive potential of a theory. Kratz (1978[68]) generated theory in the field of district nursing which is, therefore, particularly relevant to the empirical work undertaken by the investigator. As can be seen in Section II, this theory was invoked for the illumination of some research findings. One must, however, turn to other disciplines when events or findings call for interpretation or explanation that are not yet adequately covered by nursing theory. If the district nursing service, in its state provision for the care of the sick and elderly, is regarded as part of the British social structure and district nurses, their patients and colleagues as members of society, then it follows that sociological theory is relevant.

Section II (a) Some Methodological Problems

The relationship between social theory and social structure has exercised the minds not only of sociologists but also of philosophers. Merton (1957[69]) initiates a valuable and pertinent debate on the use of theory in sociological analysis and describes their interdependence, which is pursued by Nagel (1964[70]). The more widely tested a theory is the more confidence can be placed upon it. Empirical investigation, therefore, helps the development of theory and forms an important part of such development.

Emphasis in social research tends to be on the testing of theory by the structured collection of empirical data within the theory's parameters. It can and has been argued that empirical investigation without the direction of a theoretical framework is unscientific and undesirable. The reasons for such a line of arguments seems to be that data are arbitrarily collected and that their analysis and validation lack the yardstick of scientific rigour and objectivity. The counter argument stresses the frequent lack of objectivity in social research designed to test specific theories. Because of the constraints and definitive concepts inherent in the theory, the empirical investigation will be designed within these; it will be selective and may, therefore, ignore events outside its immediate terms of reference. It is possible, so the counter argument goes, that such events may be more than merely tangential to the investigation and may, if pursued, substantially influence the area of enquiry and the resulting data.

Academically initiated research tends to use the approach which leads deductively from a theory to empirical investigation. Such an approach does not only lend academic credibility to the research but, by testing the theory, also provides a valuable service to the discipline in which the theory was generated. The academic theorist

will, therefore, use theoretical concepts from his discipline as a springboard and as a compass for empirical work which will be based on it and directed by it. Merton (1957)[71.] suggests how social research may not only test, but may help to modify theory. Thus, in discussing the 'theoretic functions of research', he considers that theory may not merely be verified or negated by empirical data but that unanticipated findings may generate a new hypothesis which, when fed back into existing theory, could modify it. He makes provision for 're-modifying' in social research by allowing unanticipated and strategic findings to serve a useful purpose in theory modification. Glaser and Strauss (1967)[72.] took this approach a step further when they propounded the thesis of grounded theory. In their view, data systematically obtained, have the potential of not merely modifying existing, but also of generating new theory. They assert that generating grounded theory is a way of arriving at theory suited to its supposed uses. The authors consider that a theory should 'fit' the situation being researched and 'work' when put into use. The interpretation of 'fit' is that the categories generated must be readily applicable and indicated by the data under study; 'work' is explained as being meaningfully relevant to and able to explain the behaviour under study.[73.] Another advantage of grounded theory, claimed by the authors, is that it will be understandable to the layman involved in the area to which the theory applies. The investigator's proposition is that yet another possibility exists of relating empirical data to theory, that is the use of existing theoretical suppositions to explain empirically generated data which were not specifically collected to test such theoretical suppositions.

The role of theory in research is summarised by Sellitz et al (1962)[74.]:-

> 'Theory in research summarizes existing knowledge, provides explanation for observed facts and relationships and predicts the occurrence of as yet unobserved events and relationships on the basis of explanatory principles embodies in the theory'.

Theory can be generated by logical deduction from a -priori assumptions and tested by empirical investigations. Alternatively, theory can be grounded or modified by new empirical data. Whichever way theory has been arrived at and however sophisticated or general it is, it is only of value if it has explanatory powers. Therefore, empirical investigation should not merely be used to serve the purposes of the theorist but his theories should, in turn, be used in the explanation of empirical data. Griffiths (1959)[75], outlining the use of a theory to a practitioner states: -

> 'Theory helps to explain not only the processes but the very nature of the activity with which it is connected'.

The search for explanatory theory or explanatory principles embodied in a theory is thus one of the most vital and important stimuli to theoretical development as explanation, by definition, requires a recourse to theory.

A further argument relevant to the debate of theory versus empirical investigation related to the need for information in order to formulate social policy. Foley (1971)[76], in a paper entitled 'Wanted - A Theory of Nursing' stresses the need for and potential use of a theory of nursing especially in relation to prediction and planning.

To sum up, Cohen (1968)[77] draws attention to the relationship between scientific achievement and social reality when he says:-

> 'The achievements of any science are prompted largely by the desire to explain. But this desire occurs only when there is a recognition of something which has occurred which calls for an explanation'.

Section II (b) The investigator's research approach

The empirical work undertaken in the research programme was generated by an urgent need for information which took priority over the concern with theoretical concepts and in this respect it resembled most applied health service research. The fact that the research was generated by the need for information rather than the desire to test a theory is not intended to imply that the investigator approached social reality in a haphazard manner and collected a mass of unstructured data unsystematically, merely that the data were collected for a purpose other than the testing of a specific theory. The nature of the data collection was determined by the investigator's own experience and assumptions. During the period of development of the research programme, the findings of individual studies within it, helped to structure the further empirical approach. Moreover, the ongoing survey of the literature which began to proliferate during the period of the research programme (Chapter 14) helped to direct the thinking and to influence the plan for continuity in the programme.

As alluded to above, there is another, possibly a more constructive reason, why an approach from practice to theory may be advantageous. Studies,designed to test theories, tend to be based on a limited number of propositions or hypotheses. They are often undertaken by a scientist who is deeply involved in a specific science and who designs his empirical investigation to help him in the deepening of his scientific comprehension and to further the growth of scientific knowledge. There is, however, a widening dichotomy between specialisation in science and integration in social reality. As science becomes more specific, so the ambit of interest covered by the individual scientist narrows in relation to the general issues which concern society in its entirety. Bertalanffy (1971)[78] states: -

> 'Modern science is characterised by its ever increasing specialisation, necessitated by the enormous amount of data, the complexity of techniques and of theoretical structures within every field. This, however, has led to a breakdown of science as an integrated realm. The physicist, the biologist, the psychologist and the social scientist are, so to speak, encapsulated in a private universe and it is difficult to get word from one cocoon to another.'

Social life is not contained in isolated cocoons and, therefore, data obtained from empirical investigations of social events are almost bound to transcend the boundaries of rapidly narrowing disciplines. Specialisation in nursing is proceeding at a surprising pace and, if Bertalanffy is right, can be expected to lead to a breakdown of nursing as an integrated science or discipline. The development of one theory of nursing would become even less feasible.

The research programme made it possible to build up a picture of the social reality of the district nursing service, not merely through the empirical work of the investigator but also through the weaving together of a variety of strands of other research findings. The picture was a descriptive one but, just as reality is by definition multidimensional, so was the picture which emerged. It is contended, therefore, that it is defensible and helpful to study nursing, in this instance district nursing, not only from the perspective of one of its underlying disciplines but also from the perspective of how it is seen to function in reality. It was this approach which directed the programme. Some of the results seemed to require an explanation, the appropriate function of a theory. It is argued that if an explanation can be provided by an existing theory, (that is, in Glaser and Strauss's terminology if it 'fits' and 'works'), it is legitimate to use that theory. It also provides a powerful test of the theory and may render it a useful service by demonstrating its potential application to areas not initially claimed by it. No attempt was made to assess the empirical data systematically against a variety of

possible theories in order to compare their relative degree of applicability. Where an explanation was considered necessary and a theory, or a principle within a theory, capable of providing a satisfactory explanation was found, it was invoked for that purpose.

It is recognised that the perceived need for explanation is directly linked with the level of knowledge and understanding which are, by definition, subjective. Therefore, the findings singled out below are those perceived by the investigator as having a surprising or mystifying element. Moreover, whether an explanation is satisfactory or not, is also largely subjective but the explanations offered may provide a useful basis for further research designed to support or discard them. Although elements of sociological theories are offered for explanatory purposes it is stressed that the research programme was not designed within a sociological framework. It became evident on completion and reflection of the programme that elements of social theory and recently generated nursing theory had some relevance to it. Section III demonstrates their relevance as seen by the investigator.

Section III. Results requiring explanation.

Although no systematic analysis of sociological theories was undertaken, an attempt was made to justify those theoretical propositions or principles which are offered for explanatory purposes. Broadly speaking, the criteria used were those attributed to a useful theory by Glaser and Strauss (1967)[72], that is it should 'fit' the situation, it should 'work' and it should be understandable to the layman.

a. The structure of the district nursing service.

The composition of the district nursing service was explored in all four individual studies; the last study gives those findings national manpower statistics. It seemed, and continues to seem,

surprising that the district nursing service has remained a service with relatively few unqualified personnel. Although, more recently, the picture is beginning to change (Hardie 1978[79]) the proportion of nursing auxiliaries in the district nursing service is still much smaller than in the hospital nursing service. Even the learners in district nursing have, up to very recently, been qualified nurses, district nurse training being a post-basic qualification. In some areas and courses, basic nursing students are now given district nursing experience. It is recognised that the employment of different levels of staff is normally based on national or local policy and one could argue, therefore, that the explanation should be sought in managerial thinking. However, what must be surprising is the array of qualifications held by the district nursing staff over and above the minimum for licence to practise nursing. (Page 171).

At the time of the research programme, professionalisation and professionalism were concepts gaining popularity and every effort seemed to be made for nursing to be demonstrated as a profession rather than an occupation. Theories relating to these issues abound, as do definitions which are, of course, an essential component of a theory. An example is Glaser (1966[80]) who describes a profession as: -

> 'a cohesive and autonomous body of trained persons who perform work for the benefit of the public on the basis of applied scientific knowledge. A considerable institutional machinery guards the composition and purposes of the professions; training schools, often associated with Universities, develop knowledge and transmit knowledge, skill and appropriate social attitudes to neophytes; organisations examine and licence candidates for practice; other organisations control or informally influence members' technical performance, efficability and relations with lay clients; an association unites the membership in order to communicate knowledge internally and press for the profession's collective aim.'

Professional status conveys prestige to its members denied to those outside it. In nursing, it thereby provided the inducement which was needed once the disciplinarian and vocational ideologies of the Nightingale era were losing their appeal in a rapidly changing society. Once qualified, the nurse in hospital assumes supervisory responsibility, whereas district nursing staff undertake the full range of nursing functions themselves. Supervisory functions in a profession add to status and prestige within it which are denied to those who have no such functions. Yet, district nursing seemed to have no recruitment problems. This was especially surprising in view of the finding that the nurses' skills and qualifications did not always seem to be fully utilised. Although questions about professional choices were included in the interview with the district nursing respondents there was no comparable information about the hospital nursing staff; most of the studies of nursing to date had focused on recruitment, education and wastage rather than on differences within the various branches of the nursing profession, certainly not on differences between hospital and district nursing.

The search for an explanation led to an examination of studies of the hospital as a social system and an organisational structure which examined its effect on those working within it, including nurses. As the main distinction between the two types of nursing lies in the environmental and organisational framework it seemed logical to pursue this approach.

Most studies of the hospital as a social system seemed to explore psychiatric rather than general hospitals, for example the work by Dunham and Weinberg (1960)[81.], Goffman (1961)[82.], Levinson and Gallagher (1964)[83.], Wesson ed. (1964)[84.], Rosenberg (1970)[85.]. An important exception is the study by Menzies (1960)[86.]. Rowbottam et al (1973)[87.] studied the general hospital organisation and Dartington and Miller undertook a

study of geriatric hospitals as open systems (1975)[88]. Apart from Menzies, the researchers focused their attention on the patients in the system rather than on the staff. Towell, whose own study of psychiatric nursing adopted a modified systems approach (1975)[89], states that 'although the literature provides some important beginnings to a sociological understanding of patient care, it lacks equivalent concern with the staff perspectives which mediate between organisational factors and staff responses.' He,himself, made a useful contribution toward filling this gap, but it lies again within the structure of a psychiatric hospital. The work of Mauksch (1966)[46] was more relevant. He distinguishes between the cure and care processes which go on simultaneously in hospital. He ascribes the major part of the cure function to the medical profession whereas the care function is the prerogative of the whole system of which nursing forms merely a part, albeit the largest. He also draws attention to another important point of difference between medical and nursing care. The cure of a patient, or at least that major part of it which is medical, is not only the preserve of just one profession, namely the medical, it is the preserve of just one person, the individual consultant. Care, on the other hand, is divided among many professions, semi-professions and non-professionalised occupations and even that part of it which is exclusively nursing is not only largely determined by the other occupational groups, it is itself divided among many different nurses. In Mauksch's view, this multiplicity of persons involved in the patients' care function, causes the nurse to be caught up in conflicts and frustrations making it difficult for her to identify her own specific role and that part of her work which is independently initiated and controlled by her[90].

The district nursing field differs from the hospital setting in that it offers the opportunity for greater independence, its

organisational structure is less restrictive and less people are involved in the care of any one patient. The district nurse can organise her own activities and is less dependent on factors beyond her control, at least she is less aware of such factors. In other occupations or professions, where a section of workers has elected to undertake more independent, though perhaps even more arduous work, such as long distance lorry drivers (Hollowell 1968)[91.] the reasons were found to be in the escape from routine and its restrictive mechanisms.

There is a direct contradiction between Menzies's theory that the hospital system provides a defence mechanism against anxiety and the idea advanced here, that nurses might seek an escape from hospital by working as district nurses. The investigator explains this on the basis that district nurses, being older and professionally qualified, have overcome the anxiety which the hospital would understandably generate in the young inexperienced person learning to become a nurse.

Mauksch divided the nurse's role into two parts, that part which assists the doctor in his diagnostic and treatment function and that part which embraces the nursing part of the nurse's function.[92.] District nursing presents a strange paradox. On the one hand, it consists largely of Mauksch's medical ancillary part; on the other hand, however, it covers a wider spectrum of the caring function than hospital nursing where the full range of allied and specialist services can be more easily harnessed for individual patients. However, Mauksch provided an analysis of the work of hospital nurses and it would be unreasonable to postulate that, because district nursing takes place outside hospital, Mauksch's analysis may not equally apply to it. Further research would need to be undertaken, specifically to study the organisational context of district nursing practice. Such an approach may prove particularly fruitful in relation to the emergence of teams in primary care which, as elaborated below, have

demonstrated persistent problems. If it could be shown that nurses prefer to work in the district nursing field because of its greater independence, the current policy to create functional partnerships between them, general practitioners and other professionals, reducing this independence, may provide a possible explanation for the difficulties which have been experienced. Hunt (1975)[93.] in her study of factors influencing team work utilised the systems approach and stressed the importance of differentiating between closed and open systems and of defining their respective boundaries. Much of the debate about systems theory seems to have centred around issues of definition and interpretation and the rapidly growing volume of literature includes arguments about closed versus open systems, static versus dynamic systems, internal versus external systems. Bertanlaffy (1955)[94.], generally agreed to be the creator of systems theory has always tended to favour a flexible approach, using systems merely in an attempt to order complex environments and social data.

Mauksch's theory of the hospital as a social system explained, at least in part, why nurses felt attracted to work outside it. The explanation did not only have face validity but was supported by data obtained from the district nursing staff, explicitly and implicitly. In spite of it being likely that the more independent and autonomous working and organisational environment found in district nursing than in hospital nursing accounts for its attractiveness, it seemed relevant to seek further explanation of factors which compensate a highly qualified work force for the willing acceptance of work which did not demand its skills. In the hospital setting, much of that work could have been delegated to the freely available range of other workers, such as more junior, that is more recently qualified nurses, nurse learners, nursing auxiliaries, domestic workers and even volunteers.

Social Exchange theory was considered to provide a more satisfactory explanation. The literature on Exchange Theory is considerable and its systematic analysis in relation to different forms of nursing would be a helpful further stage. Exchange theory does not even confine itself to sociology. Emerson (1972)[95.] identifies a psychological basis for social exchange in addition to the one which is embedded in the social structure of society. Clearly, any economic system, from the simplest barter to the most complex industrial economy, is based on the principle of exchange. Gouldner (1960)[96.] draws attention to the fact that reciprocity, a similar concept to exchange, is universal in human affairs. Even gifts are received with a sense of 'incurred obligation', a thought further pursued by Titmuss (1970).[97.] There were three reasons why Blau's work (1964)[98.] was singled out by the investigator. First he developed the concept of exchange between partners in situations where exchange or reciprocity in terms of comparable goods, services or even sentiments is not possible; the relationship between a nurse and a patient represents such a situation. Second, Blau attempted to build on other available theories of society using them in a synthetic manner to explain and illumine the complexities of social life. The investigator's attempt to arrive at a better understanding of the district nursing service through an empirical research programme, using individual studies and individual theoretical propositions in a coherent and synthetic manner, represents similar thinking, albeit on a much simpler and more pragmatic level. Third, Blau's concept of the differentiation of power as a possible result of exchange seemed to make his theory particularly plausible in the context of district nursing. Abrams in 'Social Care Research' (1978)[99.] refers to Blau's work as providing notoriously the most generalised theoretical background for analyses of social care.

Referring to situations where reciprocity of service is not

possible, Blau[100] stresses the importance of social rewards and gratitude. He states: -

> 'The concept of social exchange directs attention to the emergent properties in inter-personal relations and social interaction.'

Service, in the sense of social exchange, hinges on reciprocity, either in the form of gratitude or in the form of a service rendered in return. Social exchange requires activity and effort by both parties. Exchange in social life is clearly a key concept. It explains not only the formation of friendships and mutual aid, but also that of peer groups, of the provisions of services for one another and the differentiation of power. The importance of power for professionals is clearly developed by Johnson (1972).[101]

Differentiation of power may give rise to differentiation in status and this, in turn, explains and perpetuates hierarchies and bureaucratic structures; where direct social exchange for services rendered between parties is not appropriate, opportune or feasible, the reward may be in terms of gratitude or it may come from a third source which may be impersonal and external and whose interests in the active process of interaction are secondary. Blau defines two conditions which must be met for behaviour to lead to social exchange; it must be oriented toward ends that can only be achieved through intervention with other persons and it must seek to adapt means to further the achievements of these ends.[102]

The application and use of Blau's theory to the district nursing service posed no problems and explained many of its surprising phenomena to the investigator's satisfaction. Nurses, who would, in a hospital setting, not be able to differentiate themselves as individuals from their colleagues, have a clear position of power in the homes of their patients. They are seen as the providers of a service built on an active process of human interaction and they are

able to adapt means to further the achievement of providing such a service. In most circumstances they receive an immediate reward in the form of gratitude or in seeing their own achievement. They also receive the approbation of members of the patient's family, their professional colleagues and society at large. In addition, the district nurse now has a comparable financial reward to that of her hospital colleague and the same job security.

b. Teamwork

Another result from the research programme which seemed surprising, even puzzling, is the limited success of attempts to achieve teamwork between the district nursing staff, their hospital nursing colleagues, hospital medical staff and general practitioners. The lack of collaboration between the services involved in the care of patients called for an explanation, as any expansion of community care could only be achieved by such collaboration; an understanding of the concept and the implications of division of labour is seen to be a necessary pre-requisite.

Some apparent benefits of the attachment of district nursing staff to general medical practice were beginning to show themselves.[103,104.] However, on the whole, different members of the caring professions, even when caring for the same patients, appeared to view their particular contribution in isolation from that of their colleagues. In some instances, they did not even seem to be aware of the potential contribution of colleagues in other disciplines to the care of patients. It was demonstrated in the quasi-experimental study, what could be achieved in a limited area, if continuity of and collaboration in patient care, were to be effected.[3.] The care of the patients in that setting had been seen as hospital care only. His care outside the hospital was the concern of other unrelated personnel and, at the time of the study, the cost of care in hospital and in the domiciliary

field came from two separate sources. Patient care was not seen as a shared concern, as one task which required to be undertaken by different sets of personnel, a labour which had to be divided.

District nursing itself emerged from all four studies as composite work which had not, however, been differentiated and divided among different grades and types of personnel within the service. It was suggested above, that it might be precisely the lack of division within the service, the attraction of being responsible for the 'whole', which has maintained an almost totally qualified staffing structure within district nursing. At the same time, it became obvious from the studies and from publications of other research[105.] and Government publications[106.] during the period of the research programme, that the district nursing service was seen to need expansion, specialisation within it and a wider network of communications with other workers and services. District nursing was not only beginning to widen its ambit but also lengthening the axis on which levels of skills can be plotted. From unskilled care of a kind which could be provided by a lay relative or friend it can potentially require various levels of skills in terms of procedures and of various types of patients, the care of some calling for complex social skills and problem-solving techniques.

The Report of the Committee on Nursing[107.] endorses the need for expansion: -

> 'An awareness of the scope of the (nursing) profession and the possibilities within it is an essential preparation for careers which must cross many harder lines traditionally held to be inviolable. Paradoxically, but not accidentally, the educational pattern we are proposing begins by emphasising the unity of care, yet goes on to allow for greater scope for individual specialisation than traditional separate specialised forms of training.' [108.]

The above quotation typifies the necessary transition from a series of unitary jobs called nursing specialties to a complex

divisible job of nursing.

Like the concept of social exchange, to which it is closely related, so is the concept of division of labour fundamental to an understanding of society. Without division of labour in some form, life could not be sustained; it is the level of division of labour which is relevant to the subject under study. For Adam Smith, from whom the concept originally stemmed, exchange and division of labour are inextricably linked; he cannot conceive of division of labour independently of exchange as expressed in the following excerpt: -

> 'The division of labour from which so many advantages are derived, is not originally the effect of any human wisdom, which foresees and intends that general opulence to which it gives occasion. It is the necessary, though very slow and gradual consequence of a certain propensity in human nature which has in view no such extensive utility; the propensity to truck, barter and exchange one thing for another'. (Smith"1930") 109.

Marx does not deprive division of labour of any of the importance attributed to it by Smith, but he does not tie it to exchange in the same way. Marx contends that, although division of labour is a necessary condition for the production of commodities, it does not follow that the production of commodities is a necessary condition for the division of labour.

> 'In the primitive Indian community there is social division of labour without production of commodities. Or, to take an example nearer home, in every factory the labour is divided according to a system, but this division is not brought about by the operatives' mutually exchanging their individual products. Only such products can become commodities with regard to each other as result from different kinds of labour, each kind being carried on independently and for the account of private individuals'. (Marx"1933") 110.

Marx applies the division of labour concept not merely to quantitative economic theory and science but also to social relationships. It is in this way that Marx's theory becomes more relevant to an examination of teamwork than that of Adam Smith. However, although Marx insists that economics should concern itself with social categories only, it

is within the context of political economy that he developed his view of division of labour and it seemed to have more meaning in that context than in the health care system. No thorough knowledge of Marxian sociology, politics or economics is claimed by the investigator and she returned to a theory which was considered to be more easily understood by the 'layman', namely that propounded by Durkheim (1964).[111] What appealed particularly in Durkheim's exposition was his application of the concept to many aspects of social life and also his attempt to explain success and failure in rational division of labour, precisely the phenomena which needed to be explained, as puzzling findings from the empirical research work. Thus, Durkheim's theory of Division of Labour served to explain the fragmentation of services and to illumine the way toward an effective and acceptable division of labour. Durkheim developed his concept of division of labour from the springboard of social solidarity, the connective tissue of society; without social solidarity there would be no society, no social service and no social exchange. Similarly, in the nursing profession generally, and in district nursing particularly, one can discern a social or, perhaps more appropriately, a professional solidarity. The emergence of large professional organisations with their increasing numbers of specific sub-sections, such as the Royal College of Nursing, supports this analogy.

Durkheim's concepts of mechanical and organic solidarity and their implications for division of labour proved particularly helpful. Mechanical solidarity[112] is described as that cohesion which is the result of likeness, similarity and conformity. It causes people to behave in a certain way and to conform to certain rules because they are members of a group who behave in this way and respect these rules.

The analogy to this model in nursing is not difficult to establish.

Nurses are a cohesive group and members adopt an accepted code of behaviour and accept given rules. They demonstrate mechanical solidarity; they are similar people doing similar jobs.

By tradition the nursing profession is hierarchically organised in a vertical structure. A professional ladder takes members of the profession upward to positions of responsibility and it is accepted that such ascent is a desired goal for the individual. The levels in the hierarchy or the steps in the ladder are held together by bureaucratic rigidly defined rules of accountability and spans of control. The management structure introduced by the Salmon[113.] and Mayston[114.] Committees, while hopefully improving managerial efficiency have accentuated the vertical direction of the line system. Using Durkheim's terminology, it is a system consisting of progressive 'likes' , that is members of the same discipline, and an analogy with Durkheim's mechanical solidarity is logically defensible. However, specialisation, the creation of multi-disciplinary teams and the constant widening of the nursing ambit requires a functional structure linking different disciplines horizontally. Only thus can the abstract theoretical concept of total patient care be translated into reality and remain alive and active. It is submitted, therefore, that multi-disciplinary teams are doomed to failure unless organic solidarity can be achieved. It cannot be achieved unless the job to be undertaken by the team is seen as one divisible whole to which different 'unlike' contributions are necessary.

As mechanical solidarity resting on similarity and repressive law diminishes, groups either disintegrate or another type of solidarity takes their place.

Durkheim calls this organic solidarity[115.] and suggests that it rests on division of labour, a postulate which appears relevant to the formation of teams in general medical practice. The important

requirement for such solidarity and team formation seems to be the recognition of the 'aggregate' and in the context of community care it is the recognition that community care is made up of different and not of similar segments. Therefore, so long as the doctor in the team merely delegates simple technical tasks to nurses and nurses merely delegate simple basic pseudo-professional tasks to less qualified staff, mechanical solidarity will override organic solidarity and will be less permanent. For organic solidarity to function there must be an awareness of the unique contribution of others, not merely an acknowledgement of their usefulness as substitutes in times of emergency.

District nurses provide a clearer example of the possibility of substitution than hospital nurses; they are all qualified and they all cover the whole spectrum of nursing care. One district nurse can be replaced by another whereas a charge nurse in a specialised unit can only be replaced by a nurse with the same knowledge and expertise.

Specialisation then leads away from the mechanical solidarity of groups consisting of 'likes' to another kind of solidarity which is founded on differences between people, on their individual personality, skill, experience, etc. Such solidarity can only be achieved if the differences are complementary and recognised as necessary for the common goal of the group, Durkheim's organic solidarity which forms the basis for successful division of labour.

As stated above, district nursing has changed in such a way that people of different personality, skill, experience are needed for its effective functioning and for the rational division of labour. The administrative structure is designed to establish groups of workers and it is argued, therefore, that organic solidarity is necessary.

Until the development of nursing teams in the district nursing

service the medical and nursing contribution to patient care tended to be divorced, both professions claiming to undertake different, though related, tasks. District nurses carried out the nursing part of the medical prescription but, until comparatively recently, did not and could not consider themselves as members of an organically cohesive team founded on the complementary nature of contributions by doctors, other health workers and themselves. The reason for this appeared to be mainly in lack of contact and communication, lack of awareness of the heterogeneity of a caring group and consequent lack of recognition of its common goal and varied contribution of its members. There were separate mechanical cohesive groups giving medical nursing, social and other types of care independently of each other. They had not converged or fused into a team with organic cohesion.

It is relevant to note that Burns and Stalker (1968) in their study of the management of innovations refer to mechanistic and organic management systems. Whilst they do not give any system absolute priority over the other, they contend that a mechanistic system is more suitable for a stable situation, where all activity is governed by clearly defined rules and instructions with contingency plans laid down by superiors. The authors contend that in unstable situations and in settings where a precise splitting of problems into clear specialist functions is not possible, an organic management system is more appropriate. In such a system the head of the organisation is not necessarily the leader and the processes of giving and receiving of orders give way to a system of consultation and free exchange of information. An organic system loses its bureaucratic character. Health care cannot be regarded as stable activity, as the care of each patient brings with it its own individuality. It seems, therefore, that, an organic system is

needed but the mechanistic system is not ready to give way. As far as the team in general practice is concerned, the district nurse has a dual hierarchical responsibility. She is responsible to the general practitioner for the nursing part of the medical prescription, Mauksch's curing part; she is responsible to her superior in the nursing hierarchy for the nursing aspects of care. Moreover, even the general practitioner, in his relationship to the hospital consultant, still has somewhat of a subordinate position. He refers patients for consultation and advice in the awareness that he will conform to the cure regime determined by the consultant; similarly, the district nurse, certainly before reorganisation of the health service, was considered to be in a less prestigious position than her hospital colleague, the ward sister. At the same time, all doctors considered as a group would consider themselves superior to all nurses as a group and each group is held together by its own professional code of practice, by mechanical solidarity. Durkheim's explanation that organic solidarity cannot come into its own until mechanical solidarity recedes seems entirely plausible.

Like all social theorists, Durkheim had his critics and his theory of division of labour did not remain unassailed. Durkheim diagnosed three symptoms where division of labour can be seen 'to deviate from its normal course'; presented by Lukes (1973)[117], they are: anomie, inequality and inadequate organisation. The concept of anomie was explained in terms of absence of 'a body of rules'. Durkheim's theory was intended to relate to society at large and Lukes's critique as well as Friedmann's criticism (Friedmann 1955)[118] quoted by Lukes are based on Durkheim's claim for division of labour in society and not on the investigator's use of Durkheim's theory for the specific setting of teamwork in domiciliary health care. For that setting, his symptoms seem to have been supported by research

findings. Gilmore et al (1974)[119.] and Hunt (1975)[93.] clearly identified the absence of rules and explicit leadership as crucial issues in unsuccessful teamwork. Durkheim's second symptom, inequality. emerged readily from the empirical data in the investigator's and other studies. Doctors and nurses were expected to work together for the benefit of patients and society by dividing labour. However, whereas the doctor retained his autonomy, the nurses ' work as alluded to above, was either determined by their medical partners or by the nursing hierarchy. The third symptom, namely inadequate organisation, linked as also identified by Durkheim, with confusion over roles, was also a major research finding, fully discussed in Chapter 12. The argument by Durkheim's critics that he did not suggest remedies, though true, seems an unfair attack on a correct diagnosis. The major criticism, namely that Durkheim considered his three symptoms as abnormal, as deviating from the natural course, is upheld by the research findings. Deviation was certainly found more often than not.

c. The district nurses' work pattern

The research programme produced findings which suggest that the work pattern of district nurses is determined by a variety of factors, not merely by the needs of patients. The peaks and troughs in district nursing activity shown in Chapter 11 cannot be attributed to comparable peaks and troughs in patients' need for nursing care. The fluctuations showed themselves over the periods in each day and also over the days of the week. (Figures [18] and [17]). The data demonstrate that a large proportion of district nurses in the national study were married (Table [42]) and many had children under 15 years of age (Table [43]). The nurses indicated in the interview that domestic convenience had featured prominently in their decision to work outside hospital in a system which offered flexibility in

working hours. It is reasonable to assume that the district nurses' home commitments and, possibly also a desire to work normal socially acceptable hours, have played a part in creating the work pattern but further research is needed to support the assumption.

Other factors which emerged as determinants of district nurses' work were current policies which could either encourage or restrict specific activities, organisational patterns, such as attachment to general medical practice, availability of enrolled nurses or nursing auxiliaries for purposes of delegation, quite apart from the social characteristics of the patient population, the patients' family structure, housing and others. It seems reasonable to assume that the educational background and professional preparation of the nurses might also be an important factor in the work they undertake but this aspect awaits further research. Recent research being carried out by Reedy et al (1978/79)[120.] shows the availability of treatment rooms, the types of basic training institution of the nurses and the type of the training, to be significant factors in the nurses' work patterns.

The above factors as determinants of care can be explained by common sense and experience. One of the findings, which only became apparent through the detailed analyses of the data referred to in Annex 4 deserves mention in the context of recourse to theory for explanatory purposes. The data suggested that there is a relationship between the nurses' own values and the work they do or omit to do. In those aspects of their work, where the nurses had considerable autonomy, such as the frequency of visits to patients who were not seriously ill and did not require urgent or medically prescribed care, the nurses' work preferences were found to be reflected. For example, nurses who had indicated that giving a patient a bath had their lowest preference, gave few, if any, baths during the week

of the survey. (Annex 4). It must be stressed that, although the data revealed a relationship between preference and activity, this was not necessarily a causal relationship. Thus, the fact that nurses who enjoyed giving patients a bath least of all activities, gave few such baths may, but need not, be due to deliberate avoidance of non-valued work. It may also indicate that activities rarely undertaken have less chance of becoming popular. A simple explanation of nurses avoiding non urgent work could also be that they spent their available time on work considered urgent. One would be tempted to dismiss the matter on the basis of this latter explanation were it not for the finding that nurses who did not express the same low preference for the bath, recorded more baths in the survey week. It would be possible, though unreasonable, to interpret this finding by suggesting that some patients received a bath without needing it; as can be seen from Figure 7 , only a negligible proportion of nurses included the bath within their first three preferences. The more likely explanation, which has implications for the standard of district nursing care is that some work may be avoided because it is not particularly liked, even if it might be helpful to some patients.

Whilst such an explanation can only be speculative, it is strengthened by recent research into the long term care given by district nurses to patients suffering from stroke. This study (Kratz 1978[68].) was undertaken by an experienced district nurse/researcher using participant observation. She observed that the care of patients who were seriously ill was seen by the district nurse as 'valued care' and had a focus, whereas the care of patients who were seen to be 'getting better' was not valued and had no focus. Kratz developed a 'continuum of care model'[121], with focused, valued care at one end of the continuum and diffuse non-valued care at the other. The type of patients whom most district nurses in the

investigator's national study 'Use or Abuse?' did not seem to enjoy caring for, were the 'mobile' patients, almost by definition, not seriously ill. Similarly, the type of care least preferred was the bath, a procedure usually performed for long term patients who may be frail or handicapped, but not seriously ill. In this respect, the findings seem to support the theory propounded by Kratz.[68]

As stated above, Kratz used observation of care as a basis for her theory. She, therefore, did not see patients who were receiving no care by district nurses. It may be that her 'continuum of care' model, with focused care at the positive end and diffuse care at the negative end, could be extended to 'non-care' at the latter end, leaving diffuse care as a mid-point.

The investigator did not set out to test Kratz's theory of long term care. In fact, the theory was not published until six years after completion of the research programme and after all the analyses had been undertaken. Kratz's theory is offered as having explanatory potential for the findings im the national study; it seems to 'fit', 'work' and it is intelligible to the people involved in district nursing. It, therefore, meets the criteria specified by Glaser and Strauss.[73] The application of Kratz's theory to a wider setting than that of patients suffering from stroke may help to strengthen it.

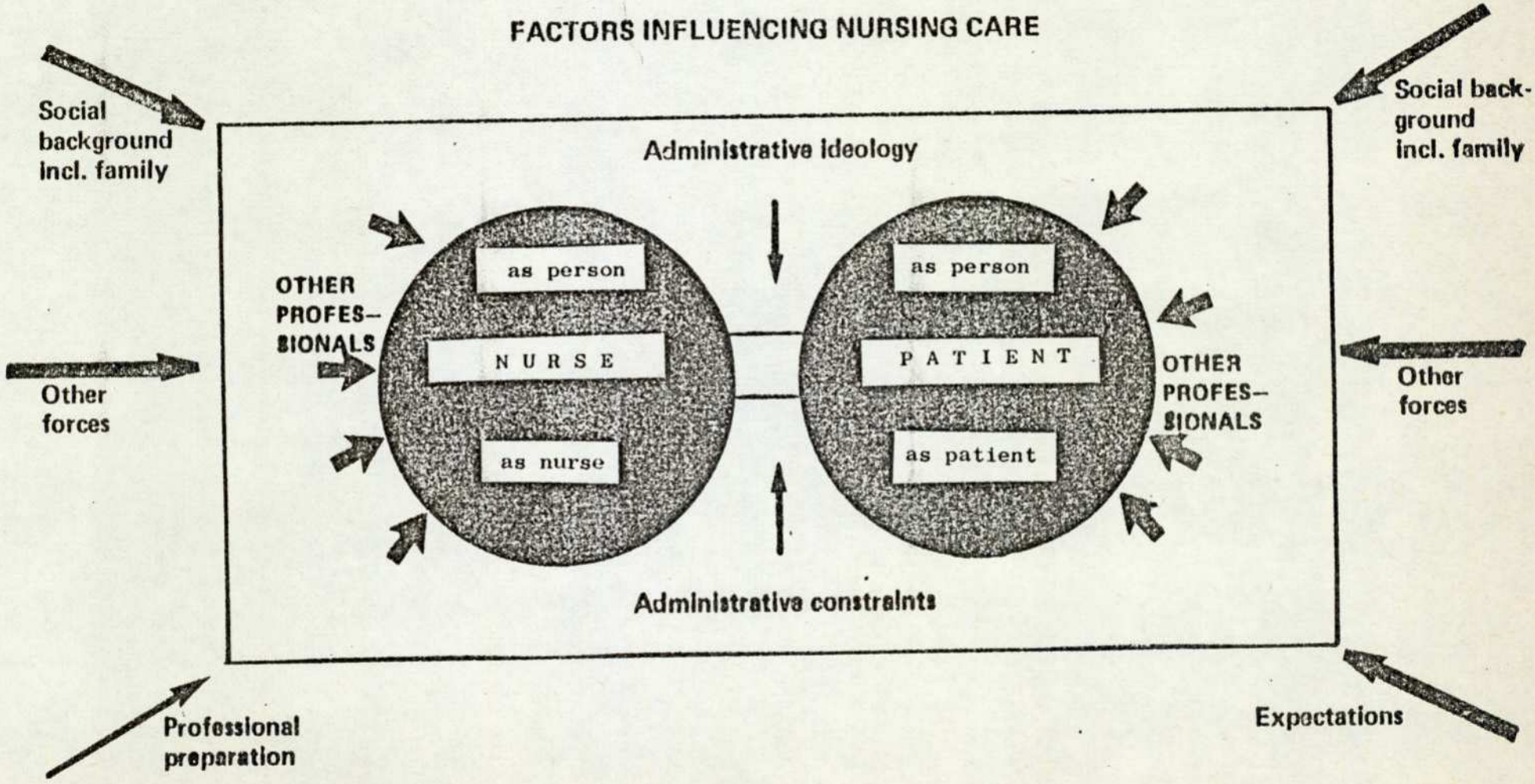
Figure 23 illustrates a conceptualisation of district nursing as it emerged from the research programme. Some of the relationships were supported by data, others are merely speculative. There is need to test all the relationships in greater detail. Some research into the origin of nurses' values and their effect on patient care would seem indicated. However, this 'coming together' of nursing and other social theory with empirical findings independently obtained, must go some way toward building up the body of knowledge

FIGURE 23

CONCEPTUAL MODEL

OF

FACTORS INFLUENCING NURSING CARE



necessary for the professional practice of nursing.

The complexity of the relationships would require the application of an enormous variety of social theories. Thus, theories relating to social structure, the family, professional and sick roles, institutions, social values, social class, theories of organisations, theories of learning and communication, psychological theories of various aspects of human behaviour and others, would all be relevant to a study of district nursing. Theories have different levels of generality with correspondingly different levels of applicability to specific situations. The greater the generality of a theory the less likely is its explanatory potential in a specific and specialised area. It is submitted that nursing in its complexity and district nursing as a superimposed specialty do not lend themselves to the development of a theory of nursing. It would have to be too general to be of practical use. What seems important and possibly more promising is a cohesive research programme which is planned in the awareness that district nursing represents a synthesis between individuals, their work, their education, their values and their relationships. The benefits of such an approach, represented by the investigator's long term programme are drawn together in the concluding section of the thesis.

CHAPTER 14.

REVIEW OF THE LITERATURE.

The paucity of research in district nursing when the investigator's programme was initiated is the reason for ending the thesis with a review of the literature rather than having used it as a starting point. In this chapter, the development of a sizeable body of literature in a relatively short period of time is traced. The review is arranged in two parts. The first and main part deals with the sparse literature which was available when the research programme was in its early planning stages and with the new literature which was published as the programme progressed. Some of the publications during this period were taken into consideration in the planning of the individual studies. Conversely, it can be seen from the literature, that the individually published studies by the investigator were used by other research workers and frequently cited as reference material. There was, obviously, a cross-fertilisation of ideas as evidenced in an impressive proliferation of research; the pervading problems in the primary care sector, which characterised the period under discussion, acted as triggers.

The literature in this first part of the review is presented in approximately chronological order, so that the parallels between it and the investigator's research programme can be pointed out. It covers the period up to 1971, when the last study 'Use or abuse?' was ready for printing.

The second part of the literature review relates to the district nursing service during the period 1972 to 1978. It is included to show how research in district nursing continued to develop. It is less detailed than the first part and has its focus on that literature which is seen to be particularly relevant to the issues raised in the thesis.

Part I.

At the time of the initiation of the research programme, in 1964, three studies relating to the district nursing service were available, of which two had been partially or wholly initiated by the Queen's Institute. The first of these, published in 1952,[8.] was concerned with the care of cancer patients in their own homes and was undertaken in collaboration with the Marie Curie Memorial Foundation, another voluntary organisation. Information was collected from practising district nurses about any patients with cancer nursed at home. The report is based on the analysis of 7050 questionnaires. The objective of that investigation was to identify unmet needs of cancer patients which the Marie Curie Memorial Foundation might be able to meet. As far as the study's relevance to the investigator's research programme is concerned, it indicated that the Queen's Institute of District Nursing was aware of the need to obtain facts as an aid to policy formulation. At that time, the Institute was the national body, voluntary in nature, which provided for the training of district nurses and was also largely responsible for the placement of qualified district nurses. Its national influence and strength might have accounted for the high response rate (93%) which was achieved. The study also demonstrated, however, that district nurses were capable of responding to such a national enquiry and that they had the necessary knowledge about social and physical needs of their patients to provide useful information. As the Queen's Institute, some years later, became the base for the extended research programme and the studies within the programme needed the cooperation of practising district nurses, this very early study augured well.

The second study, initiated by the Queen's Institute, was published in 1965.[6.] (Chapter 1). It consisted of a detailed investigation

into the methods of sterilisation of equipment used by district nurses. Like the studies in the research programme it was generated by an urgent need for practical, applied factual data and its method was correspondingly practical and applied. The theoretical basis was the knowledge on the prevention of infection through safe methods of sterilisation of equipment used.

As research officer for the Queen's Institute at that time, the author of this thesis had a major responsibility for the study and it influenced, in no small way, the beginning of the research programme. If district nurses behaved so differently in the way they coped with their work, it seemed pertinent to find out what sort of people they were, how they had been educated and prepared for their professional work and what kinds of problems they encountered in it.

The only other study, traced at that time, which focused particularly on district nurses was 'Home nursing activities' (Brewin 1963)[9]. It was a study undertaken in a large county and showed, among other aspects of district nurses' work, that they spent no more than 58.6% of their time on nursing activities. This finding contributed to the decision to undertake a detailed breakdown of the nurses' time as a central part of the first study in the research programme, 'Feeling the pulse'[1].

A paper by Swift and McDougall (1964)[122.] and a government report published in 1963[123.] highlighted the need for better communication between doctors and nurses and for a greater awareness among both groups of their respective contributions to the domiciliary care of patients.

Discussing the relative merits of health visitors and district nurses, Silver (1963)[124.] considered that patients would accept advice more readily from a person identifiable as a nurse, a view endorsed in a study undertaken by the Wessex Region, entitled 'What do they

really want?'[29]. A year later, Anderson (1965)[125.] suggested that family doctors need more help in their surgery and also with the care of patients in their own homes.

All the above studies and reports were borne in mind when the design for the first study in the research programme, 'Feeling the pulse', was finalised. It became clear that the information necessary for an understanding of the district nursing service, even at the most simple level, would have to be obtained from a wide variety of sources, an important one being the general practitioner.

By 1965 the first study was, of course, well under way. Work undertaken by others around the same time continued to re-enforce the need for this type of global research in the district nursing service. Fry, a general practitioner reputed to be a pioneer in initiating team work, published two relevant papers in that year. The first, 'Operations research in family clinical practice'[126.] predicted that the future of general practice would lie in the development of team work and in the second study 'The evolution of a health team'[127.] he and his colleagues presented the development of such a team, although in this case it focused more particularly on the association of a health visitor with the medical practice.

Anderson and Warren, in 1966[128.] demonstrated that the general practitioners lacked information on the full range of statutory and voluntary services provided by the local authority. They set out to discover what information was circulated to general practitioners, to establish the sources of information and to assess its effectiveness. The second study in the investigator's programme developed this line of approach by including a section which investigated the collaboration between the district nursing service and other statutory and voluntary agencies.

In 1966, the first study by the investigator was published [1] and

so was the study by Carstairs[11], relating to the district nursing service in Scotland. Although the two studies had been planned and undertaken entirely separately, there were remarkable similarities in design and in the findings. In Carstairs's study, nurses in eleven local authority areas in Scotland were asked to keep comprehensive records of all their work for a two week period. The records included information about the patients and a diary showing how the nurse spent her time. In addition, the nurses were interviewed. The investigator's study 'Feeling the pulse' included diaries as well as interviews with district nurses, but the nurses did not record quite such detailed information about their patients. Instead, as shown in chapters 4 and 5, it concerned itself with the relationships between district nurses and other workers, especially the general practitioners. In Carstairs's study, the district nurses spent just over half their working time on home visits to patients. Carstairs used the 'International Classification of Diseases' for the categorisation of the patients, a method considered, but decided against, in the national study 'Use or abuse', reported in chapters 8 to 12. Carstairs's study was by far the most detailed survey of the district nursing service around that time and provided a great deal of useful information relating to method as well as findings.

A multidisciplinary conference was held in that year and the proceedings were published in 1967, as 'The team'[129]. The publication of the two studies of district nursing, referred to above, was partially rsponsible for the initiation of the conference and the investigator was a member of its planning committee. The relevant point, as far as this literature review is concerned, is the content of the conference report which included the main issues raised in discussion. The theme which recurred throughout the conference was the need for the different professional groups to work together, but the increasing difficulty in communication which is fundamental to such collaboration was voiced

by many participants.

Although the focus of the report was the domiciliary team it stressed the need for rational use of the hospital and other services and the need for better education and information systems. The report was given a measure of authority through its introduction, written by The Right Honorable Kenneth Robinson, then Minister of Health. At the time of the conference, the planning for the second study in the research programme 'Care in the balance' [2] was well in hand and the proceedings of the conference provided valuable pointers.

Other research which contributed to the investigator's thinking in preparation for the second study were two early projects, both undertaken by World Health Organisation Fellows. Madsen (1965) [130.] reported on the discharge arrangements for fifty patients in one hospital. It was a small but thorough study, in that it included not only the actual arrangements made by the hospital for the discharge of patients, but also the patients' views of these arrangements before leaving the hospital and also after returning home. Although there seemed to be little direct communication between hospital nursing and district nursing staff, most arrangements being made by the 'almoner' (current term for the medical social worker at the time of the study), most patients seemed satisfied at the time of discharge. On interview in their own home after discharge, twenty of the fifty patients had experienced some difficulty.

Classen (1966) [131.] observed methods of referral of discharged patients to the community services and demonstrated substantial areas of discontinuity of care. Priest (1962) [132.] and Backett (1966) [133.] had shown that for 64% and 74% of patients respectively, the result of first attendances at the out-patient department was re-attendance. Moreover, 11% of Priest's sample of patients were still attending the out-patient

department after one year. Although the above studies influenced the design of the investigator's work, for example in causing her to examine in detail the referral patterns of re-attending out-patients, the major impetus for the study 'Care in the balance'[2.] was provided by her own research findings in 'Feeling the pulse'[1.], which related to the lack of surgical care undertaken by district nurses.

From 1967 onwards, studies exploring various aspects of district nursing proliferated rapidly, as demonstrated in the chronological bibliography. Reedy in 'Trends in general practice' (1977)[134.] showed that research reports including nurses as a focus of attention almost trebled between 1967 and 1970 compared with the period before 1967. This trend is in line with the increase in the size of general medical practices and the attachment of nursing staff. Government statistics[135.] show an increase of practices with groups of three or more principals from one-fifth to one-third of all practices and practices with five or more principals are shown to have increased from three per cent to seven per cent of the total. The larger a group practice is, the more likely is it to have attached nursing staff. It is, undoubtedly, for this reason that most of the research from 1967 onwards concentrated on nurses in attachment schemes.

Hasler et al[136.] published a paper in 1968 describing the development of an organised nursing section within their group practice, including a programme of work for the treatment room nursing staff. The paper commences by quoting findings from 'Feeling the pulse'[1.], that:-

> 'district nurses frequently lacked full information about patients and had little contact with the general practitioners with whom they shared the care of their patients. Most doctors were ignorant about the district nursing service.....' (p.XI)

Thus, work undertaken by Hasler and his colleagues demonstrates their awareness of the investigator's first district nursing study and the

steps they took to overcome some of the weaknesses identified in it. Much later, but relevant to this point, Morris (1971)[137.] reported how she translated some findings of 'Feeling the pulse'[1.] into appropriate action.

In 1968, the study 'Care in the balance'[2] was published, as the second project in the research programme. Its focus was on the relationship between the district nursing and the hospital nursing services. In the same year, research undertaken by Forsyth and Logan (1968)[12.] drew public attention to the problems generated by overcrowded out-patient departments. News items in The Times of August 13[138.] and August 14,[139.] indicated public pressure to reduce waiting time in out-patient departments. It was at this time that the third study in the research programme, the quasi-experiment, was being planned. In its attempt to discover whether the district nursing service could help in reducing out-patient attendances, it could hardly have been more timely.

Other research which confirmed the decision to set up the quasi-experimental study demonstrated that patients' hospital stay could be substantially reduced if adequate domiciliary services were made available. Thus, Aldridge (1965)[140.] commenced an early discharge scheme in 1960 and followed his patients up for a three year period. He reported satisfactory progress of his patients, patient satisfaction and a substantial saving of national finance. Similarly satisfactory results were reported by Peatfield (1969)[141.]. Morris et al (1968)[142.] reported the results of a controlled experiment which demonstrated no adverse effects of an early discharge scheme. The results also showed no major increase in the GP work load, although the GP rather than the district nurses gave the necessary post-operative care, such as the removal of sutures.

An important experimental scheme was reported by Hutchinson and

Kane (1967)[143]. The authors, both nurses, described the organisation and effects of a 'Short Stay' or 'Five Day Ward' initiated in their busy general hospital. The scheme made it possible for the ward to be closed at the weekend, thereby making a helpful contribution to the alleviation of staffing problems. The scheme is referred to in chapter 6, as the patients discharged from the experimental ward were included in the sample studied. Also in 1967, the Scottish Home and Health Department issued Planning Note 6[144], on the organisation and design of out-patient departments. Weaknesses in the departments which had been surveyed were highlighted. Recommendations relating to patients, nurses and doctors were made and included efforts to reduce out-patient attendances as far as possible.

Two other publications, a year later, drew attention to weaknesses relating to some aspects of the hospital service which have relevance to district nursing. Brocklehurst and Shergold (1968)[145] followed up 200 geriatric patients over a two year period, interviewing half of them in depth. There was a re-admission rate of 26%, a high demand for social services and a large number of unmet needs. The authors suggest that the domiciliary nursing service might make a more effective contribution to the care of discharged geriatric patients. Hattersley (1968)[146], in a study of cooperation between the hospital and domiciliary services argues cogently for greater cooperation not only between members of the practice team, but also between all hospital and domiciliary services, medical and nursing. He attributes to the GP the role of coordinator of health services because 'it is he who knows the patients'. The author contends that the GP, in his task as coordinator should be aided by district nurses and health visitors.

A Working Group, set up by the Scottish Home and Health Department

reported in 1968[147] on the field of work and organisation of the local authority home nursing service. The Working Group consisted of representatives of the Scottish Branches of the British Medical Association, the Society of Medical Officers of Health and the Queen's Institute of District Nursing, thereby reflecting bodies with authority and responsibility for the formulation of policy. The Group's starting point in dealing with their remit was the study by Carstairs[11], mentioned above. The Group's report includes suggestions on the future objectives of the district nursing service, its future functions, future personnel requirements and organisation, as well as staff development. There are several parallels between the Working Group's recommendations and the research programme discussed in this thesis. Thus, the Working Group commented on the need to relieve pressure on the hospital services, to extend the district nursing service in every possible way by, for example, providing a 24 hour service, to employ more enrolled nurses with district nurse training and to attempt a more rational deployment of staff by the inclusion of nursing auxiliaries in the domiciliary team. All those points were covered by the investigator's research programme, either directly or indirectly. The quasi-experimental study, described in chapter 7, was in its early stages of development when the Working Group's report was published.

Relevant to the developments within general medical practice which demonstrated that larger practices could benefit from the help of a nurse in the practice and the simultaneous attempt by local health authorities to deploy their nursing staff rationally, was the publication of 'The Practice nurse' by the Royal College of General Practitioners.[148] It is the report of an experiment in which four medical practices participated by employing a nurse themselves, monitoring her work and its effect on the practice. The practices were of different sizes from

single-handed to a group practice of five partners. All of them had been able to engage a nurse who was not employed at the time and were, therefore, not competing with the local health authorities for the same manpower resources. The report cited the work of Pinsent (1950)[149], thereby revealing that the employment of nurses by general practitioners had been a long standing arrangement and had demonstrated a nurse's contribution to general medical practice.

After 1966, when the Government began to reimburse general practitioners a substantial proportion of expenses incurred in the employment of 'ancillary staff' , such employment increased rapidly. It has relevance to the investigator's research programme in that the likelihood of such a trend was pin-pointed in 'Feeling the pulse'[150]. furthermore, the employment of nurses by the general practitioners contributed to some of the conflicts and dilemmas discussed in chapter 12.

A study on nursing attachments to general medical practice was published in 1969[25]. It was important for two reasons; first, it suggested an operational definition of attachment and liaison schemes which, probably because the report was published by the Department of Health and Social Security, tended to be used by researchers afterwards; second, it was a national study, covering England and Wales through a random sample of local health authorities.

McGregor, in the same year, reported on a complete unification scheme[151]. It was undertaken in one local health authority as a means of expediting attachment. The innovation lay in the creation of three teams within the district nursing service, whose members covered all duties for eachother within the team. In this way, though not formally attached to the medical practices, the nurses worked more closely with the general practitioners. McGregor identified a problem

which has caused concern ever since attachment began, namely that of transport and travelling time when patients may be widely scattered rather than concentrated within a defined and compact geographical area. The point of travelling time was taken cognisance of in the design of 'Use or abuse?' in which detailed data on the duration of all activities including travelling, were obtained. McGregor raised the question of freedom in the patient's choice of his GP, which he considers to be the main factor militating against a circumscribed practice area. The distance between a patient's home and his GP's surgery could be a significant variable in the use of hospital services and warrants further research.

The need to obtain systematic information about the work of district nurses had obviously been recognised by some nursing administrators. Riddell (1968)[152.] reported the results of comparisons between patients treated by district nurses in two local authority areas in Scotland and between two three-year periods, the first 1958 to 1961 and the other 1962 to 1965. Many detailed data were recorded about the patients' age, sex, conditions treated and duration of district nursing care; no conclusions were drawn and further research was suggested. The publication of the study, in 1968, coincided with the publication of the investigator's second study,'Care in the balance'[2] and supported many of its findings. It strengthened the investigator's resolution to aim at a study which would link data relating to nurses with data relating to patients, which was achieved, at least in part, in 'Use or abuse?'[4].

It was understandable that, during the period of rapidly increasing schemes of nurses being attached to general practice, attempts at comparing the work of attached nurses with geographically based nurses should be undertaken. Pinsent, the general practitioner mentioned above

as a very early employer of a practice nurse,[149] published in 1968 the results of a carefully planned study designed to demonstrate the effect of attachment on a district nurse's work[153]. He showed no significant change in the attached nurse's work except that she spent more time on 'assessment of social needs and provision of services'. Relevant to the investigator's research programme was the conclusion by Pinsent that better cooperation between doctor and nurse resulted in better patient care, although this did not seem to be measured in any way. A similar statement had been made by Abel[25], who had attempted to assess the views of local authority staff on attachment schemes. Almost intuitively, staff felt that a closer working relationship between members of the health care team was bound to improve the care of patients. The difficulty of evaluating any aspect of the health service and particularly the contribution of the health team in the community was stressed by Anderson, reporting in the Lancet[154]. In fact, the investigator has been able to trace one study only, undertaken before 1970, which included the opinions of patients in an effort to evaluate innovations in general medical practice. This study, by Smith and Mottram (1967)[155], was concerned with the privately employed practice nurse rather than the local health authority employed district nurse. The researchers reported an experiment of nine months duration, during which period a registered nurse was employed, part time, to assess the urgency of requests for home visits. Postal questionnaires to households were used to elicit consumer opinion, achieving a 94% response rate. The results were sufficiently favourable to introduce the service on a full time basis.

The report of a Joint Working Party on group attachment (1970)[156], in its summary, states that attachment is a means of enhancing the quality of patient care and of making more effective use of medical

and nursing skills. It also stresses the importance of enthusiasm of all concerned, of adequate preparation for team work and of good communications.

Two consecutive issues of the British Medical Journal in 1969 dealt with the professionals' views on attachment. The first of these papers by Boddy (1969)[157], reported the 'attitudes' of a random sample of general practitioners in Scotland. His sample consisted of 500 doctors and he achieved a response rate of 89%, reflecting the interest of GPs in attachment. Only 13% of the respondents had an attached district nurse and 70% of the remainder wanted an attachment in the expectation of benefit in being able to delegate some work. Anticipated benefits of an attached nurse by doctors who had none, were compared with advantages thought important by those doctors who already had a nurse attached. It is worthy of note that, whereas the most frequently mentioned anticipated benefits were 'some supervision and/or follow-up currently done by the doctor' and 'technical procedures in the surgery currently undertaken by the doctor', the most frequently mentioned benefits based on experience of a nurse were 'better information about the progress of patients' and 'the nurse's better understanding of the needs of her patients'. Thus, attachment suggested that it might enable the nurse to function more effectively in a professional nursing role rather than relieve the doctor of tasks conventionally undertaken by him. Half the doctors thought that the district nurse did not use her professional training and skills fully, referring particularly to the registered nurse with district nurse training. This finding was further explored by the investigator in 'Use or abuse?'[4].

The other paper, by Walker and McClure (1968)[158] reported a study of the community nurses' views on attachment to general practice. Interviews with 98 community nurses, attached and unattached health

visitors and district nurses, were conducted and comparisons made. The respondents were asked to list advantages and disadvantages of attachment. The most frequently stated advantage was 'access to the family history', which is in line with the advantages mentioned by the GPs in Boddy's study referred to above. The most frequently mentioned disadvantages, all three having an equal number of mentions, were 'personality difficulties, mileage increase and work load increase'.

Also in 1969, Dixon and Trounson[159], published the results of an experimental attachment of a community nursing team to a new health centre for a six months' period. The innovation in this experiment lay in 'community nurses' undertaking health visiting and some nursing duties. Most of the 'bedside nursing in the home' was done by the enrolled nurses. The authors claim that the experimental work pattern held advantages for patients, doctors and nurses. They consider that it is potentially capable of providing a satisfying and economic division of responsibilities, with different tasks being carried out by the individual 'most appropriately qualified'. Such a scheme appears, on the face of it, to support the need for the kind of 'organic solidarity' referred to in chapter 13. Unfortunately, the experiment was limited to the division of labour within the nursing component of the team only; it did not include the GP or any other allied professionals. The study contributed to the investigator's decision to ascertain whether there was agreement between professionals on the 'appropriate' qualification for certain tasks. It became part of 'Use or abuse?'[4.] and the findings are reported in chapter 12, which deals with dilemmas and conflicts, indicating that there was no clear agreement.

The literature over the two year period 1967 to 1969 reveals a consistent pattern of difficulties relating to collaboration within

the newly created practice teams. An idea, which seemed eminently sensible in theory was, clearly, more difficult to put into practice than had been expected. Research, aimed at discovering how teams worked or what factors hindered team work, had been initiated by the Council for the Education and Training of Health visitors; the results of the pilot study were reported in 1970.[160] The pilot study suggested that some preparation for team work seemed to be necessary, a finding which was certainly supported by the results of the main study, published by Gilmore et al. in 1974.[119] Anderson et al.(1970)[161], showed a marked increase in attachment schemes but also the reasons why 23 such schemes had been discontinued. Administrative and personality problems were seen to be the main factors and this supports the investigator's suggestion for research which would explore the relationships in her conceptual model (chapter 13). Further support comes from Crombie (1970)who, in his Gale Memorial Lecture, entitled 'Group dynamics and the domiciliary team'[162], stressed the importance of inter-personal relationships for successful team work.

The literature of 1970 and 1971 continued to pursue three main themes; these were first, descriptions of the work of nurses in attachment schemes and in other settings and roles; second, administrative and organisational issues related to team work and third, the relationship between the hospital and community services. There were easily identifiable parallels between the chronological sequence of the literature and the investigator's research programme.

Buttimore (1970)[163], undertook a study of seven attachment schemes which were geographically scattered throughout the country. The objectives of the study were to examine more closely similarities and differences in the working arrangements of nurses in general practice attachment schemes and also to explore difficulties as well as possibilities for expansion. The study was initiated to provide

factual information for one local authority with plans for attaching a comprehensive team, including auxiliary workers and home helps, to a general medical practice. It was an attempt to link research directly with policy. This study, by Buttimore, and the investigator's third project, 'Cooperation in patient care, Part I'[3], were undertaken simultaneously from the same research base. It was, therefore, possible to collaborate in the choice of categories and activities of patients and also in the use of some identical questions, thereby facilitating some comparisons of findings. Buttimore's results were consistent with those obtained from most other studies of attachment schemes; like so many others, she stressed the need for adequate preparation. The attached nurses expressed greater job satisfaction mainly because they had more information about their patients. It was yet another study in which all professionals claimed that better patient care resulted from the attachment although no patients were included in the study.

Two major publications relating to the attachment of nursing staff became available in 1970. The first of these, was the report of a Joint Working Party[156] alluded to earlier. The Working Party had been set up jointly by seven organisations representing interested parties in group attachment. Its terms of reference were:-

1. to review the existing literature on attachment schemes with particular reference to the difficulties encountered.

2. to consider the type of community health team likely to be required for the future and the appropriate training for members of this team.

One of the Working Party's main suggestions was that enrolled nurses, nursing auxiliaries and other ancillary staff will be necessary to deal effectively with practice needs. The investigator's national study, with its emphasis on the enrolled nurse, was in line with this

suggestion.

The other major publication was Report XIII by the Royal College of General Practitioners[164]. The report stressed the importance of close collaboration with nursing staff if general practice is to meet the increasing needs of the community.

A study of the domiciliary nursing services in Hertfordshire by Allen et al. (1970)[165] followed fairly closely the method used in 'Feeling the pulse'. Most of the findings were also reproduced and, although published four years later, similar communication problems between district nursing staff, general practitioners and the hospital nursing services were identified. Almost identical with the findings of 'Feeling the pulse' was the apparent under-utilisation of nursing skills. A new function for a district nursing sister in a group practice was described by McNabola, also in 1970[166]. It consisted of a systematic assessment of the elderly patients on the list of the practice, a function more readily associated with a health visitor, as the objective was seen to be mainly preventive. The author shows clearly the interchangeability between district nurse and health visitor for this function although there was no attempt at comparing the effectiveness of the two types of workers. The transfer of work from one type of worker to another has, of course, important administrative implications for the 'appropriate' staffing of the service. Written from an administrative perspective was a paper by Buckoke and Irvine (1971)[167], who consider that a substantial amount of work currently undertaken by registered nurses could be undertaken by enrolled nurses, giving the registered nurse more time and more freedom to work more closely with the doctor in an innovative and leadership role.

The blurring of functions and roles between professionals was

not confined to different members of the nursing team in general practice, in fact not even to the community nursing services. There was general concern in the nursing profession about boundaries of professional responsibility between nurses and members of other professions. The Royal College of Nursing of the United Kingdom responded to the concern by the publication in 1970 of the document 'The duties and position of the nurse'[55]. It suggests that questions relating to the respective frontiers of professional responsibility could be effectively handled at local level through special machinery. Relevant to the continued confusion and conflict about professional role boundaries, discussed in chapter 12, was the publication in 1971 of a report by a sub-committee of the Standing Medical Advisory Committee, entitled 'The organisation of group practice'[168]. The report makes a plea for experimentation especially in relation to role blurring. However, as demonstrated by Jupp in the same year [7], district nurse 'do not (even) participate in a division of labour in relation to each other'. If, as stated by Jupp, their tasks are initiated at the front line and are largely unpredictable, an official machinery, as suggested by the Royal College of Nursing, would not readily solve any local problems.

The third theme in the literature, as identified above, was the relationship between the hospital and community services. Skeet [13] (1970) undertook a major study of the home care needs of discharged patients. She sought answers to the following three questions:-

1. What do discharged patients themselves see as their home care needs?
2. How are these needs met?
3. What are the present hospital arrangements and existing community services for discharged hospital patients?

Skeet's study was not confined to nursing needs but she found contact

between the hospital and community nursing services to be sparse and suggested that some of the patients' needs might be met by more effective continuity of nursing care.

Lockwood and McCallum (1970)[169], explored the communication patterns between the hospital and community services with specific reference to the information available to the GP about discharged patients on his list. Data relating to 132 discharged patients demonstrated a serious lack of information being transmitted. If the GP does not have the necessary information the district nurse is not likely to have it, although it was found in 'Feeling the pulse' that some patients had been referred to the district nurse before the medical communication had been established.

Ruckley et al.(1971)[170] reported on a special scheme to reduce waiting lists and to make more effective use of hospital beds. Quoting the investigator's quasi-experiment, which had been published the year before, the authors emphasize the advantage in their two schemes, one of early discharge of patients and the other of day surgery for selected procedures, in that no additional staff had to be appointed. The domiciliary nursing service was able to absorb the additional work and enjoyed the new dimension to it. It is another example of a change in the nurse's work through administrative policy changes, discussed in chapter 13. The theme of continuity of care between the hospital and community services in the nursing field was not pursued again until Roberts embarked on her study which was published in 1975[14].

It is submitted that there is value in reviewing the literature chronologically in a subject area which is relatively new and which speedily generates interest and concern. The contribution to health care of community nursing in general and district nursing in particular

represented such a subject. By surveying the literature horizontally on a wide basis rather than pursuing a narrow theme vertically, the more common approach in an academic literature review, matters of general interest and concern could be identified.

Part II.

This part of the review of the literature relating to the period 1972 to 1978, that is since the publication of the national study 'Use or abuse?'[4.] in 1972, is less detailed than Part I. The main themes of the studies which formed the research programme are reflected in the literature of this period. Though inter-related, certain topics can be identified as follows:-

1. Studies of the work of district nurses, including manpower studies and local descriptions of the district nursing service
2. Studies describing the work of district nurses in special schemes and in new roles
3. Studies focusing on communication between professionals, especially between the hospital and community nursing services
4. Studies of specific groups of patients or clients to whose care the district nursing service might make a different or greater contribution.

Most studies were undertaken with the expressed objective of identifying staffing needs in relation to current and predicted needs for care and to ideas of deploying staff in new and extended roles.

Linday (1972)[171] reported the results of an innovative approach to the deployment of enrolled nurses. Each enrolled nurse was paired with a registered nurse, each pair being responsible for the community needs of four GPs' patients and two or more pairs working as a group to provide relief cover for each other. The investigator suggested in 'Use or abuse?'[4.] experimentation along these lines not knowing of the

work pattern described by Linday.

Donaldson (1974)[172], in a survey undertaken in Teeside, identified relationships between a variety of organisational factors, nurses' personal attributes and the work undertaken by them. Richardson, in the same year, published a study of referral patterns among general practitioners in Aberdeen to the district nursing service.[173] He identified substantial variations, some of which were related to the size of the practice, to the practice population, to the doctor's experience and to the attachment of nurses. There was, however, a 'large unexplained variation which reflects, it is suggested, different general practitioner perception of nursing need and nursing skill... '. Thus, the investigator's ideas expressed in chapter 13, relating to the variety of factors which may determine the work of district nurses, are supported by Donaldson and by Richardson.

McIntosh and Richardson (1976)[174], in a work study of district nursing staff in Aberdeen, used the investigator's four studies as background references. The authors conclude that the work of district nurses cannot easily be measured because of its complexity and they suggest that better use could be made of the service if general practitioners were more knowledgeable about the work of nurses, an assumption which had been held by the investigator in the design of 'Feeling the pulse'.[4] Wilkes and Nimmo (1976)[175] analysed the work pattern of district nurses for the purpose of establishing work loads and staffing needs. A great deal of detailed information on the duration and frequency of all activities was produced. The researchers demonstrated that the duration of visits was largely controlled by the nurse herself; on days with a larger work load the visits were shorter. This finding supports yet again that factors besides the needs of patients are important determinants in the work of district nurses.

The work of Kratz (1978)[68], referred to in chapter 13 and also at the end of this chapter, provides further evidence.

A new way of measuring district nurses' work loads was used in a work study by Whitaker (1977)[176]. The method of measurement consisted of using 'forecast hours' against 'actual hours', the rationale being that staffing should be based on what should be done rather than on what is being done. The implicit assumption in advancing this new method is the awareness that what district nurses do is not necessarily what they themselves feel they ought to do. The author of this study concludes yet again that effective time studying of the district nursing service is not possible because of the unpredictability of the situation. In another analysis of district nurses' work in Birmingham (Watts 1976)[177], a self-recording instrument, adapted from that designed by the investigator (chapter 9) was used. The emerging picture of the Birmingham district nursing service demonstrated very similar peaks and troughs in district nursing activity as those described in chapter 11. On the basis that patients' needs do not manifest themselves in such marked fluctuations, one must assume that factors other than the needs of patients dictate the work pattern. The investigator's recording instrument was also used by the Suffolk Health Authority in a work study published in 1977[178]. Eccles (1977)[179] refined the method of collecting district nursing data by using a sophisticated computer system, which has the advantage of providing on-going information, thereby affording the opportunity of observing trends. Its disadvantage lies in the resources necessary to set the system up in the first instance and to process the data as they are generated.

Although, as alluded to above, most of the studies mentioned so far, were said to have their purpose in identifying staffing

requirements to meet patient need, none of them attempted to demonstrate or measure such need. A valuable contribution in that respect was made by Shaw and Opit (1976)[180]. They reported on a survey undertaken by a group practice team which included four district nurses and was designed to assess whether the elderly patients in the practice were having adequate supervision in the self-administration of their prescribed medication and also whether they were having adequate general surveillance. The results of the survey suggest that 'reliance on self-referral by elderly infirm patients, whether on long term treatment or not, will not guarantee adequate supervision of their medical needs', Hoadley (1976)[181] reported on a survey of persons of 65 years of age and over. The purpose was to assess potential medical and social needs and resources to meet new levels of need. Again it was demonstrated that the needs of the elderly are not always known to the domiciliary team. It was for this reason that a regular assessment of the elderly has been pioneered by some practices, district nurses being involved in such new roles. Wallace (1973)[182] reported an assessment of the practice population of 75 years and over, demonstrating how a district nurse might cope with this responsibility, providing she has access to an age/sex register. This type of function had, in fact, been reported by McNabola (1970)[166], who had been working in the same practice.

The likelihood of hidden needs in the community, apart from those of the elderly, some of which might be met by the district nursing service was demonstrated by the findings of Cartwright et al.(1973)[183]. Their study attempted to identify the needs of people in the last year of life, through interviews with bereaved relatives, friends and other carers. The findings showed that only a small proportion of deceased whose death had been preceded by an illness had been receiving help

from the district nursing service.

It is not easy to separate studies investigating the needs of specific patient groups from those which describe new functions and roles for district nurses. There is an inevitable overlap as the attempt to meet specific needs is often the characteristic feature in the development of nurses' new roles.

In Part I of the literature review the rapid growth of schemes attaching district nursing staff to general medical practice is highlighted. It is understandable, that during a period when such new working arrangements were encouraged and the potential of domiciliary care was stressed, manpower implications should have been studied. A major survey, including all of Scotland was undertaken in 1973 to establish a profile of qualified nursing staff in the community. It was published three years later (SHHD 1976)[184].

Dalton et al.(1972)[185] reported on a national survey which related staffing needs to attachment schemes. Although necessary staff increases were demonstrated, they seemed to be balanced by reputed improvements in the standard of care and greater professional satisfaction. Not all improvements were merely reputed; if an increase in exchange of information between doctor and nurse is accepted as desirable, a comparative study of an attachment scheme in Edinburgh[186] showed a 200% increase in information exchange attributed to the attachment arrangements.

There is, however, a permeating thread in the literature of the period under review, which demonstrates factors causing team work to be less than fully satisfactory. The work of Hunt (1975)[93] is particularly relevant. She undertook a systematic analysis of such factors from the literature and from empirical work. Lack of knowledge and understanding of each others' contribution, divergence

in expectations and interests, as well as administrative constraints were shown to be the most important factors; structural problems limiting available space and lack of leadership were others. The importance of leadership featured prominently in the study by Gilmore et al.(1974)[119] to which Hunt 's work had contributed. The lack of knowledge and understanding of each others' contributions was not limited to doctor and nurse; it extended to the different types of nursing staff, that is the district nurse, the health visitor and the practice nurse. Conflicts and disagreement over role boundaries were identified in several studies. (Hockey 1972[4], Gilmore et al.1974,[119] Reedy 1977[134] and 1978[187], Hockey dir.1976[188]). It was this continued evidence of friction within teams in spite of their potential for inter-disciplinary collaboration with its promise of stimulation and interests of all team members, which cause the investigator to search for a theoretical explanation (chapter 13). Relevant to the difficulty among community nursing staff in the division of their responsibilities was the study 'Women in nursing'(Hockey dir.1976[188]). As part of that study, job satisfaction of different types and grades of nurses was measured. The triple duty workers, that is those who combined district nursing, midwifery and health visiting activities, produced the largest proportion of any group with high job satisfaction scores. They were the people, though few in number, who undertook all functions themselves and were personally and directly in charge of the total nursing care of their patients. Whether their work was more directly related to the needs of their patients would need to be explored. It is, of course, equally possible that nurses who find satisfaction in nursing seek posts in which they can combine all their skills.

The theme of collaboration between hospital and domiciliary services and continuity of care was taken up again by Lawton 1973).[189] She reported an early discharge scheme similar to the quasi-

experimental study reported in chapter 7. Patients admitted for appendicectomy or hernia repair were included in the scheme with a follow-up by the district nurse. In line with the findings of the study 'Collaboration in patient care, Part I', the scheme seemed acceptable to patients and staff and showed a reduction in NHS costs for the care of patients.

A subtle way of testing the expressed desire by hospital nursing staff to communicate direct with their district nursing colleagues was a systematic monitoring of telephone messages received by seven general practices (Reedy 1975)[190]. The results showed that there was little direct telephone communication between the nursing staff of the hospital and those attached to the general medical practices.

A helpful contribution to the literature on gaps in continuity of care between hospital and home is the study 'Discharged from hospital' (Roberts 1975)[14]. Her specific contribution lies in her attempt to arrive at an objective measure of the need for care. Defining care as 'help that compensates for incapacity', Roberts developed an incapacity scoring system which could be applied to all discharged patients and which removed some of the subjectivity of perceived need by an observer.

Integration between the hospital and domiciliary services for specific types of care and specific patient groups, other than surgical, was slow in developing. However, in 1977, two publications demonstrated such efforts in paediatric care. Smith (1977)[191] described the development of an integrated paediatric unit which involved new functions for district nursing staff. Based on returns from questionnaires, the staff liked the innovation. The other paper, by Buchanan (1977)[192], also described an integrated programme of paediatric care, the difference lying in the domiciliary nurse being based in the hospital and having

received special training. Another scheme using specially trained 'community nurses' as support for the general practitioner in order to either avoid the hospital admission of children altogether, or to provide nursing care after their discharge, was reported by Reedy et al.(1978).[193]

A study describing an innovative approach to continuity of care for institutionalised elderly, giving them week-end breaks at home, was reported by Parnell and Naylor (1973).[194] Another new role for the district nurse was suggested by Mitchell (1977)[195], this time in mental health education in a variety of areas where nursing skills might also be needed. Community psychiatric nursing is a developing specialty. Two major research studies were undertaken by nurses in this field. Parnell (1977)[196] undertook a large survey which identified many different types of provision of psychiatric nursing in the community. Sladden (1977)[197] focused on the details of work undertaken by psychiatric community nurses, using a case study approach. In both studies, as well as in developments generally, community psychiatric nurses tend to be hospital based nurses with a psychiatric nursing qualification rather than district nurses.

The most recent study of the work of district nurses is that by Kratz (1978)[68], already referred to. Kratz looked particularly at the care of patients suffering from stroke, observing the care they received by the district nursing staff. More extensive mention of Kratz's work and its significance is made in chapter 13. By identifying determinants of care other than the needs of patients and emphasizing the individual differences between nurses in the way they coped with their work, Kratz's explanation provides support for the investigator's intuitive observation in 1964, which set the whole research programme into motion. A study

of district nursing, intended to lead to a better understanding of the service, must not only explore what nurses do, but also who they are, how they are prepared for their job, what values and views they hold and what type of organisational framework encourages or constrains them. Their work is, clearly, not determined merely by the needs of patients.

CONCLUSIONS

It is stated in Chapter 1 that the development and progression of a long term research programme has advantages over disparate individual studies. The defence of the claim is the major concern of this concluding section.

The desirability of coherence in social research which includes research in nursing has been expressed by research methodologists, by the government and, not least, by administrators and policy makers.

Lazarsfeld, in his paper 'Problems in Methodology' (1959)[198] stresses the necessity for the systematisation of empirical findings. He says: -

> 'It is possible to organise an array of empirical findings so that they can be compared and loosely related to one another.'

He identifies coherence as a main objective in social research and sees an urgent need to 'convert the vast and ever shifting web of social relations into an understandable system of manageable knowledge'.

Swedish researchers at the University of Linkoping, in a publication aptly named 'Themes' (1977)[199], describe how their research department has developed in response to the urgent need for coherence. Their coherence applies to the linkage of research over time as well as to collaboration between disciplines. They say: -

> 'Alongside of the special academic disciplines that have been developed we need a wider perspective which would encourage us to unite for example the technical subjects based on the natural sciences and the humanities. This is especially important when it comes to the identification of problems and the formulation of questions, processes which should not be allowed to be dictated exclusively by traditional academic concepts or needs.'

In Britain, the 'Rothschild Report' (1971)[200] which deals with government funded research, adopts the same principle and subscribes to

research into priority areas of concern.

A report of a seminar on Social Care Research was published in 1978, too late to be discussed in the preceding chapters. It is encouraging to note, however, that, although its main concern was research into the Local Authority Social Services, many of the recommendations are applicable to nursing research. Indeed, the case made by the investigator for her method of progression in research design is echoed by Rutter (1978), who says: -

> '... there has to be a recognition that research is a process and that almost any policy question will require a series of studies each of which progressively takes the matter a little further.' 202.

The investigator's programme, which began in 1964, consisted of a series of studies each of which 'progressively took the matter a little further'.

It is in 'progressively taking the matter a little further' that the benefit of a long term coherent research programme lies. It can be argued that it would be possible for individual studies to be so designed that they can reap the benefit of progression. Indeed, the investigator's programme consisted of individual studies, which could, in theory, have been undertaken by different people. In practice, however, it has been shown that researchers tend not to build on each other's work. They go back to information gathering instead of thinking about the 'why'. For example, Rutter quotes the ample evidence available to identify children at risk, but little knowledge about <u>why</u> they are at risk. Precisely the same is true for nursing research and the review of the literature, as well as the chronological bibliography, bear witness to it. There is a great deal of information available about the working day of district nurses, about the organisation of general practice attachment schemes, about role conflicts, about lack of communication. The same subjects are being studied with almost monotonous regularity, but with just

enough difference in design to make them unsuitable for helpful comparisons. In spite of the large amount of data on certain subjects which are available, little has found its way into policy, the reason being that in Rutter's words 'the matter was not taken far enough' to warrant implementation. Descriptive data are needed to provide necessary information as a basis for the formulation of policy but they do not, in themselves warrant implementation. Descriptive data, by definition, describe the status quo, they do not indicate what should be done. They do not usually go far enough to aid understanding of the problem studied. In the discussion following Rutter's paper it was stated: 'what is not required is a strategy which "sprinkles research around like drops of water in a desert". What is required is planning which identifies particular problems or issues, and which translates these into researchable questions; and then research is needed which will follow the analysis through in a "programmatic" way'. Barnes and Connelly (1978) in their conclusion to the proceedings of the seminar state that in areas of recognised policy interest programmes of research are required, with work 'in advance of clear views on how the research could be used'. They go on to say: -

203.

> 'What is needed is to strengthen the body of longer-term programmes as opposed to fact-finding operations...'

In order to undertake programmatic research, aimed at a better understanding, it is necessary to ask a series of pragmatic questions, the answer to one generating the next. It was the awareness of this need which directed the research programme.

The first study 'Feeling the Pulse'[1] opened up the subject to be studied - district nursing. It provided basic descriptive data which, at the time of the study, represented new information. District nursing had not been studied before and there was no knowledge about who district nurses were in terms of their personal and social

characteristics, about what they did, about what they thought, about their work or about how they related to their professional colleagues. Some of the findings were used immediately. For example, the fact that general practitioners did not know the district nurses who cared for their patients and were unaware of their qualifications could be recognised on the basis of professional judgment to be undesirable. It did not require further research to demonstrate it. Morris (1971)[137.] took immediate action by giving the GPs in the area for which she was responsible such information about the district nursing staff which would make a closer working relationship possible.

The analyses of the district nurses' work showed among other things that it was concerned mainly with the care of the elderly population, that it included a sizeable proportion of work for which the nurses' qualifications did not seem necessary and that the after-care of discharged hospital patients or the care of any type of younger patients played a negligible part. Interviews with the nurses suggested their own wish to widen their responsibilities in this direction which was also in line with national policy. The above findings enabled the investigator to formulate her hypotheses for the second study 'Care in the Balance'[2.]. The questions underlying this study, concerning the care of out-patients and that of discharged in-patients would not have been asked without the results of 'Feeling the Pulse'[1.]. They were contingent upon those results. The findings of 'Care in the Balance'[2.] revealed a lack in communication and contact between the hospital and domiciliary nursing services. It became apparent that part of the reason for the absence of discharged patients from the district nurses' workload was a lack of knowledge among hospital nursing staff about the potential of the district nursing service. Without 'Feeling the Pulse'[1.], which had tentatively explored the district nurses' relationship with their hospital colleagues, many of the direct

questions about relationships between them, would again not have been asked. Without the questions there would have been no answers and large gaps in knowledge and understanding would have remained.

Professional judgment alone was not enough to make a change in policy designed to transfer some patients into the care of the district nursing service earlier than had been the practice. A demonstration of such a scheme was considered necessary and was initiated in the form of a quasi-experiment. The acceptability and effects of an early planned discharge scheme needed to be studied before it could be considered for implementation. As stated by Willcocks (1973)[204.] real administrative experiment in the health service prior to implementation of new policies has hardly ever been attempted or been possible. Although the quasi-experiment in the programme was of a very limited scale, it met its desired objective of demonstrating that it was possible to transfer some hospital care to the domiciliary care setting without apparent detriment to patients, a change in policy which had a considerable potential for reducing the cost of care per patient. As shown in the literature review this was by no means the first or the only study around that time which had been concerned with early discharge of patients. It was, however, the only study (as far as could be established), which pursued the implications for nursing of such a new working arrangement. It was the cumulative experience of 'Feeling the Pulse'[1.], 'Care in the Balance'[2.] and the experimental attachment of a district nurse to the hospital which caused the investigator to mount the national study with its focus on the state enrolled nurse. The intention of this study was to explore on a countrywide basis whether the district nursing service was structured and organised in a way which used the available staff to the best advantage - a necessary pre-condition to the implementation of an early discharge scheme on a major scale. Without such a

follow-up study, it could be assumed that administrators of the district nursing service would be reluctant to accept responsibility for large numbers of discharged hospital patients on the grounds that their staff was already fully committed. The questions which were asked in 'Use or Abuse'[4.] were prompted largely by the previous studies, they were generated from the reality of the service and, therefore, considered more relevant. The request by the Department of Health and Social Security for a further detailed set of analyses of the national data was some evidence of the study's recognised usefulness.

If the studies had not been published separately, the programme would have appeared as one major research endeavour and the coherence of the studies would not have needed to be explained or defended. Separate publications were not only necessary but also helpful. They were necessary because each study was funded separately and, therefore, had to be concluded with a report. Moreover, the information was urgently needed and had to be made widely accessible. The inevitable time interval between the request for information which can only be obtained by research and its availability after completion of the research may undermine its usefulness to those who requested the information in the first instance. This difficulty was discussed at some length at the Seminar on Social Care Research[201.] referred to above; nursing represents an analogous situation. The investigator attempted to reduce the time interval to a minimum by publishing the individual studies as quickly as possible. Separate publications were also helpful because, as can be identified in the literature review, they acted as triggers in some instances, either for research or for other forms of reaction. As stated above, the publication of 'Feeling the Pulse'[1.] acted as change agent in one local health authority. The fact that each study had to be complete in itself,

inevitably meant some repetition in the collection of basic data. Although this was first seen as a disadvantage, it became apparent that the repeated exercise afforded a valuable opportunity in improving the data collecting instruments over time. It also provided a useful experience in the analysis and presentation of data.

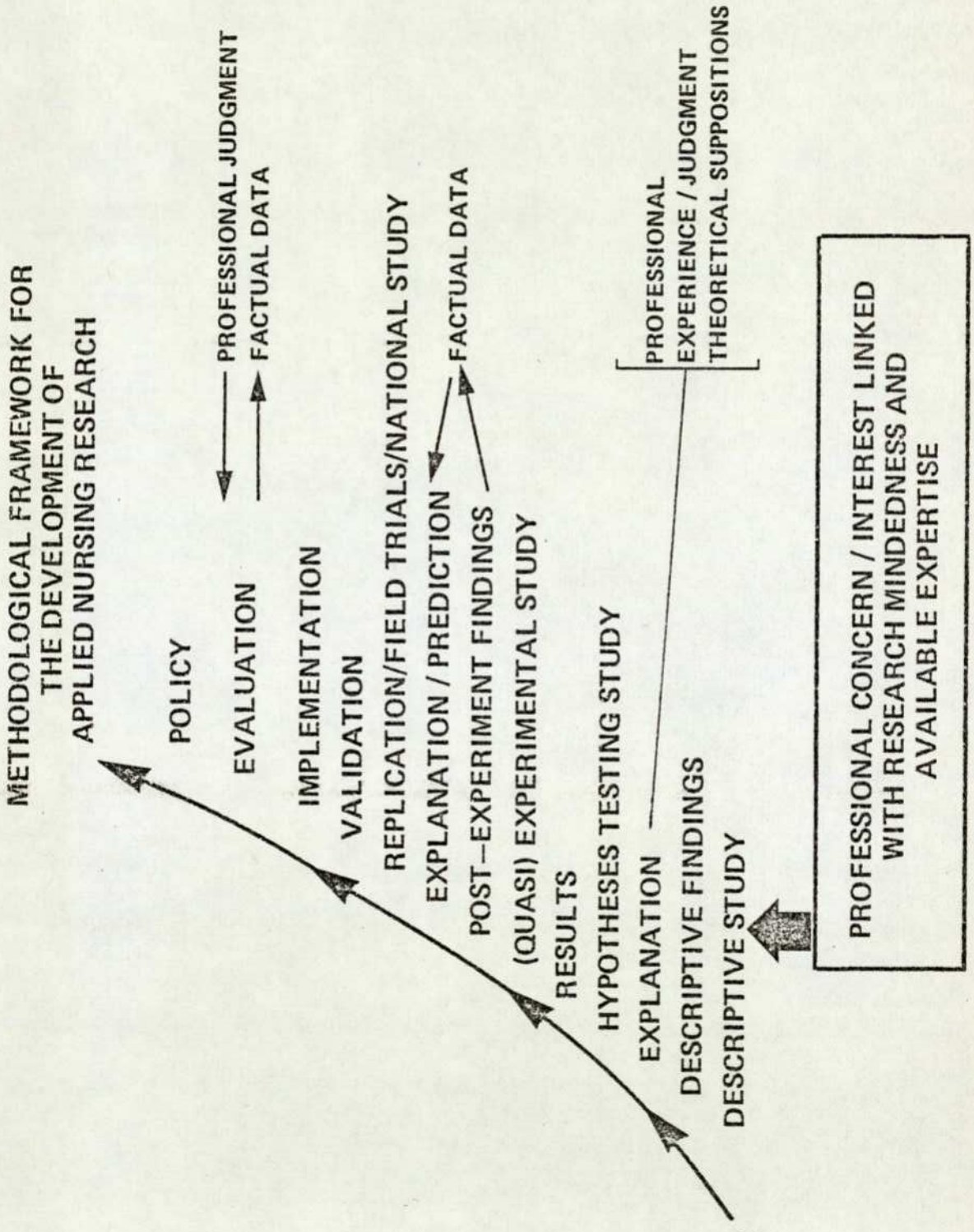
The progression of the four studies, each with its own implications for policy, caused the investigator to develop a conceptual model to illustrate the path from initial concern about a problem to implementation of research findings.

Figure 24 shows the steps considered necessary and it is claimed that the research programme has gone some way toward bridging the distance. Social administrators in academic and service fields, seem united in their regret at the lack of omplementation; for example Pinker (1971)[205], Willcocks (1973)[206], Donnison (1978)[207], Barnes and Connelly(1978)[208]. It is submitted that if more research could be pursued in long term programmes, giving the opportunity to progress from descriptive studies to experimentation and validation, field trials and evaluation, the gap between research and policy would be rapidly narrowed.

The identification of areas for further research, in a field which is policy oriented, such as district nursing, must inevitably be linked with the gaps between concern about a problem and the knowledge required to understand it sufficiently for effective action. Hard descriptive data providing information about the structure of the district nursing service, as it <u>is</u> functioning, about the work of district nurses, as it <u>is</u> being performed, about the diagnostic categories of patients <u>currently</u> cared for by district nurses, important though they are, do not go far enough. Descriptive information, as emphasized throughout the preceding chapters cannot, in itself, explain findings or prescribe action, neither can it predict. Research is not embodied in fact finding, it is a process of enquiry, a way of looking at and

FIGURE 24

Methodological framework for the development of applied nursing research



understanding the world, ... the best research being a means to the understanding of relationships between events or phenomena'.[208] An understanding of relationships requires also soft data, difficult to obtain and even more difficult to analyse, but essential for the development of policy. Soft data include motives, attitudes, opinions, perceptions of problems. District nursing has been presented as a complex social service and a conceptual model was offered in Chapter 13 to illustrate some of the relationships which require to be tested. As can be seen, the model includes the patient, his family and his expectations. For an understanding of district nursing and for any attempt to increase its effectiveness, the informal as well as the formal caring systems need to be explored. The investigator's awareness of the need to include the opinions of patients in research is shown in the study 'Care in the Balance'[2] and also in 'Co-operation in Patient Care'[3]. Her awareness of the need to explore the views, opinions and 'values' of nurses is shown in all four studies. It is recognised, however, that the questions, in all instances, were merely superficial and that, using Rutter's terminology again 'they did not go far enough'. Therefore, further research is needed, preferably of a progressive type, in which results of one study can generate the next and in which a multidisciplinary approach can be applied to the multidisciplinary nature of the problem inherent in the district nursing service.

Some specific further research has been suggested in previous chapters. In this concluding paragraph the investigator's aim is to summarise a 'programme' of research based on her experience and on her findings of the programme of research defended in this thesis. In any service provision, recruitment to the service is fundamental. Although there have been studies on recruitment to the nursing profession (e.g., Marsh and Willcocks 1965[209], Brown and Stones 1973[210]) and

on attrition which is related to recruitment (MacGuire 1969), there is a need to study recruitment into the district nursing rather than the hospital nursing service. Although reorganisation of the Health Service has merged the administration of both types of nursing, the field staff providing the service are not interchangeable but are recruited to one or the other. As discussed in Chapter 13, the structure of the district nursing service has shown remarkable stability of highly qualified staff and a small proportion of unqualified nursing auxiliaries. Reasons for this finding were suggested, but these require to be tested. If it is found that it is the relative autonomy of the service which makes it attractive to some nurses, then the trend to establish large teams of workers, making each member more dependent on others, may reduce recruitment which, clearly, has a policy implication. If the explanation offered is proved false, an alternative must be sought. Thus, the second stage of the research programme will be contingent upon the results of the first. In relation to teamwork, demonstration projects are suggested. Research findings demonstrating weaknesses abound; if teamwork is to be a rational policy objective, a series of deliberately planned comparative 'field trials' need to be initiated, which will show how and why people do or do not work happily together. Such work would lead to a better understanding of the problems, which alone can lead on to the search for solutions. Although some deliberately planned specific work settings, either linking hospital and domiciliary services or linking different professionals within general practice teams are described in the literature, they cannot be compared with each other.

Lastly, what seems to be needed is research to show what sort of district nursing service would be effective which requires evaluation with its inherent fundamental problem of setting criteria of effectiveness. For this to be done, all the inter-relationship

between the variables illustrated in Figure [23] must be systematically explored. Such an approach requires a long-term programme of complex sophisticated, preferably multidisciplinary, research. The investigator's programme has demonstrated a small part of the complexity of the district nursing service and has attempted to illuminate that small part. A complex service involving many people, lay and professional, demands complex research to understand, evaluate and improve it.

ANNEX 1

DATA RELATING TO THE BASELINE STUDY OF DISTRICT NURSING IN SIX AREAS

The purpose of this Annex is to present additional findings to those in Chapters 4 and 5, particularly those which provided the impetus for the next stage in the research programme.

The relevant findings were obtained from personal interviews with the nursing staff and with other professional workers in the health service, especially general practitioners. Another important source of information was the work record completed by the district nursing staff.

The work record proforma is reproduced at the end of this Annex.(p324)

The nature of district nursing can lead to a feeling of professional isolation which was even more likely at the time of the first study when the attachment of district nurses to general medical practice was a rare exception. A third of the nurse respondents expressed such a feeling. Table 77 shows that the feeling of

TABLE 77

Percentage distribution of nurses expressing professional isolation

	Age		Length of time in present post			Functions		
	Under 40	50 and over	Less than 2 years	2-9 years	10 + years	DN only	DN/ mid-wife	DN/ mid-wife/ HV
	%	%	%	%	%	%	%	%
Feel professionally isolated	58	25	59	26	24	53	29	23
Do not feel profes-sionally isolated	42	73	41	74	75	46	71	77
Not answered	0	2	0	0	1	1	0	0

professional isolation decreased with age, length of time in post and multiplicity of functions. Whether nurses who did not express

professional isolation had more contact with colleagues or whether they did not feel the need for such contact cannot be deduced from the data.

Table 78 presents the breakdown of a nurse's working day. In none of the areas was the proportion of working hours spent in contact with patients more than 70% of the total working day.

TABLE 78

Average working day

Time spent	Areas					
	A hr.min.	B hr.min.	C hr.min.	D hr.min.	E hr.min.	F hr.min.
With patients	3.51	5.38	5.9	5.35	4.40	3.23
Travelling	1.17	1.45	1.36	1.37	1.32	1.17
On other activities	54	45	1.16	1.3	1.6	51
Total working day	6.2	8.8	8.1	8.15	7.18	5.31

Communication with other professional colleagues is part of 'other activities' and their breakdown is shown in Table 79. Communication with GPs amounted to no more than five minutes anywhere; three minutes was the average time recorded for hospital visits, which implies that a large number of respondents did not pay such visits. Telephone communications with other agencies, including hospitals amounted to no more than seven minutes. From these data, it seems that inter-disciplinary discussion of patients or other professional matters was rare.

Figure 25 is relevant to the formulation of the hypotheses which were tested in the second study of the programme. It indicates the relatively small proportion of time given to patients under the age of fifty years, the exception being the rural areas. Further impetus

TABLE 79

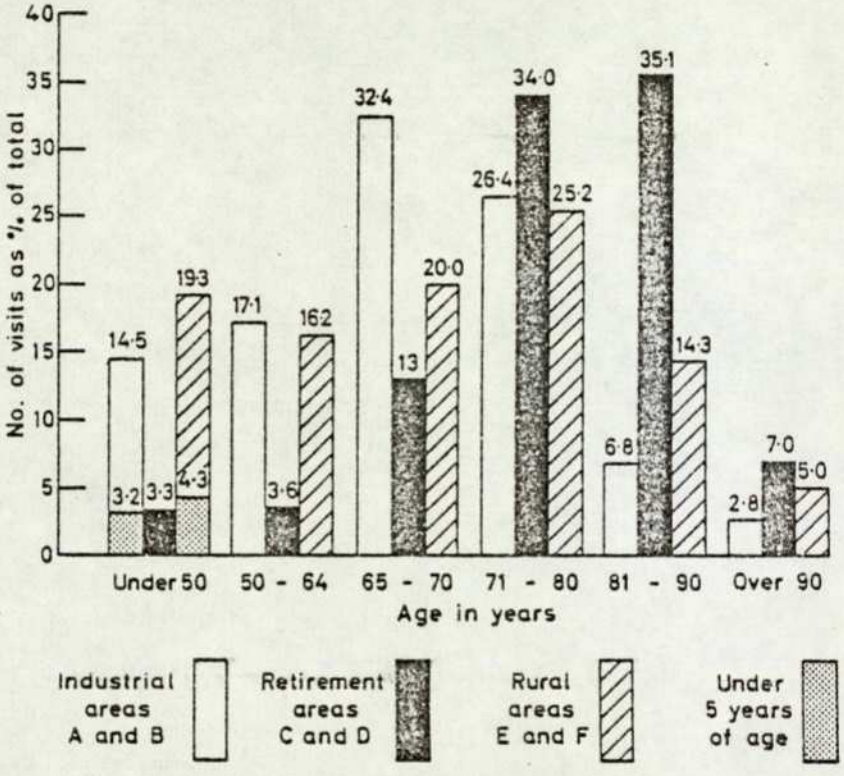
Breakdown of time spent on 'other activities' referred to in Table 78

Time spent on other activities	Areas					
	A min.	B min.	C min.	D min.	E min.	F min.
Record keeping	30	18	30	58*	40	32
Communication with GPs	2	5	4	0	5	5
Communication with other agencies	6	1	7	0	4	4
Communication with Admin. Centre, inc. care of equipment	13	22	33	5*	16	9
Hospital visits	3	0	2	0	1	1

*The nurses in D were required to write their records at the administrative centre.

FIGURE 25

Distribution of nurses' visits by age group of patients



was provided by the findings in Table 80 indicating the sizeable percentage of nurses who expressed a wish to have their duties extended. Figure 25 also demonstrates the understandable effect of the population age structure on the work of district nurses.

TABLE 80

Nurses' views on extension of duties

	Length of time in post		
	Less than one year	1-9 years	10 years or more
	%	%	%
Would appreciate extension of duties	57	52	41
Would not appreciate extension of duties	41	48	55
Not answered	2	0	4

Table 81 adds to the information on type of work undertaken by many district nurses and Table 82 gives a little more detail on suggested delegation to less qualified workers. These data contributed to the general building up of the programme to the national study. Further findings and other details relating to the baseline study of district nursing can be found in 'Feeling the Pulse'[1] (Hockey, 1966).

TABLE 81

Number of nurses undertaking simple nursing care

	Baths for frail handicapped	Getting patients dressed and undressed	Getting patients in and out of bed
Regularly (at each visit)	161	118	131
Periodically, e.g. at weekends	13	32	18
In emergencies	3	17	14
Never	0	10	14

TABLE 82

Suggested delegation to SEN

	Needed for longer	Suggested as new worker	
	No. visits	No. visits	%
Areas A and B			
Under 65 years		336	19*
65 years and over	1	1,279	30*
Total		1,615	29
Medical		1,407	25
Surgical	1	200	4
All others and dual cases		20/	0.4
Areas C and D			
Under 65 years	0	147	18*
65 years and over	6	464	18*
Total		611	18
Medical	5	582	17
Surgical		25	7
All others and dual cases	1	6/	2
Areas E and F			
Under 65 years	0	141	20*
65 years and over	1	462	26*
Total		603	24
Medical	1	534	21
Surgical		71	3
All others and dual cases		11/	0.4

*Percentage of visits to respective age groups.
/Dual cases are also included with 'medical' and 'surgical'.

SURVEY OF DISTRICT NURSING

For Admin. Authority (to identify Nurse and Area)

Col. 1	Col. 2	Col. 3

Date .....

Name of Local Authority

CODING KEY

Code No.	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10	Col. 11	Col. 12	Col. 13	Col. 14	Code No.
0			NO CODE (ACTUAL AGE OF PATIENT IN YEARS)	No Reply (Call only)	Call to Assess need	NO CODE (ACTUAL LENGTH OF VISIT IN HOURS AND MINUTES)	No Delegation possible	Full Delegation possible	None	None	0
1	Medical	Antenatal Visit		Injection	Call to check on equipment		Simple basic care	Shaving	S.E.N.	S.E.N.	1
2	Surgical	Visit during Labour or Delivery		Dressing	Midwifery		Getting patient in and out of bed, dressing & undressing	Bed making	Auxiliary	Auxiliary	2
3	Gynaecological	Post-natal visit		General nursing care	Infant care		Bedpan, commode, W.C.	Preparing or giving food	Bath Attendant	Bath Attendant	3
4	Tuberculosis	Health visit		Douche or Bladder Lavage	Supervision		Bath	Fetching fuel & lighting fire	Night Nurse	Night Nurse	4
5	Other infectious Diseases	CLINICS. School		Enema or Catheterisation	Others*		Simple Injection	Shopping	Home Help	Home Help	5
6	Mental ill-health	Local Health Authority		Treatment to Eyes or Ears			Dressing of simple wound	Taking prescriptions to Chemist	Chiropodist	Chiropodist	6
7	MATERNITY Miscarriage or other ante-natal complications	General Practitioner		Rehabilitation Exercises			Foot Toilet	Transport of Patients	Friendly Visitor	Friendly Visitor	7
8	Early hospital discharge (maternity)	Hospital		Pre-symptomatic Tests			Supervisory Nursing call	Supervisory Call	Night Sitter	Night Sitter	8
9	Others*	Others*		Maternity Nursing			Walking Exercises	Others*	Others*	Others*	9

Please put appropriate number (or numbers) in space provided under each column

							FOR GENERAL NURSING CASES ONLY				
Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10	Col. 11	Col. 12	Col. 13	Col. 14	Col. 15
Patient No.	Type of Case (General)	Midwifery Health Visiting Clinics	Age of Patient Yrs.	Purpose of Visit		Length of Visit or clinic hrs. min.	Retaining supervision of patient or complete delegation of patient (see Code 0, Col. 12)		Additional Worker: Already in action	Additional Worker: Suggested or needed for longer than at present	Travelling time to next patient or clinic hrs. min.

*IF 'OTHERS' IS USED PLEASE SPECIFY BELOW

Col. 16		Col. 17		Col. 18		Col. 19		Col. 20	
TIME SPENT ON:-									
Records		Telephone or consultation with doctors		Communication with other agencies		Telephone or Calls to Admin. Centre incl. care of equipment		Hospital Visits	
hrs.	min.	hrs.	min.	hrs.	min.	hrs.	min.	hrs.	min.

Col. 21
Total mileage per day

ANNEX 2

DATA RELATING TO CHAPTER 6

The study, summarised in Chapter 6, had two main areas of concern which were: -

1. Discharged In-Patients
2. Re-attending Out-Patients.

The supplementary data in this Annex are, therefore, presented separately for each of those areas. In both instances, the first part of the data is that which was extracted from the hospital records, whereas the second part was generated from interviews with the patients.

1. Discharged In-Patient Enquiry

Requests for community services

Table 83 shows requests for community services recorded by the hospital. The paucity of recorded requests is obvious and, taken by themselves, medical records would have conveyed a picture of poor collaboration between the hospital and community services. However, it became clear in discussion that some referrals were made by telephone, but were not recorded. This was so particularly in Hospital 4 where, in addition to telephone communications, the district nurses visited at least the Five Day Ward, and had patients referred to their care in the course of such personal direct contact.

This system enhanced informal communication between hospital and district nursing staff generally.

TABLE 83

Requests for community services recorded by the hospital

Services in the Community	Hospitals						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
General practitioner	-	40	6	38	-	28	17
District nurse	1	-	1	1	-	4	1
Home help	-	-	-	-	-	-	-
Other*	1	1	3	3	-	-	1
Combination	-	1	-	1	-	1	1
Not stated	98	58	90	57	100	67	80
No. of patients (100%)	240	120	164	165	93	150	932/

*Other includes: medical loans, health visitor, meals-on-wheels, family planning, in that order of frequency.
/Number for which records were available.

The records showed that the help of the district nursing service was enlisted for more surgical than medical patients. Ninety-seven patients had been visited by a district nurse since their discharge from hospital, although a request by the hospital for the service was recorded in only 12 cases. As regards communication between the hospital and the general practitioner, it was not always easy to distinguish between a request to the general practitioner for further care and a simple notification of discharge. In most cases the communication seemed to be of the latter kind, either a discharge summary or a letter informing the general practitioner of diagnosis and treatment, stating also that the patient's progress would be supervised in the out-patient department. Over 25 per cent of the

respondents had already attended the hospital since their discharge two weeks or so earlier. Where letters to general practitioners were written at all, they were usually dictated within a week of discharge. It was impossible to establish when the letters were signed or posted.

Although the patients' records did not show any referral to the home help service, this was, in fact, requested in a number of cases. Methods of referral differed somewhat between the hospitals, but in most cases the ward sister either asked the medical social worker to see the patient or his relatives, or she sent a request form to the medical social worker's department. The requests were sometimes sent to the Medical Officer of Health, sometimes to the Chief Nursing Officer and, more frequently, to the Home Help Organiser. There appeared little opportunity for a 'follow-up' of these requests. Two medical social workers said that relatives had occasionally complained that the home help had never materialised or that she only came so infrequently that the support given was negligible.

Response

The analysis of the data obtained from interviews with discharged in-patients was based on 727 such interviews.

Table 84 indicates the reasons for non-response. The decision not to make appointments with patients accounted, at least in part, for the main reason, which was 'not at home'.

TABLE 84

Reasons for non-response

Reasons	Hospitals						Total
	1	2	3	4	5	6	
Not at home (holiday, etc.)	57	10	14	14	6	4	105
Outside area	23	37	3	8	3	4	78
In hospital or convalescent home	6	-	1	6	15	1	29
Communication difficulties (language, deafness)	2	-	2	-	1	-	5
Too ill	2	-	3	-	-	1	6
Died	-	-	-	3	-	-	3
Address not found	4	-	-	1	1	4	10
Refused	2	-	2	-	2	-	6
Not stated	8	-	-	2	-	2	12
Total	104	47	25	34	28	16	254

Socio-economic conditions

Socio-economic conditions can be expected to colour people's assessment of their illness and their ability to cope with additional stresses. The distribution of patients in the six areas according to their socio-economic classes is shown in Table 85. The sparse representation of patients in classes I and II was probably due to the fact that patients discharged from private wards were not included in the sample. In Area 1, where no hospitals in the district had private beds, the proportion of these

patients was substantially higher. There might be other reasons for this difference, none of which were investigated. There was a significant difference between the patients in classes I and II and those in the other classes with regard to their return to work. Seventeen per cent of the former and 96 per cent of the latter had already resumed work. In the interpretation of this finding it is important to realise that other factors which may influence a person's return to work after illness were not held constant in this comparison, and may have had a part to play.

TABLE 85

Distribution of discharged in-patients by socio-economic class† and hospital

Socio-economic Class	Hospitals						Total	
	1	2	3	4	5	6	No.	%
	%	%	%	%	%	%		
I	3	3	3	3	3	3	21	3
II	27	2	9	6	14	11	81	11
III	48	56	56	57	65	49	383	55
IV	15	32	20	27	5	26	155	22
V	4	6	12	5	5	10	51	7
Unclassifiable	3	1	-	2	8	1	14	2
No. of patients (100%)	127	103	143	128	64	140	705*	100

†Classification of Occupations 1966. General Register Office

Class I Professional, etc. occupations
Class II Intermediate
Class III Skilled)
Class IV Partly skilled) Manual
Class V Unskilled)
Unclassifiable - Armed Forces; inadequately described.

*For 22 patients the information had not been recorded.

Continued treatment

Just over half (372) the patients were having tablets or medicines of some sort, 10 per cent needed dressings, 3 per cent injections and 9 per cent other treatments, e.g., suppositories, enemata, pessaries, or combinations of these.

One hundred and one of these patients (27%) said that they were worried about their treatment, the proportion being similar in all areas. Seven per cent of the patients were having the help of relatives or friends for their treatment; in some cases this amounted to sorting out tablets, occasionally a daughter was giving an injection to her mother, or, in a very few cases, a relative or friend applied dressings or special bandages.

Seventy-three patients (10%) said that they had to buy some nursing equipment. In most cases this was a bedpan, mackintosh or sorbo cushion. Some patients had bought extra night clothing or bed linen and had called this nursing equipment; 16 had bought syringes, dressings or bandages. In three instances the syringes were bought in case the one obtained on prescription should be broken. A few patients volunteered that they had bought patent medicines to hasten their recovery. Fifty-three patients (7%) had been able to borrow equipment they needed, either from the hospital or the local authority medical loans department. Neighbours had lent articles in a very small number of cases.

Home commitments, personal care and mobility

On enquiring into the home commitments of the discharged patients, one in seven said that they did not always feel well enough to look after their children; a few were being helped by friends and neighbours.

In none of the eight cases where local authority home helps assisted with the housework did they help with the care of children.

The comparative affluence of Area 5 was reflected in some measure in the findings, a higher proportion of patients having private help with children and housework. Of the patients who had other dependants living with them who needed care, most were able to manage. There were 71 patients in all who, although not feeling sufficiently fit to look after their children or other dependants, had no kind of help.

In most cases household duties were shouldered by the patient and members of the household. Only eight patients (1%) had a local authority home help and a further 1% employed domestic assistance. Seventy-five patients (10%) needed help with washing and dressing (18% in Area 6). Other members of the family seemed to help out in most cases, nine patients paid for private assistance. In only four cases did the district nursing service, which included auxiliary staff, provide this simple personal care for patients. One would not wish to remove all responsibility for the care of a patient from his family. However, in many of the cases in this survey no one had assessed family needs or resources, and the patients on interview revealed considerable anxiety and burden on their part.

A standard mobility scale was used to assess each patient's approximate dependence. Only just over half of all the patients were able to walk without restriction. The proportion of fully mobile patients was biggest in the London teaching hospital (61%) and smallest in Hospital 6 (34%). This difference may be contributed to by the older age structure of the patients in the latter area (Table 22). Only seven patients, less than 1% of the total, were bedfast at the time of the interview. Of the 43 patients whose mobility was restricted to the building, a quarter had no indoor toilet.

District nursing care

Although the patients' records mentioned referral to the district nursing service in only 12 cases, 97 patients had, in fact, been visited by a district nurse since their discharge from hospital (Table 86). Apart from one or two, who had made an

TABLE 86

Number of discharged in-patients classified by reason and frequency of district nurses' visits

Type of Care	Frequency of visits					
	One	Two	Three	Four to ten	More than ten	Total
Call only	5	-	1	-	1	7
Dressing	3	2	9	23	14	51
General nursing Care	-	1	1	1	1	4
Injection	5	3	-	-	1	9
Removal of sutures	3	1	-	-	-	4
Other	1	6	1	1	1	10
Combination of treatments	1	2	-	-	9	12
Total	18	15	12	25	27	97

approach themselves, the patients were not at all sure about who had arranged for the district nurse to call. Two-thirds thought that it was probably the hospital, the others suggested the general practitioner, or they did not even hazard a guess. One old lady said: -

'I asked the nurse how she knew I needed
her and she said it just gets around;
astonishing, isn't it?'

In view of the fact that 15 per cent of the patients who had district nursing care had not been seen by their general practitioner, it could be that the hospital had asked for help from the district nursing service in more cases than the records suggested. On the other hand, it is possible that the general practitioner, having been informed of the patient's discharge, asked the district nurse to visit and relied on her to call him, if needed.

The care the patients received from the district nursing service and the frequency of the nurse's visits, shown in Table 87 reflects the limited extent of district nursing involvement in the after-care of patients discharged from hospital. The higher proportion of patients having district nursing care in Area 4 was, at least partially, due to the Five Day Ward; the only four patients for whom the district nurses removed sutures were definitely referred from that ward. No doubt pressure on the facilities of Hospital 6 provided an urgent incentive to use the district nursing service as much as possible. Moreover, there seemed to be informal links between the hospital and the town's district nursing service and there was frequent contact between the heads of the two nursing services. This resulted in better knowledge of each other's contributions, difficulties and problems, and full co-operation at all levels.

TABLE 87

Number of discharged in-patients by type of care received from district nursing staff in areas

Type of care	Areas						Total
	1	2	3	4	5	6	
Call only	-	-	6	-	-	1	7
Dressing	10	6	7	9	-	19	51
Washing, bathing, etc.	-	-	1	1	-	2	4
Injection	-	3	1	1	2	2	9
Removal of sutures	-	-	-	4	-	-	4
Other	3	-	1	3	-	3	10
Combination	6	-	-	6	-	-	12
Total number of patients having district nursing care	19	9	16	24	2	27	97
As % of discharged patients in each area	13.5	8.7	11.2	18.0	3.1	19.0	13.3

Consultation with general practitioner

In this survey, 68 per cent of all the patients had seen their general practitioner, his partner or locum since leaving hospital. Most of these patients had called at the doctor's surgery, 33 per cent had been visited at home, almost half without having asked for a visit. In the London area, only 4 per cent had received a doctor's visit without making a request themselves.

Return visits to the hospital

Table 88 shows that well over a quarter (205) of the patients

had already been back to the hospital since their discharge two weeks earlier, some as many as four or more times.

TABLE 88

Number of discharged medical and surgical in-patients by number of return visits paid to hospital

Return visits	Type of patient			
	Surgical	Medical	Not stated	Total
None	258	210	49	517
One	74	56	18	148
Two	22	8	3	33
Three	7	5	-	12
Four or more	10	2	-	12
Not stated/Not applicable	1	1	3	5
Total	372	282	73	727

Most of the patients who had not yet re-attended the hospital had appointments for future visits, some were expecting letters from the hospital, a negligible number did not know whether they would have to go back or not. It seemed established routine in all hospitals to re-call the majority of discharged patients to the out-patient department. Just over one-third of the 205 patients had received some nursing care, which included injections, dressings and the removal of sutures, on the occasion of their hospital visit. in only eleven cases had the patients attended the out-patient department for this care, mostly their visits had been to wards or the casualty units, which indicated that they had attended for the sole purpose of nursing care and their visits were not linked with

their check examinations by the consultants. Though not common, the practice of requesting patients to come back to the wards for treatment after their discharge seemed surprising. One would expect this to add considerably to the pressure of work mentioned by many ward sisters. It was interesting to find that, in at least one hospital, neither the consultant medical staff nor the hospital administrator were aware of the amount of this additional work shouldered by the nursing staff of the wards; on the face of it this work could have been undertaken by district nurses.

Twelve per cent of the patients who had already been back to hospital had to have special examinations, tests or X-rays, for which no alternative to a hospital visit was available.

Over half the patients either accepted the journey to the hospital without comment or found it quite easy. Forty-two patients commented on expense and inconvenience, nine regarded their hospital visit as a welcome outing. Of the 39 respondents who had been transported by ambulance, 29 said that the journey had been 'tough', 'painful', 'tiring because of waiting about', or had made them ill. These comments were not intended to be critical of the ambulance service which is obviously provided for those patients who are too ill, old or disabled to make their own way to the hospital, and for whom such a journey by any means of transport is likely to be an ordeal; they suggest, however, that alternative provisions for care, avoiding lengthy trips, might be preferable for some of these patients.

Patients' preference for care

Most patients said that they preferred to have their care in hospital than either in their home or at the doctor's surgery. Table 89 shows that, although this applied to patients in all areas, it was a high priority in London.

TABLE 89

Patients' preference for care

Preference (place for attention)	Areas						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Hospital	42	76	58	51	45	48	53
Home	21	10	17	14	5	29	18
Surgery	6	6	6	13	12	5	8
Immaterial	11	2	6	5	9	4	6
Other	3	4	1	14	11	1	3
Not stated/Not applicable	17	2	12	3	18	13	12
No. of patients (100%)	141	103	143	133	65	142	727

There was no suggestion in any of the six areas that the patient's socio-economic class influenced his choice of hospital, home or general practitioner surgery care. The reasons for preferences given by the patients are shown at the end of the out-patient data, section (p.348) as they applied also to the out-patient respondents.

Patients' opinions about their length of stay in hospital

The patients' opinions about their length of stay in hospital, presented in Table 90, showed that almost three-quarters of them felt that it had been right. In five of the six areas, more patients considered themselves prematurely discharged than excessively retained. The exception was Area 5, where the relationship was reversed. This might help to explain further the exceptionally small part played by the district nursing service of

that area in providing further care for patients discharged from hospital.

TABLE 90

Patients' views about length of hospital stay

Patients' views	Areas						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Right time	69	77	76	65	57	80	72
Too long	6	3	7	13	18	2	7
Not long enough	13	13	11	16	12	14	13
Other	10	7	4	5	12	4	7
Not stated/Not applicable	2	-	2	1	1	-	1
No. of patients (100%)	141	103	143	133	65	142	727

Patients' assessment of their well-being

Patients' opinions about their care and attitudes to their illness can be expected to be influenced by their state of well-being at the time of the interview. An attempt was made to place the answers along a seven point scale and the results are shown in Table 91 . The only variation, suggestive of a real difference, was in Area 1, where one in ten patients felt ill or very ill compared with the average of one in twenty-five elsewhere. Surgical patients appeared, in their own assessment, to have made overall better progress than medical patients. Fifty-two per cent of the former and 43 per cent of the latter were on the positive 'well' side of the seven point scale, whereas 11 per cent of the former and 17 per cent of the latter were on the negative 'ill' side.

TABLE 91

Patients' views of their well-being

Question: How are you?	Areas						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Very well indeed	13	17	16	18	14	12	15
Alright	10	24	28	20	27	32	23
Making progress	27	26	22	26	25	20	24
As well as can be expected	21	15	20	11	20	18	17
Not too good	17	15	10	19	14	11	14
Ill/bad	8	1	3	2	-	3	3
Very ill/very poorly	2	-	-	2	-	1	1
Other	1	-	-	2	-	1	1
Not stated/Not applicable	1	1	1	-	-	2	2
No. of patients (100%)	141	103	143	133	65	142	727

Although the patients' statement of well-being bore no relation to the actual length of their hospital stay, it showed an interesting correlation with their opinions as to whether they had been in hospital for the right length of time. Seventy-eight per cent of those patients who felt unwell were among the group of respondents who considered that they had not been kept in hospital long enough. Whether they really had been discharged too soon and were, therefore, making less progress, whether they felt unwell and blamed early discharge for it, or whether they wanted to show their dissatisfaction by attracting sympathy, cannot be deduced from the evidence.

The findings suggested that there is room for improvement in the aftercare of discharged hospital patients, even if it is merely reassurance.

II. Out-patient enquiry

Sources of referral

As already indicated, out-patient re-attenders were mostly those who had been given the appointment at a previous out-patient clinic. The minority (18%) of the patients had either been referred from the ward or other hospital department, or their visit had been arranged by their general practitioner who wanted an earlier appointment than the patient had been given. A very small number, barely 1%, had either asked for an appointment on their own initiative or had come to the clinic without an appointment, hoping to be 'fitted in'. All patients in the sample had attended the clinic for the same condition before, and had not been discharged since that attendance. The out-patients classified by diagnoses and age groups are the content of Table 93 (overleaf). Table 92 shows requests for community services recorded by the hospital. Similar to the

TABLE 92

Requests for community services for out-patients recorded by the hospital

Services in the community	Hospitals						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
General Practitioner	6	6	1	18	-	31	11
District Nursing Service	-	-	-	1	-	1	-
Home Help Service	-	-	-	-	-	-	-
Other*	1	2	1	1	-	-	1
Combination	-	-	-	1	-	-	-
No. of patients (100%)	424	422	400	387	203	394	2,230**

*Other includes medical loans, health visitors, meals on wheels, family planning, in that order of frequency.

**The number of patients for whom records were available.

TABLE 93

Out-patients classified by diagnosis and age groups

Diagnostic Groups	Age groups						
	0–14	15–24	25–44	45–64	65 or over	Not stated	Total
	%	%	%	%	%	%	%
I. Infective and Parasitic	1	1	3	1	1	–	1
II. Neoplasms	7	10	7	9	15	8	10
III. Allergic, Endocrine Metabolic and Nutritional	5	12	14	13	13	6	13
IV. Blood and Blood Forming Organs	–	4	2	2	3	3	2
V. Mental, Psycho-neurotic and Personality Disorders	–	3	1	1	–	3	1
VI. Nervous System	3	4	3	2	–	–	2
VII. Circulatory	3	6	20	24	17	14	19
VIII. Respiratory	3	–	–	1	2	3	1
IX. Digestive	32	25	23	22	21	28	23
X. Genito-Urinary	17	11	9	5	6	20	7
XI. Deliveries and Complications of Pregnancy, Childbirth, etc.	–	1	–	–	–	–	–
XII. Skin and Cellular Tissue	1	4	2	2	2	–	2
XIII. Bones and Organs of Movement	–	1	2	3	2	–	2
XIV. Congenital Malformations	11	2	1	1	1	6	1
XV. Diseases of Early Infancy	1	–	–	–	–	–	–
XVI. Symptoms, Senility and Illdefined Conditions	6	14	12	14	16	3	14
XVII. Accidents, Poisonings, and Violence	9	1	1	–	1	–	1
Not Stated	1	1	–	–	–	6	1
No. of patients (100%)	81	134	531	959	490	35	2,230

finding regarding the discharged in-patients, medical records showed little more than the sparsity of recorded information about arrangements for community services made by the hospital staff.

The records showed that just over half of the out-patients were asked to re-attend after a specified time interval (Table 94); further analysis of the data suggested that, after each subsequent attendance about one in three of the patients are either discharged or transferred elsewhere. The reduction in the number is, however, exceeded by the number of new patients, thereby exerting the pressure on out-patient departments referred to in Chapter 6.

TABLE 94

Method of disposal of out-patients

Disposal of patient	Hospitals						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Discharged	13	8	12	13	9	19	12
To re-attend after specified interval	57	60	61	46	57	40	53
To re-attend (if necessary)	1	7	2	4	2	4	4
To be admitted	5	8	4	2	8	3	5
Put on waiting list	2	1	4	6	4	10	5
Transferred to other hospital	1	-	-	1	-	-	-
Other	6	6	4	5	7	13	7
Combination	1	1	1	1	3	1	1
Not stated	14	9	12	22	10	10	13
No. of patients (100%)	424	422	400	387	203	394	2,230

Response

The information provided by the out-patients is based on 1524 interviews, which represents a relatively high non-response rate of 33%. Reasons for non-response are shown in Table 95.

TABLE 95

Reasons for non-response

Reasons for non-response	Numbers of non-respondents in hospitals						Total
	1	2	3	4	5	6	
Refused	-	1	3	1	1	1	7
Too ill or upset	8	1	2	-	1	4	16
Communication difficulties (foreign language, deafness, etc.)	3	2	9	-	-	9	23
No time to wait	7	2	21	-	4	5	39
Missed	73	125	139	123	54	137	651
Total	91	131	174	124	60	156	736

Because the patients were asked about that particular visit and their reaction to it, it was necessary to interview them on their way out, when all the attention had been given. There is no doubt that a much higher response rate would have been achieved had it been possible to use patients' waiting time for the interviews. Several patients even asked for this to be done, some because they were curious, some because they were pleased to start a conversation, but some also because they really wanted to be helpful but knew they would have to get away as soon as possible after being seen.

Seven patients only refused to be interviewed; there may have been others who, not wishing to participate, slipped out or pretended that they had no time; the large number of 651 'missed' patients simply

disappeared in the crowd. In order to achieve a higher response rate one would have needed a larger research team for which most out-patient departments would not have had sufficient space.

Travelling to the hospital

The distance between the home of patients and the hospital is shown in Figure 26 and the mode of transport is presented in Table 29. The fact that only eight per cent of the patients were able to reach the hospital on foot is reflected in the cost of their journey to the hospital as shown in Table 96.

TABLE 96

Cost of return journey to and from the hospital

Cost of journey	Percentage of patients in each cost group for hospitals						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
£1 or more	4	6	1	5	5	2	4
10/- less than £1	4	8	3	8	14	9	7
5/- less than 10/-	10	15	9	13	19	13	13
Less than 5/-	64	54	67	50	38	64	57
Nothing	14	15	18	21	21	10	16
Not known	4	2	2	3	3	2	3
No. of patients (100%)	318	324	226	270	145	241	1,524

In Table 97 this cost is related to the patients' social class. (It relates to costs in 1967 when the data were collected.)

Tables 98 and 99 are relevant in any assessment of the effect of out-patient attendances.

FIGURE 26

Proportionate distance of residence of discharged in-patients from hospital

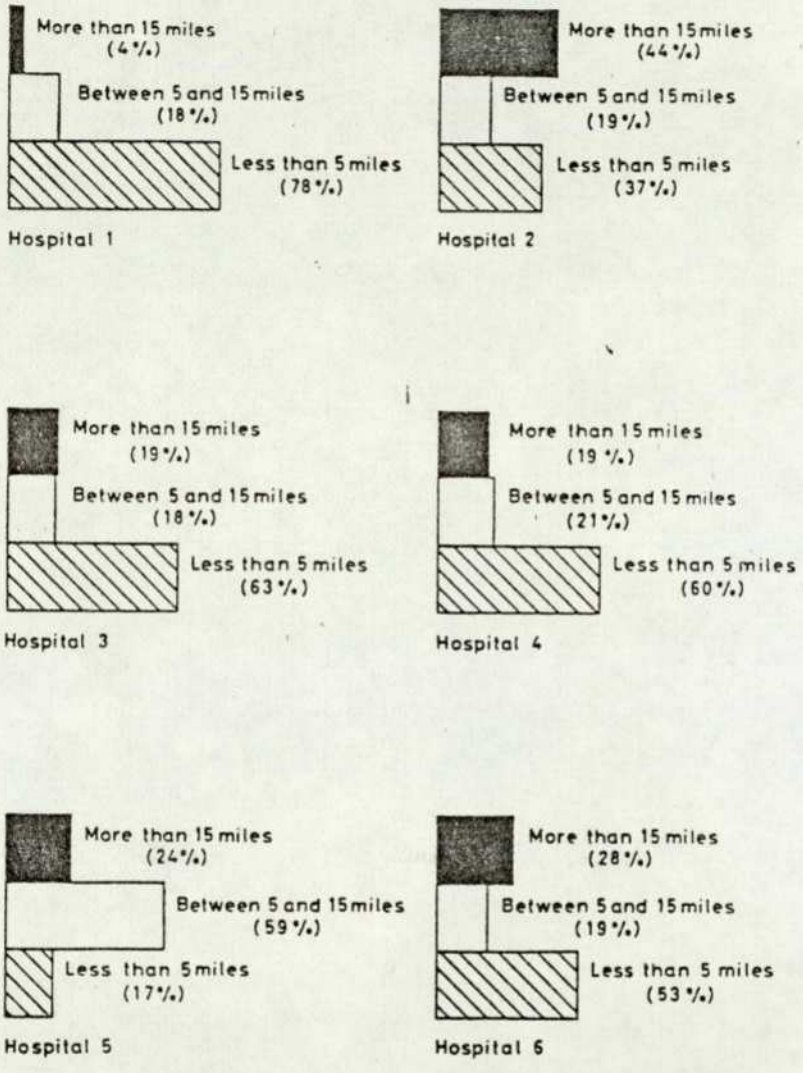


TABLE 97

Out-patients' cost of return journey to hospital by social class

Cost of return journey	Social Class							Total
	I	II	III	IV	V	VI	Not stated	
£1 or more	3	16	27	9	3	2	-	60
10/- less than £1	7	25	52	21	3	2	2	112
5/- less than 10/-	15	37	85	34	12	5	3	191
2/- less than 5/-	27	66	226	68	33	7	4	431
1/- less than 2/-	8	22	147	65	31	1	6	280
Less than 1/-	7	9	90	33	14	3	5	161
Not known	2	2	5	1	-	-	1	11
Nothing	4	23	120	63	24	8	5	247
Not answered and Not applicable	-	3	7	4	1	4	12	31
Total	73	203	759	298	121	32	38	1,524

TABLE 98

Patients' statements about loss of working time

Loss of working time	Percentage of patients losing working time by hospital						Total
	1	2	3	4	5	6	
	%	%	%	%	%	%	%
Less than half a day	12	12	15	12	11	8	12
Half a day	6	19	10	16	10	11	12
One whole day	4	8	3	4	7	3	5
Other, incl. self employed	3	1	-	1	3	-	1
No working time lost	34	7	20	11	8	16	17
*Not applicable	38	51	52	53	61	62	51
Not stated	3	2	-	3	-	-	2
No. of patients (100%)	318	324	226	270	145	241	1,524

Table 98 shows the loss of working time due to out-patient attendance and in Table 99 the duration of the journey is related to loss of income.

TABLE 99

Duration of journey and loss of income

Duration of journey	Percentage of patients giving details of income loss					Total
	No	Yes	Don't know	Other	Not stated/ Not applicable	
	%	%	%	%	%	%
Less then 10 mins.	21	22	-	12	15	18
10 mins. to 20 mins.	32	28	50	25	25	29
20 mins. to 30 mins.	24	20	50	13	20	22
½ hr. to less than 1 hr.	18	19	-	25	26	21
1 hr. to less than 2 hrs	5	8	-	25	10	8
2 hrs. or more	-	3	-	-	2	1
Not stated/ Not applicable	-	-	-	-	2	1
No. of patients (100%)	750	148	4	16	606	1,524

Patients preferences

In line with the discharged in-patients, 53% of the out-patients stated a preference for hospital care. Answers by both groups were given in answer to a hypothetical question 'If you had the choice of ..... (appropriate alternatives for the two groups being inserted), which would you prefer?'. Answers to hypothetical questions are notoriously unreliable and the findings must be interpreted in this awareness.

The reasons for preferences given were so similar for both

groups that they have been merged. They were recorded verbatim and a cross-section is shown below: most of the reasons for hospital preference were positive points in favour as, for example, 'they have all the facilities', 'they give you confidence', 'I like the surgeon', 'they have the best people'. Just a few patients selected the hospital because the alternatives were even worse. 'Impossible at home with the kids and my doctor has no facilities' or 'no-one at home to help and my doctor is rushed off his feet as it is' or 'the surgery is crowded and full of smoke and chatter'.

Home care appeared to be preferred by the older people and by those who felt less well; 'I'd love to stay at home' or 'the journey gets me down' or 'hospital always scares me a bit' or 'I hate all that waiting' were some typical comments. The most frequent comments for hospital care implied the lack of help in the home. Several patients said that somebody ...., husband, daughter, etc., would have to stay home from work, which would cause hardship. A higher proportion of men opted for home care than women, but the difference was not significant.

The patients who chose the doctor's surgery as the most acceptable alternative were, in most cases, those who had been in the care of their doctor for a long time and knew him very well and those who had found the doctor interested and attentive. These points were reflected in answers such as 'he has been my doctor for 40 years, I'd let him do anything to me' or 'he takes a real interest in his patients' or 'he doesn't mind what he does or when he is called out'.

It became clear that for most patients the hospital epitomised skill and knowledge and, therefore, patients did not seem to mind the inconveniences or other disadvantages which hospital care entailed for some of them. If any transfer from hospital to community care were to be achieved without causing concern to patients that they might be

having a 'second best' type of care, a change of attitude by all concerned was seen to be needed. It was also considered necessary, as alluded to in Chapter 6, to discover the views of the GPs and whether the district nursing service would be able to cope with additional work. Some GPs had indicated that, in order to make an extension of community care possible, district nurses would have to be available to spend more time with patients. The study suggested that this could be achieved. However, it was considered by the investigator that a helpful way to change attitudes of at least a small number of professionals and to increase their confidence in each other's contribution, was to mount a limited demonstration experiment. It was its success in achieving the above objectives which caused the investigator in the concluding discussion to suggest demonstration studies as useful further research.

INTERVIEWING SCHEDULE FOR DISTRICT NURSES

DISTRICT NURSES' SCHEDULE

QUEEN'S INSTITUTE OF DISTRICT NURSING

Area	Col. 1	D.N. Code	Col. 2	Col. 3	Col. 4

Please place a cross opposite the answer you wish to give

Question	Answer		For official use only
1. Are you employed on a full-time or part-time basis?	Full-time		5
	Part-time		
2. Which branches of public health nursing do you cover?	General Nursing		6
	Midwifery		
	Health Visiting		
	Other (specify)		
3. Are you attached to a general medical practice?	No		7
	Yes, fully seconded		
	Partially attached		
	Other (specify)		
4. What are your professional qualifications?	S.R.N.		8, 9
	S.C.M.		
	S.E.N.		
	H.V.		
	R.M.P.A. or R.M.N.		
	Dist. Nursing Cert.		
	Other (specify)		
5. What is your date of birth?			10
6. What is your sex?	Male		11
	Female		

Now a few questions about your opinion regarding district nursing

Question	Answer		For official use only
7. Do you feel that your professional training fitted you for your present job? If no, please explain on the back of this form	Very well		12
	Fairly well		
	Not at all		
8. Do you feel that your professional training is being utilised?	Always		13
	Nearly always		
	Occasionally		
	Hardly ever		
	Not at all		
9. Do you feel that your work load is suitable?	Yes, just right		14
	Rather heavy		
	Could cope with more work		
	Type of work unsuitable		
	Other (specify)		
10. Do you get opportunity to meet other members of the health and welfare services?	Very frequently		15
	Fairly frequently		
	Hardly ever		
	Never		
11. Do you have direct contact with hospital staff?	Very frequently		16
	Fairly frequently		
	Hardly ever		
	Never		
12. Could you estimate how many times you had direct contact with hospital staff about your patients within the last month?			18

COMMENTS ON ANY MATTER RELATING TO THE DISTRICT NURSING SERVICE

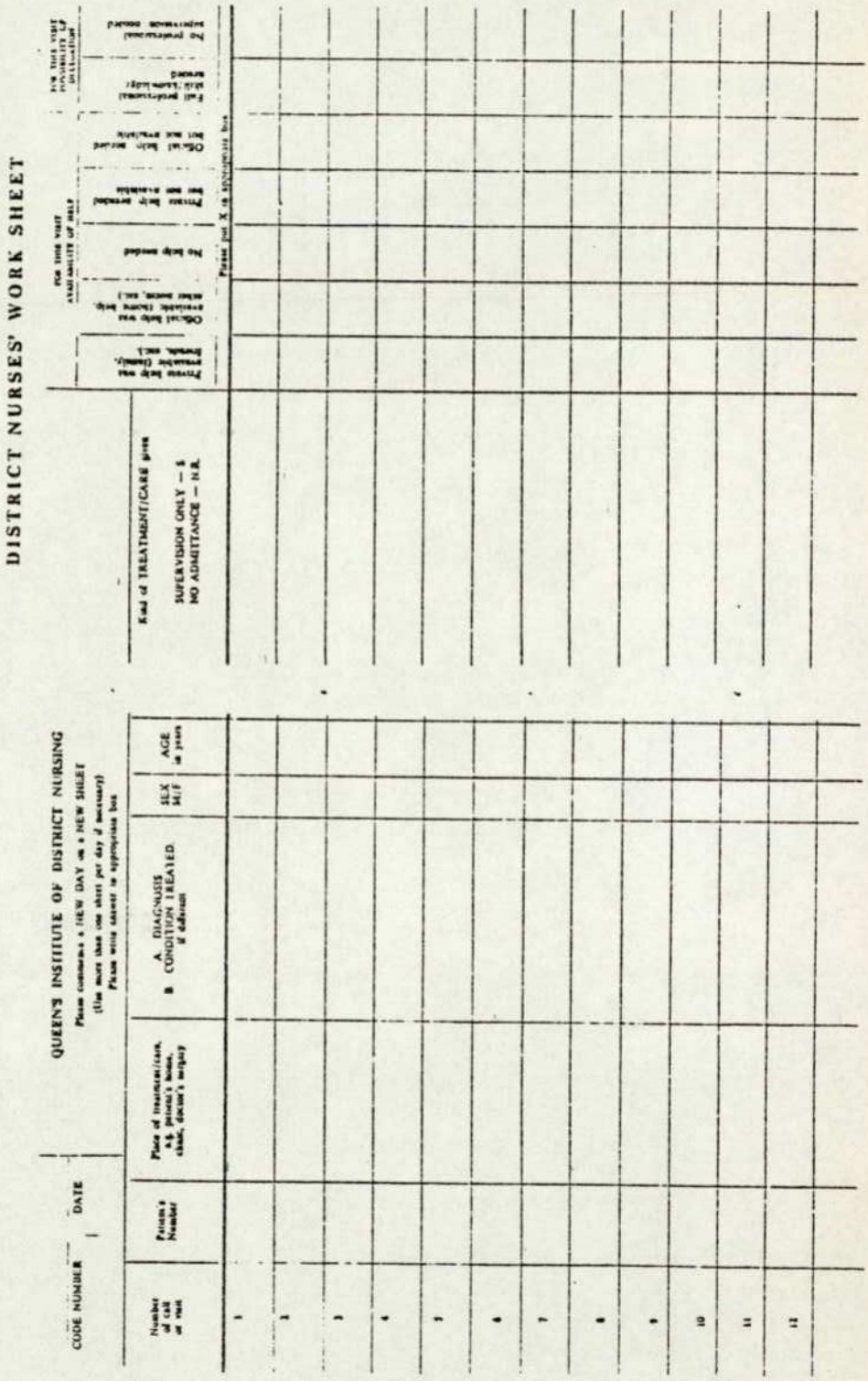
Did you have anything further to say about question 7?

Is there anything else you would like to say?

Please feel free to comment on any matter relating to the district nursing service, but do not feel obliged to do so.

ANNEX 2b

DISTRICT NURSES' WORK RECORD SHEET



ANNEX 3

DATA RELATING TO CHAPTER 7

During the period of the experiment, 126 patients were discharged from hospital 'early', that is earlier than would normally have been the case, and were subsequently discharged from district nursing care. Patients who were still receiving such care are not included in this report. One patient who had been in hospital twice during the 15 week period for two unrelated procedures is counted twice in the hospital statistics but she completed only one questionnaire.

The patients were discharged from five wards, three male and two female. The three male wards totalled 67 beds, the female wards 52 beds. Table 100 shows the age and sex distribution of the discharged patients. Although the potential number of male patients for the scheme, based on the number of beds, was greater than the number of female patients, in the actual number of discharged patients the women out-numbered the men by more than two to one.

TABLE 100

Age and sex distribution of patients

Age groups	Male	Female	Total
0 - 14	2	3	5
15 - 20	3	15	18
21 - 30	3	8	11
31 - 40	10	10	20
41 - 50	7	16	23
51 - 60	12	11	23
61 - 70	2	9	11
71 - 80	1	10	11
80 +	1	3	4
Total	41	85	126

One would expect that it would be easier to discharge men, some of whom might have spouses available to care for them at home. It may be, however, that, for one reason or another, women are more anxious to resume their normal routine of life than men. If more information about the patients who did not opt for early discharge were available, one might have been able to compare the two groups on several variables. This was, however, considered to be outside the scope of this particular experimental study.

Length of hospital stay.

One of the aims of the experiment was to show how many bed days could be saved by discharging patients earlier than would normally have been the case, to receive their after-care from the local authority district nursing service. The number of days thus saved are referred to as 'early' days.

Any calculation of 'early' days must be to some extent hypothetical. The hospital secretary provided this information for each patient based on: -

(a) The usual period of hospitalisation for the specific procedure.

(b) The condition of the specific patient, as assessed by the consultant.

On that basis the total number of 'early' days for the 126 patients in the scheme was 590, which is an average of 4.7 days per patient. The length of hospital stay tends to be determined by custom, which varies between one hospital and another. The figures for 'early' days obtained from this particular scheme cannot, therefore, be applied to all hospitals, but only to those where a similar custom prevails and where the 'normal' length of stay is similar to that at the hospital in the scheme. Comparative statistical hospital data are presented in Table 101 .

TABLE 101

Comparative Statistical Hospital Data

Data	Hospital in experiment	Relevant Hospital Region	National Average
Average stay per case in days 1968 - 1969	9.3	10.5	10.7
% occupancy of staffed beds 1968 - 1969	87	81	79
Cost per in-patient week 1968 - 1969	£43/1/7	£47/0/3	£50/5/5
Cost per in-patient case 1968 - 1969	£57/5/2	£70/5/6	£76/15/1
Cost of dressings per in-patient week	£0.19	-	-

Sources: Hospital Costing Returns, Year ending March 31st 1969.
Summary of Hospital Costing Statements for the Regional Hospital Board, Year ending March 31st 1969.

The saving of bed-days would occur in the interval between operation and discharge - the post-operative stay, which in Table 102 is related to the patient's age group and in Table 103 the surgical procedure. (page 357).

The marked increase in the length of post-operative hospitalisation for patients after the age of 50 may have a variety of reasons. It is probable, however, that it is due to the inclusion of patients who had a cholecystectomy or laparatomy performed, for which post-operative hospital care was generally longer. The average age of the former group of patients was 52 years and of the latter 64 years.

TABLE 102

Age group by interval between operation and discharge

Age group	Length of post-operative stay (in days)											Length of average post-operative stay (in days)	Total number of patients in group
	Day case	1	2	3	4	5	6	7	8	9	10 or more		
0 - 14			2		1	1	1					2.8	5
15 - 20	1		1	2	1	5	4	1		1	1	4.5	18
21 - 30	2			2	1	2	1	2	1			3.5	11
31 - 40			4	7	1	2	1		2	2	1	3.7	20
41 - 50	1		6	5		2	3	2		2	2	3.9	23
51 - 60			1	2	5	1	1		1	2	6	6.5	23
61 - 70	1		1		1			1	1	1	3	6.6	11
71 - 80			1	1		3	1	1		3	1	5.7	11
81 and over			1	1							2	5.8	4
Total	5		17	20	10	16	12	7	5	6	12 16	4.0	126

The number of patients in individual categories is too small to justify generalisations as to whether some surgical procedures can be expected to yield more 'early' days than others. However, in this experiment 'repair of anal fissure' was the operation after which the length of in-patient care was reduced most because of the special scheme and which, therefore, yielded the most 'early' days.

One might expect the number of 'early' days to be in some direct proportion to the overall length of stay, so that for a longer period of hospitalisation relatively more days could be saved. This would be a reasonable expectation on the assumption of gradually diminishing need for nursing care. The experiment, however, did not support this and there was no discernible connection between the two variables. As an illustration, for two of the four patients whose hospital stay was 20 days or more, less than six days per

patient were saved, whereas for four of the 22 patients who were in hospital for one day or less, six or more days had been saved.

TABLE 103

Length of post-operative hospital stay for nine most frequent surgical procedures.

Surgical procedure	Shortest post-operative stay (in days)	Longest post-operative stay (in days)	Average post-operative stay (in days)
Appendicectomy	2	10	5
Herniorrhaphy	2	12	6.4
Excision of cyst of breast	0	4	1.8
Excision of tumour	1	5	2.1
Cholecystectomy	7	16	10.1
Various surgical procedures for varicose veins	1	4	2.7
Mastectomy	1	10*	6.4*
Repair of anal fissure	0	6/	2.4/
Laparotomy	6	18	12.2
Overall for nine procedures	2.2	9.4	5.0

* Excludes one patient who was in hospital for 29 days after a complicated mastectomy and ischaemic lesion.

/ Excludes one patient who was in hospital for 16 days after the operation.

District nursing care.

The 126 patients together had just under 700 district nursing visits, that is an average of roughly 5.5 visits per patient, between the day of discharge from hospital and discharge from the district nurse's visiting list. Most patients were visited daily, at least for the first few days; occasionally it was necessary to visit twice a day. This was, of course, dependent on the type of care needed and Table 104 shows that the surgical procedure most demanding

of nursing care was 'repair of anal fissure'. This was also the condition for which most hospital bed days had been saved.

TABLE 104

Amount of district nursing care for patients after most frequent surgical procedures

Surgical procedure	Average No. of days on district nurse's books	Average No. of visits by the district nurse
Appendicectomy	7.1	4.2
Herniorrhaphy	10.1	4.6
Excision of cyst of breast	8.8	4.1
Excision of tumour	11.1	4.5
Cholecystectomy	10.9	5.6
Treatment of varicose veins	21.6	8.5
Mastectomy	20.5	13.1
Repair of anal fissure	29.8	32.0
Laparotomy	9.6	6.6

One must particularly welcome the possibility of this type of patient being discharged to the privacy of his own home. Not only post-operative treatment but also bowel training may be unpleasant and may cause the patient considerable discomfort. It would seem easier to cope with this in a suitable private house. As there were only six patients in the sample who had had this type of surgery it is not possible to draw general conclusions. It is worthy of comment, however, that four of these patients spontaneously commented on their preference for the privacy which their own home afforded.

Almost all the district nurse's visits were for the purpose of giving some specific kind of nursing treatment, mostly a surgical dressing. The district nurse was also responsible for the removal of

sutures or clips. All equipment such as clip removers, special stitch scissors, mosquito forceps for the removal of fine sutures, aspirating sets, dressings, lotions and bandages were provided by the hospital.

Nearly all the patients (120) were discharged from the district nurse's visiting list because they no longer required care at all. Although the remaining six patients were re-admitted for hospital care, in only one case might this have been due to the early discharge. This was a patient who had an embolism. Further hospital treatment had been planned for four of the others, whilst the fifth had contracted another disease altogether which required hospital care.

As one would expect there was a clear relationship between the average number of 'early' days and the average number of days a patient was kept under the district nurse's care, which is shown in Table 105 .

TABLE 105

Average number of days on district nurse's books by number of 'early' days.

Number of 'early' days	Average number of days on district nurse's books.
One	6.0
Two	6.4
Three	10.7
Four	11.4
Five	13.3
Six	15.3
Seven	18.0
Eight or more	22.6

The attached district nurse.

A detailed analysis of one week's work undertaken by the district nurse is shown in Table 106 and Table 107 .

As Table 107 indicates, the district nurse did a ward round with the consultant each day except Sunday. She then talked individually with the patients who were due for discharge and arranged her first home visit with them. Apart from giving the necessary nursing treatment she was, of course, able to give encouragement and support to the patient and his family. She was also responsible for the collection of specimens where appropriate and for the delivery of these to the hospital's pathological laboratory. Some of her working day was used for communication with doctors and colleagues at general practitioners' surgeries and the health centre. It was administratively important to keep the designated district nurse integrated in the local authority nursing staff team, particularly as her special experimental function was of a temporary nature.

Table 106 Time analysis of district nurse's week

Day	*Time spent on visits*	*Time spent on ward rounds and interviews with patients in hospital*	*Time spent at health centre*	*Time spent on record and book keeping*	*Time spent at lunch*	*Time spent travelling*	*Total length of working day*
	hrs mins	*hrs mins*	*hrs mins*	*hrs mins*	*hrs mins*	*hrs mins*	*hrs mins*
1	3 25	1 30	- 5	- -	1 15	1 35	7 50
2	3 40	1 35	- 15	- -	1 -	1 15	7 45
3	3 20	1 25	- 15	- -	1 -	1 20	7 20
4 half day	3 -	1 5	- -	- -	- -	- 40	4 45
Sunday	- -	- -	- -	2 -	- -	- -	2 -
5	3 35	1 40	- 20	- -	1 -	1 20	7 55
6	1 55	1 55	- 45	2 -	- 45	1 40	9 -
7	3 -	2 10	- -	2 -	- 40	1 40	9 30
Average for week	3 30	1 45	- 15	- 55	- 50	1 25	8 40

In Table 106 the time analysis is given. The length of the working day, though inclusive of meals, may seen excessive. This was due to the record keeping entailed in the experiment. One would not expect a district nurse in the normal course of her work to have to spend an average of almost an hour daily on book and record keeping.

It can be argued that the proportion of time spent on travelling is rather high (17%) but it compares favourably with the normal travelling time of district nurses both in conventional geographic or attachment settings. The travelling time was, of course, increased because one district nurse was responsible for the after-care of all patients discharged under the experimental scheme. There is no reason why this type of work should not be absorbed by the whole district nursing service, the patient being cared for by either the nurse who covers his home area or who is attached to his general practitioner. This would be a desirable development.

In this case the district nurse was not only particularly interested in surgery but was also experienced in district nursing. Even so, and just because she had been in the district nursing service for a number of years, she needed some instruction in the more recently developed technical procedures and instruments as well as new drugs. She mentioned some of the additional knowledge she acquired during her initiation period. In her own words, 'I was shown various equipment, e.g., the Zimmer Drain and Roberts' Pump. The different types of sutures - continuous and intradermal. The house surgeon explained how to remove sutures and nylon splint following epididymo-vasostomy.'

The period of initial instruction was invaluable to the district nurse and necessary if the surgeon was to trust her completely to provide continuity of care. It would seem, therefore, that all district nursing staff involved in this type of care need regular

Table 107 Breakdown of nurse's work for seven days (Wednesday to Wednesday inclusive)

Day	*No. of visits*	*No. of patients visited*	*No. of new patients*	*No. of discharges*	*No. of dressings*	*No. of removals of sutures*	*Other reasons for visits*	*Ward rounds*	*Interviews with patients in hospital*	*Visits to health centre*	*Other calls*
1	7	6	1	–	6	–	Antibiotic therapy	1	1	1	G.P. surgery
2	7	7	1	1	7	–	–	1	1	1	–
3	7	7	1	3	3	1	–	1	–	2	–
4 half-day	6	6	–	1	4	1	–	1	–	–	Ambulance Station
5	6	6	–	–	4	2	–	1	–	1	–
6	4	4	–	–	3	1	–	1	2	2	Hospital Pathologist
7	6	6	3	–	5	–	Collection of pathological specimen	1	2	–	–

The week was abnormal in that it included six and a half working days, but the proportional distribution of work was described as average.

learning periods in hospital. This would increase mutual respect between members of staff inside and outside hospital, it would enhance the understanding of each other's roles and would keep the district nursing staff technically competent.

The district nurse in this experiment obviously enjoyed this new dimension to her work. She appreciated particularly the detailed information about each patient and the opportunity to discuss the patients' treatment and care with the hospital staff. This suggests that a closer working relationship between the hospital and district nursing service is likely to result in improved job satisfaction and greater confidence of the district nurse which might ultimately well be reflected in a higher standard of patient care.

The patients' views.

The results of an experiment such as this must be assessed from different viewpoints, not least important being those of the patients themselves. As explained in the description of the method, the patients were sent brief questionnaires asking for their views and comments. One hundred and six patients co-operated and this response rate of 84% for a postal enquiry among the general public is encouraging.

In the interpretation of the patients' answers it must, however, be borne in mind that they constituted a biased sample, in as much as they had volunteered to take part in the experiment by agreeing to go home 'early'. On the other hand, the option to do so had been presented to them partly as means to ease the pressure on hospital beds and it is, therefore, reasonable to assume that some patients accepted the option because they felt morally bound to do so. Some of their answers and added comments supported this assumption. Eighteen patients said that they were 'not at all glad' at the thought of going home and seven had actually been worried about it. Four of these were

under forty, and the other three over sixty-five years of age. Two of the younger group were patients who had undergone diagnostic surgery, one an exploratory laparotomy and the other a biopsy. Their uncertain future might well have increased their anxiety. It is worthy of note that only one of the patients who were worried had requested the general practitioner to visit.

Table 108 shows how the patients felt at the time of the postal enquiry. As can be seen only four patients felt that they were not as well as could be expected. Two of these were the patients mentioned earlier who had undergone diagnostic surgery and the third patient had also had a laparotomy which had led to an unfavourable prognosis.

TABLE 108

Patients' state of well-being.

Reply to the question: 'How are you?'	Number of patients replying
Very well indeed	57
Fairly well	30
As well as can be expected	15
Rather poorly	4
Very unwell	-
No response	20
Total	126

The patients were asked for their opinion about the length of their hospital stay and their answers are shown in Table .

It seems somewhat contradictory that patients who had opted for early discharge should yet have felt that their hospital stay had been too short. Two main reasons are likely to be responsible for this. First, it is quite possible for patients to feel reasonably well in hospital and to anticipate their discharge with pleasure, but, once they get home, to miss the constant availability of help which gives

them security. Secondly, as commented earlier, some of the patients had obviously agreed to early discharge in a half-hearted way, because they did not want to add to the bed shortage.

The first group were represented by comments such as: 'I was anxious to get home to the children, but I found the noise upset me - my children are 9 and 5 - and I think a day or two more in hospital would have been beneficial'; 'I thought I was better than I was but when I got home I felt a bit worried'.

TABLE 109

Patients' age groups and their opinion about length of their hospital stay.

Age group	No. of patients who thought length of hospital stay was:			No response	Total
	Too long	Too short	Just right		
0 - 14		1	1	3	5
15 - 20		1	12	5	18
21 - 30		4	6	1	11
31 - 40	1	2	16	1	20
41 - 50		1	18	4	23
51 - 60		2	17	4	23
61 - 70	1	2	7	1	11
71 - 80	2	3	6		11
81 and over			3	1	4
Total	4	16	86	20	126

Other studies have suggested that patients feel more helpless after their discharge home from hospital than either they or the hospital staff anticipate (Skeet 1970[13], Roberts 1975[14]).

Some of the patients who were sensitive to the great demand for beds appeared to have their reasons for judging their hospital stay as 'too short' more on convention than experience: 'I only had my operation the afternoon previously'; 'I still had my clips in, but

they needed my bed'.

Two of the four patients who thought that they had been in hospital too long had not come to terms with the atmosphere of the hospital ward: 'I was upset by the troubles of other patients'; 'I just didn't like being in a ward'. The third patient indicated that the care she needed could easily be provided in her home, thus freeing her bed for someone else; the remaining patient in this group did not give a reason.

The 86 patients who considered their hospital stay just right advanced two main types of reasons, fairly evenly distributed in the sample. They either considered that they were sufficiently well to go home or that the hospital made adequate provision for their after-care and it was, therefore, right that they should have gone home when they did. Five of the six patients who had been worried at the thought of going home were in this latter group. The district nurse who continued their care had obviously relieved their anxiety.

It was thought that patients who needed a great deal of nursing after their discharge from hospital might, on a future occasion, prefer to go to a convalescent home where nursing care is readily available. Table 110 shows that this was not so. The average number of days on the district nurse's books for patients who preferred to go to their own home rather than to a convalescent home was higher rather than lower, although the differences were minimal. It must be remembered that the group of patients who preferred to go home with district nursing care included those who had a repair of anal fissure whose emphasis on the need for privacy has already been mentioned.

TABLE 110

Patient's preference by amount of district nursing care

Patient's preference	Average number of days on the district nurse's books.	Average number of visits by the district nurse
Convalescent home	11.4	7.6
Own home with visits from district nurse	13.2	7.7
No preference	11.6	7.5
No response	10.9	5.2

These data continue to support those given in Chapter 7 in the general acceptability and benefits of the 'early' discharge and 'follow up' of certain categories of surgical patients.

ANNEX 4

STATEMENT OF DEFINITIONS SENT TO GENERAL PRACTITIONERS

As explained in our covering letter we hope, by means of this questionnaire, to obtain the views of general practitioners about some aspects of the community nursing services. More particularly, we would like to know how doctors feel about the employment of State Enrolled Nurses, as this information is essential for the planning of community care

DEFINITION OF TERMS (To avoid misunderstanding)

'State Enrolled Nurse' (SEN)

A nurse who has successfully completed a training course of two years in basic nursing care and simple technical procedures, has passed a statutory examination and whose name has been included in the Roll of Nurses maintained by the General Nursing Councils. Some older SENs were enrolled by virtue of their experience which must have been gained before 1949. Some SENs are also qualified midwives. Our questions do not refer to such SENs employed in the midwifery service. Some SENs working in the domiciliary field have undertaken an additional course of approximately ten weeks in district or public health nursing. This is not compulsory.

'State Registered Nurse' (SRN)

In Scotland 'Registered General Nurse' (RGN)

A nurse who ha s successfully completed a training course of three years, which includes more theory than the SENs course and more advanced technical procedures, has passed a statutory examination and whose name has been included in the Register of Nurses maintained by the General Nursing Councils. Some SRNs working in the district nursing service have undertaken an additional course of 12 or 16 weeks in district nursing. This is not compulsory.

'Health Visitor'

State Registered Nurse who has successfully completed an additional course of one year and has passed a statutory examination approved by the Council for the Education and Training of Health Visitors. The health visitors certificate is compulsory for licence to practise health visiting.

Auxiliary Staff

Are workers without full professional qualifications although many local authorities provide some in-service training for them. They may be employed in any branch of the service to assist the qualified workers. They are sometimes called nursing aides, bath attendants, hygiene attendants or washers depending on the work allocated to them.

Attachment

Is an arrangement by which the local authority seconds workers to a general medical practice to care only or mainly for the patients on the list(s) of the respective general practitioner(s).

ANNEX 5

FURTHER ANALYSIS AND USE OF THE DATA IN THE NATIONAL DATA BASE

At the request of the Department of Health and Social Security the national survey of the state enrolled nurse in the community nursing services which covered the United Kingdom was re-analysed in order to extract data specific to England. The findings were reported in 'District Nurses in England'.[16].

The Department's objective in making this request was to obtain data about the district nurses in England as a companion report to a study of health visitors which had been undertaken independently and two years earlier.[212].

The reason for including a small part of the further analysis as an annex is to show how the initial sampling method adopted in the national study added to this further usefulness of the data.

In line with the request from DHSS to isolate from the U.K. survey information relevant to England alone, data relating to the English local health authorities were extracted. In the original survey these authorities represented a proportion of a total U.K. random sample drawn with a probability proportional to population after stratification by region and type of area. However, as Scotland, Northern Ireland and Wales were treated as separate regions for the purpose of stratification, the principle of the original sample design is preserved in spite of the removal of the non-English regions for the purpose of this report.

The initial sample of the U.K. included 50 local health authorities of which three were drawn twice. The English authorities numbered 36, as follows: -

Durham	Norwich C.B.
Yorkshire N. Riding	Buckinghamshire
Teesside C.B.	Essex
Yorkshire W. Riding	Hampshire
Doncaster C.B.	Kent
Sheffield C.B.	Oxfordshire
Cheshire	East Sussex
Lancashire	Southend-on-Sea C.B.
Bootle C.B.	Bromley L.B.
Manchester C.B.	Enfield L.B.
Part of Derbyshire	Havering L.B.
Northamptonshire	Lambeth L.B.
Leicestershire C.B.	Redbridge L.B.
Staffordshire	Wandsworth
Warwickshire	Oxford C.B.
West Bromwich C.B.	Part of Dorset
Birmingham C.B.	Somerset
Cambridgeshire and Isle of Ely	Bristol C.B.

Two areas were drawn twice, Lancashire and the West Riding of Yorkshire. The population in the English sample presented approximately 45 per cent of the total population of England at the time of the survey.

The focus in this further analysis was on the data obtained from the work record, the design of which is explained in Chapter 9.

The number of work records sent out to nursing staff in England for completion was 732. Of these, 576 were satisfactorily completed and every second appropriate record was fully analysed. This amounted to the work of 287 members of the district nursing staff in England. The response rate relating to the work records is shown below in Table 111, which also indicates reasons for non-completion.

TABLE 111

Response to work records

Response rate for work records	No.	%
Work records sent out	825	100
Work records returned	682	82.8
Work records completed	576	69.8
Work records where reasons were given for non-completion of work records	91	11.0

Reasons given for non-completion of work records	No.
Nurse had resigned or retired	32
On holiday or other leave	24
Sick leave (one nurse was away looking after a sick member of her family)	21
Type of work was not appropriate to the study (e.g., HV Assistants)	14
Total	91

The health visitor companion study in London (Marris 1969)[212].

In the London Health Visitors Report the study areas had been grouped into Central, Middle and Outer Boroughs. The distribution of the population for this study in the whole of England afforded a number of possibilities in relation to grouping of areas. It was finally decided, for ease of presentation, to group the areas as follows: -

1. London Boroughs 6
2. County Boroughs 12
3. County Councils 18

It is appreciated that this might have been a somewhat arbitrary division; it was justified by the stratification method adopted

in the original study.

Owing to the sample design, which was in keeping with the objectives of the original study, SENs are over-represented and for this reason the two groups were kept disparate in most analyses.

Table 112 shows the total numbers of enrolled and registered nurses employed in the English research areas in 1971 when the study was undertaken. Employment figures in 1973 are included to show the changes in the subsequent two years.

The changes show a considerable increase of enrolled nurses especially in relation to the increase in registered nurses over the same period. Thus, in the County Council areas the increase of SENs was 32 per cent against 6 per cent of SRNs; in the County Borough areas the increase of SENs was 31 per cent against 7 per cent of SRNs and in the London Boroughs, SENs increased by 55 per cent against an increase of 3 per cent of SRNs. Taking the areas overall, there was a general increase of 10 per cent of all community nurses, representing 33 per cent enrolled and only 6 per cent registered nurses.

It can be argued, therefore, that the predominance of SENs in the study which was in line with the objectives of 'Use or Abuse?'[4] may result in more useful pointers to the realities of the service than had been assumed.

All the data presented for the U.K. in Chapters 10 and 11 were extracted for England only.

The further analysis of the data afforded the opportunity to compare nurses' activities in the different types of areas.

One of the notable variations between the different types of areas were 'on call' periods and, although such periods amounted

TABLE 112

Number of home nurses employed by local health authorities in the study for years 1971 and 1973 (as at 30th September).

	1971				1973				Difference between 1971 and 1973			
	S.E.N.		S.R.N.		S.E.N.		S.R.N.		S.E.N.		S.R.N.	
County Councils	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Buckinghamshire	1	7	15	157	1	10	17	146	nil	3	2	-11
Cambridgeshire & Isle of Ely		8	5	68	-	14	4	63	nil	6	-1	- 5
Cheshire	1	31	8	154	1	32	8	206	nil	1	nil	52
Derbyshire	-	5	-	136	-	11	-	135	nil	6	nil	- 1
Dorset	-	8	2	45	-	6	2	85	nil	-2	nil	40
Durham	-	7	-	117	-	15	-	139	nil	8	nil	22
Essex	2	28	27	213	1	25	30	218	-1	-3	3	5
Hampshire	-	4	3	220	-	21	3	248	nil	17	nil	28
Kent	-	22	6	277	-	33	8	302	nil	11	2	25
Lancashire	4	201	20	442	1	219	21	448	-3	18	1	6
Northamptonshire	-	10	2	88	-	7	3	101	nil	-3	1	13
Oxfordshire	-	6	-	71	-	10	-	75	nil	4	nil	4
Somerset	-	23	7	278	-	33	7	253	nil	10	nil	-25
Staffordshire	-	3	6	128	-	7	7	137	nil	4	1	9
Sussex East	-	14	5	151	3	23	6	154	3	9	1	3
Warwickshire		(8)		(136)	*	*	*	*	*	*	*	*
Yorkshire, N. Riding.	-	4	1	106	-	8	1	110	nil	4	nil	4
Yorkshire, W. Riding.	-	20	-	318	-	58	-	330	nil	38	nil	12
Total: County Councils.	8	401	107	2,969	7	532	117	3150	-1	131	10	181
County Boroughs												
Birmingham	1	70	14	147	3	81	8	160	2	11	-6	13
Bootle	-	1	-	14	-	3	1	15	nil	2	1	1
Bristol	1	23	3	55	-	25	5	64	-1	2	2	9
Doncaster	-	4	-	14	-	9	1	13	nil	5	1	-1
Leicester	2	14	7	56	-	17	3	58	-2	3	-4	2
Manchester	2	37	5	87	-	42	7	92	-2	5	2	5
Norwich	-	-	1	15	-	-	1	17	nil	nil	nil	2
Oxford	-	5	-	24	-	5	-	30	nil	nil	nil	6
Sheffield	-	53	2	110	-	55	2	112	nil	2	nil	2
Southend on Sea	-	-	5	27	1	2	4	34	1	2	-1	7
Teeside	-	-	5	52	-	30	5	61	nil	30	nil	9
West Bromwich	-	3	2	19	-	10	1	17	nil	7	-1	-2
Total: County Boroughs	6	210	44	620	4	279	38	673	-2	69	-6	53
London Boroughs												
Bromley	-	4	2	35	-	3	2	34	nil	-1	nil	-1
Enfield	-	2	4	44	-	4	4	45	nil	2	nil	1
Havering	-	3	8	31	-	7	8	34	nil	4	nil	3
Lambeth	-	15	1	57	-	21	1	57	nil	6	nil	nil
Redbridge	-	4	2	34	-	4	4	38	nil	nil	2	4
Wandsworth	-	5	2	44	1	11	2	43	1	6	nil	-1
Total: London Boroughs	-	33	19	245	1	50	21	251	1	17	2	6
Total: All areas excluding Warwickshire.	14	644	170	3,834	12	861	176	4,074	-2	217	6	240

* Figures not available for Warwickshire in 1973.

Source: DHSS, Statistical Office, London.

to no more than 6 per cent of all activities in any area, in the County Boroughs they were a mere third of that number.

Patient care/contact

The most important activity in the course of a district nurse's day is patient care/contact. Apart from travelling, it was also the most frequently recorded activity and it absorbed most time. Patient care/contact was analysed in considerable detail. Probably the most striking result of the analyses of the nurses' day was the similarity in the frequency of all activities for both types of nurses and in all areas.

Figure 27 was constructed from an intricate detailed analysis of a sub-sample of 200 working days for each type of nurse. It was based on a 'real' working day in a five day week. Owing to the irregularity of 'off duty' periods it was impossible to design a computer programme which could make relevant allowances and the Tables had to be developed from the seven-day week over which the work was recorded.

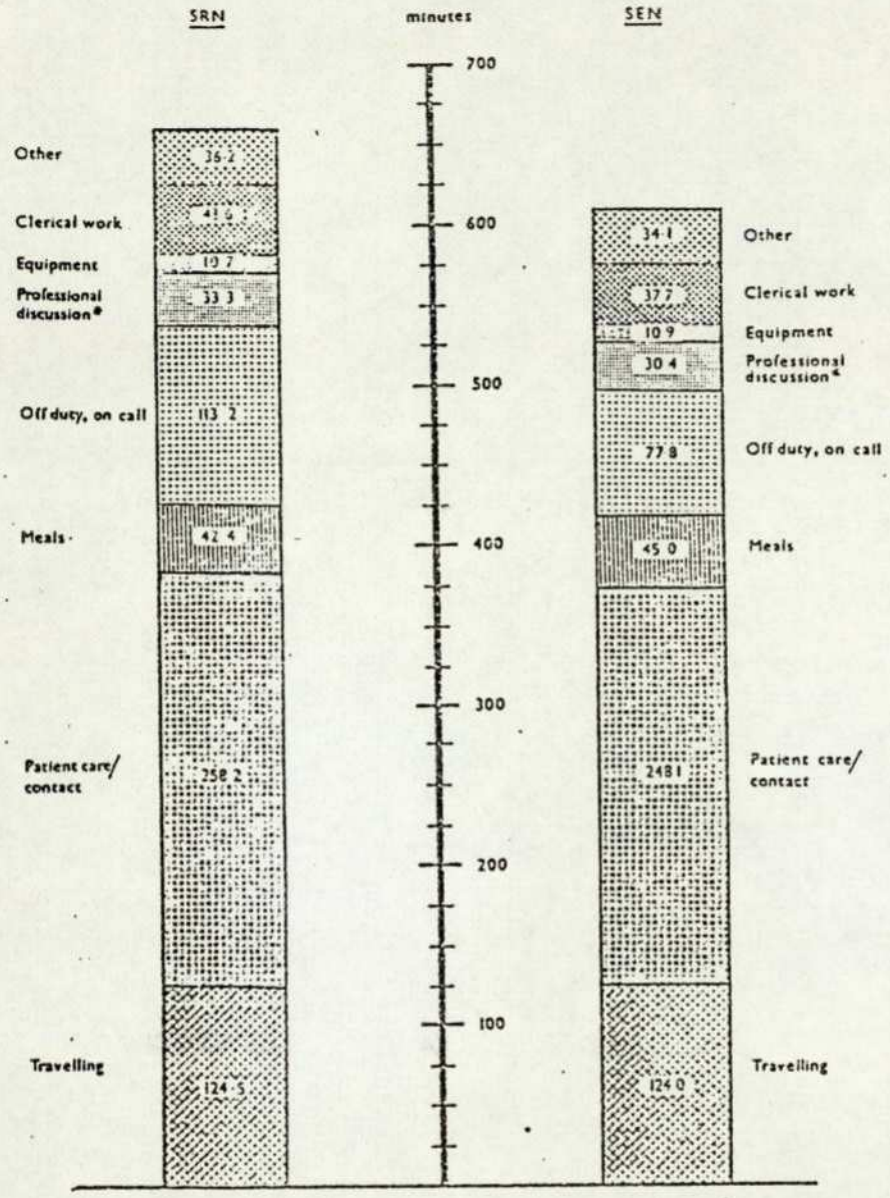
Figure 27 emphasises the similarity in the structure of the working day for all nurses. The day for the SRN is seen to be longer but the difference is accounted for largely by a longer period of off duty 'on call', slightly more professional discussion and clerical work.

The similarities demonstrate yet again the blurring of role boundaries between the two types of workers.

The structure of a working day is not merely determined by the duration of the various activities within it, but also to their timing and distribution through the day.

FIGURE 27

An average working day of district nurses



*Both face to face discussions and by telephone

The peaks and troughs described in Chapter 11 for the U.K. were reproduced for the English study (Figures 28 and 29).

The request by the DHSS was to produce the same analyses of the work of district nurses in England as had been published in the U.K. study. The response to this request represented a very small part only of further possible analyses.

The investigator analysed, for example, the nurses' work preferences in relation to the record of their work.

Of the 268 registered nurses who gave the 'big bath' the last or second last work preference, 82 per cent recorded no such bath in the survey week. Of the 253 enrolled nurses with the same preferences, 66 per cent recorded no 'big bath' in the survey week. Conversely of the 89 registered nurses for whom the bath gained a slightly higher preference ranking 80 per cent recorded three or more instances of this activity with the corresponding finding for the 48 enrolled nurses, being 74 per cent.

Statistical tests are almost irrelevant, given such large differences. They were, however, undertaken and, not surprisingly the differences, using Chi-squared test, were highly significant, that is $p < 0.001$ in each case.

The second type of further analysis compared the work of nurses who gave different patient groups high and low priority ratings. The difference is as striking and again it reached high statistical significance.

Of the 63 per cent enrolled nurses who gave the mobile sick top or second preference rating, almost half (47%) recorded ten or more mobile patients during the survey week; of the 58 per cent registered nurses expressing the same priority 42 per cent recorded ten or more of such patients. Conversely,

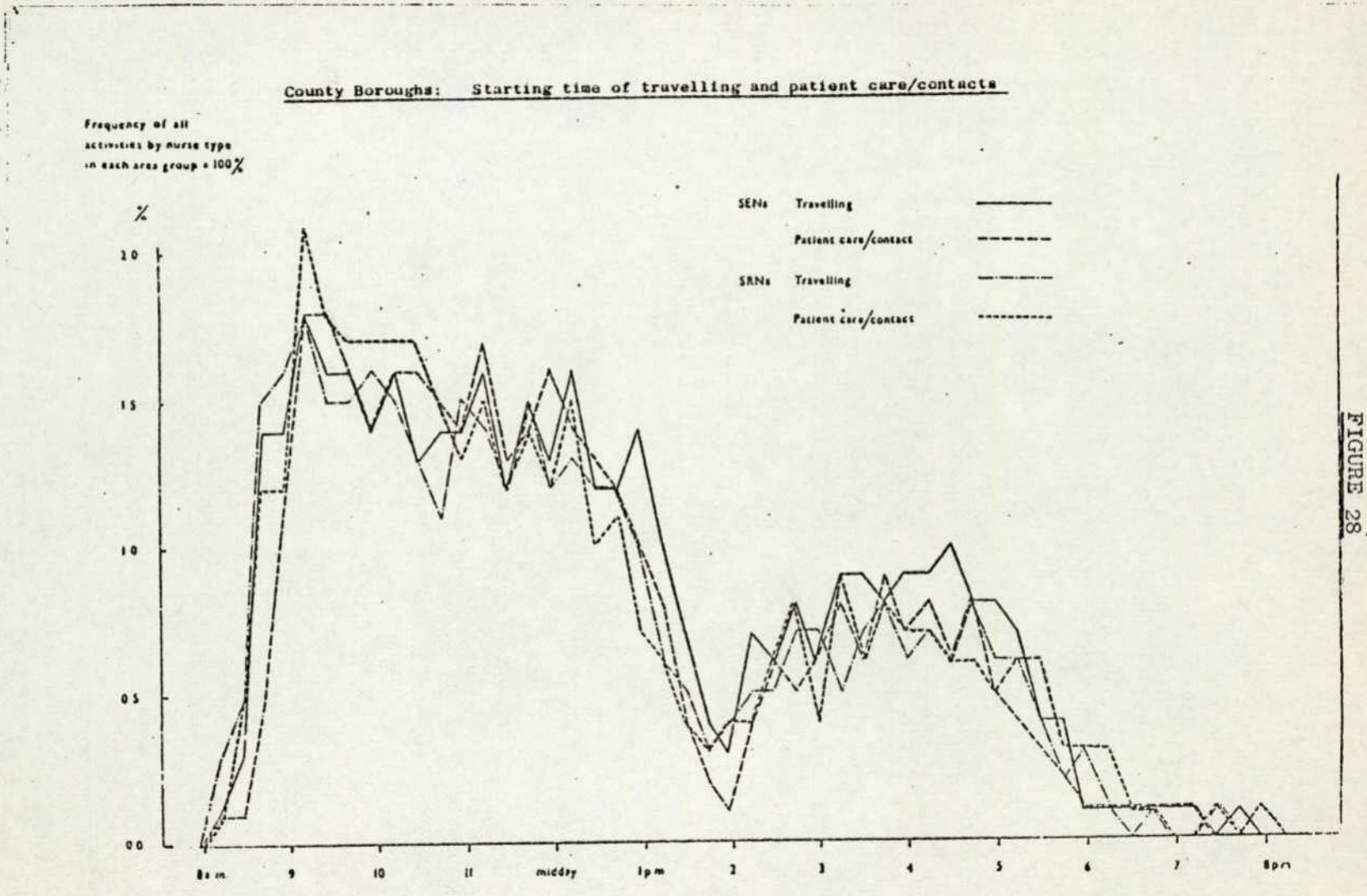
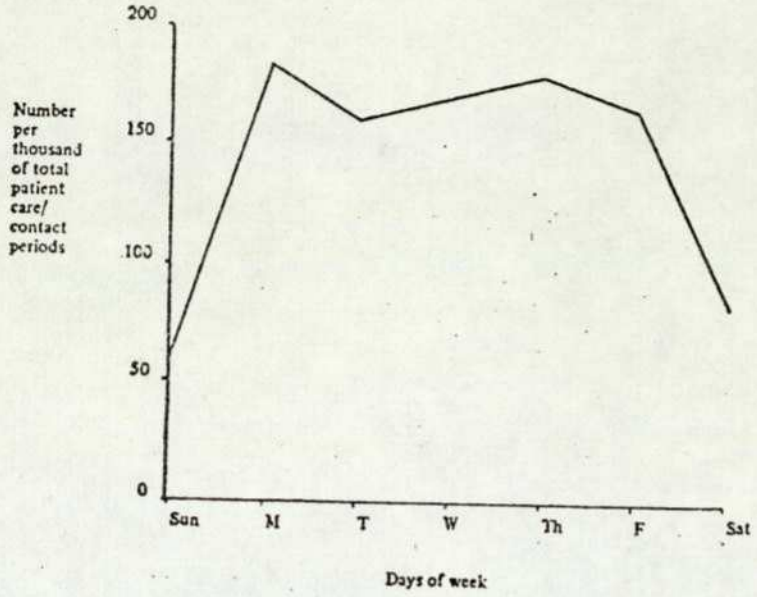
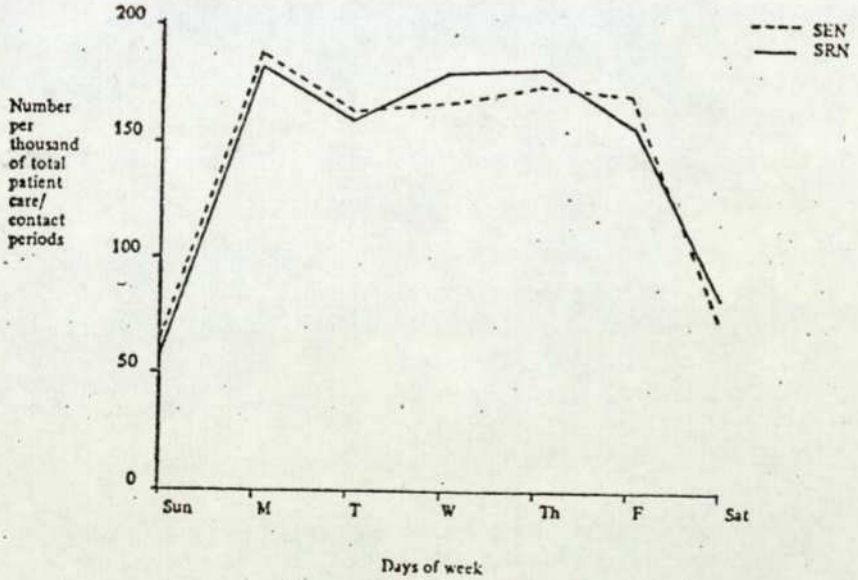

County Boroughs: Starting time of travelling and patient care/contacts
Frequency of all activities by nurse type in each area group = 100%
%
20
15
10
05
00
SENs Travelling
Patient care/contact
SRNs Travelling
Patient care/contact
8a m
9
10
11
midday
1p m
2
3
4
5
6
7
8p m

FIGURE 28.

FIGURE 29



Frequency of commenced patient care/contact periods during survey week.
—shown for all nurses.



—shown for SENs and SRNs respectively.

of the 30 per cent enrolled nurses who gave mobile sick patients the lowest preference rating, one/fifth recorded ten or more of such patients, the comparable figure for the 48 per cent registered nurses being 22 per cent.

A similar analysis was undertaken for priorities regarding the place of work. This analysis was only relevant for registered nurses. It showed that of the 46 per cent registered nurses who wanted to give care only or mainly in the patient's home, 86 per cent did not record care anywhere else. Of the 40 per cent who stated a preference for 'about equal amounts in patient's home and at clinic/surgery', only one third did not record care anywhere else beside the patient's home.

As stated in Chapter 12, there were several registered nurses who could not exercise their choice regarding the place of care as it was dictated by policy. The data do not distinguish between those nurses who would have preferred to give some of the care in a clinic/surgery but were not allowed to do so and those who were able to exercise their choice.

Regarding the interpretation it is also necessary to establish whether nurses who undertake certain types of work often, begin to like it, whether being familiar with a certain type of work makes it easier and, therefore, preferable or whether nurses arrange their work to suit their preferences.

However, what the data suggest, although they do not clearly demonstrate it, is that important aspects in the domiciliary care of patients may be determined either by policy or by the preferences of staff rather than the needs of patients.

The data base provides a foundation for further analyses and testing of relationships. The principle of such a linked

collection of data relating to patients, nurses and their work could be used in other research with similar objectives.

The more subtle issues regarding causal relationships between work preference and work undertaken in situations of choice would need to be explored by more sophisticated methods. This study and its further analysis merely provides pointers to the need for such a progression.

ADDENDUM 1

NUMBER OF NURSE TRAINEES 1963-1977 (BASIC COURSES)

England and Wales

	Total	Students	Pupils
1963	62,605	87%	13%
1964	62,885	86%	14%
1965	63,398	83%	17%
1966	66,609	80%	20%
1967	70,412	78%	22%
1968	71,397	75%	25%
1969	70,212	73%	27%
1970	68,955	71%	29%
1971	70,235	69%	31%
1972	76,537*	69%	31%
1973	74,310	65%	35%
1974	77,816	68%	32%
1975	84,791	66%	34%
1976	92,451	69%	31%
1977	90,815	70%	30%

*Figures inflated by change-over to computer processing.

Scotland

1963	2,280	74%	26%
1964	3,786	68%	32%
1965	4,097	62%	38%
1966	3,980	61%	39%
1967	4,373	59%	41%
1968	4,203	56%	44%
1969	3,806	58%	42%
1970	4,188	58%	42%
1971	4,897	58%	42%
1972	5,141	55%	45%
1973	4,677	54%	46%
1974	4,162	57%	43%
1975	4,879	58%	42%
1976	5,150	60%	40%
1977	4,097	63%	37%

Source: General Nursing Councils for England and Wales and for Scotland Annual Reports.

ADDENDUM 2

DEVELOPMENTAL MILESTONES WITH EMPHASIS ON THE EVOLUTION OF THE STATE ENROLLED NURSE IN THE DISTRICT NURSING SERVICE

1938 The Alness Report

This Report of the 'Scottish Department of Committee on Nursing' recommended that 'the setting-up of a grade of assistant nurse should not be adopted'.

1939 The Athlone Interim Report

This Report of the Inter-Departmental Committee on Nursing Service recommended that 'The grade of nurse known as "Assistant Nurse" should be given a recognised status and placed on a Roll under the control of the General Nursing Council'.

1943 Nurses Act created the statutory title 'ASSISTANT NURSE'. ROLL OF ASSISTANT NURSES was established.

Training of two years was created, but enrolment by virtue of experience was possible.

1949 New Syllabus for the training of State Enrolled Assistant Nurses published by General Nursing Council.

Experience gained after 1949 did not qualify for admission to the Roll.

1954 Report by the Standing Nursing Advisory Committee in the POSITION OF THE STATE ENROLLED ASSISTANT NURSE within the NATIONAL HEALTH SERVICE.

This Report recognised the place of the State Enrolled Assistant Nurse in most fields of nursing provided that she is under supervision of a State Registered Nurse.

1955 Report by The Standing Nursing and Midwifery Advisory Committee (Scotland).

This Report also gives recognition to the place of the State Enrolled Assistant Nurse particularly in chronic sick hospitals. This Report shows greater reluctance and reserve than its English counterpart.

1956 Statement by Royal College of Nursing attributing to the assistant nurse a 'pivotal position'.

1961 Nurses (Amendment) Act 1961

This Act deleted the word 'Assistant' from the official title and thus created the STATE ENROLLED NURSE.

1962 Re-Introduction of Minimum Educational Requirements

For student nurses training for admission to the State Register - a development likely to reduce student nurse recruitment.

1962-63 Experimental Course of Instruction in district nursing for State Enrolled Nurses was pioneered by the Queen's Institute.

Candidates successful in the institute's written and practical assessment were awarded a certificate.

1964 Introduction of Senior Enrolled Nurse Grade in Non-Psychiatric Hospitals recognises ability of some SENs to undertake supervisory functions.

1964 'A Reform of Nursing Education'.

NCN (The Platt Report) suggests that a considerable increase in the proportion of SENs in relation to SRNs will be necessary to meet the needs of the service.

1964 New Syllabus for the training of pupil nurses for admission to the Roll.

1965 Integrated Courses including district nursing in the basic training for the Roll were started.

These courses were arranged by various pupil nurse training schools in conjunction with the Queen's Institute.

The courses had GNC approval.

1966 Implementation of 1964 Syllabus

The syllabus was enlarged to include many technical nursing procedures.

1967 The Queen's Institute relinquished its responsibilities for training.

1970 Circular 8/70 Department of Health and Social Security

This makes provision for 'a national district nursing certificate for SENs employed in the home nursing service who satisfy the requirements of the Department's Panel of Assessors'.

1971 The State Enrolled Nurse

A report by the Sub-Committee of the Standing Nursing Advisory Committee.

1972 Circular 25/72. Department of Health and Social Security.

Panel of Assessors produced new syllabus.

1972 Report of the Committee on Nursing, Cmnd. 5115, HMSO.

1973 National Health Service Reorganisation Act made provision for registered and enrolled district nurses to be employed by area health authorities (England and Wales) area health boards (Scotland).

1974 Reorganisation of the Health Service implemented.

1976 Recommendations of the Committee on Nursing accepted by the Secretary of State.

Provision for 'one portal of entry' and Certificate of Nursing Practice, also creates Family Clinical Sister.

1978 Publication of Bill 3·47/5 - Nurses, Midwives and Health Visitors.

ADDENDUM 3

LEGISLATIVE AND ADMINISTRATIVE CHANGES SINCE COMPLETION OF THE RESEARCH PROGRAMME

This addendum is included for three reasons: -

First, the knowledge of impending changes is likely to have coloured parts of the national study, especially the views of medical and nursing administrators; second, the reasons for and objectives of the changes were closely related to the research programme and other research undertaken over the same period; third, some of the literature referred to in the second part of the literature review (Chapter 14), must be interpreted in the light of the changes.

The research programme was undertaken against the background of a tripartite National Health Service. Many of the problems identified in all four individual projects appeared to be rooted in the divisions between the three arms of the health service, which separated the hospital service, the general practitioner service and the community nursing service from each other administratively. Regional Hospital Boards and Boards of Governors controlled the hospital service, Executive Councils administered the General Practitioner Service and the local health authorities were responsible for the community nursing services.

While the second study 'Care in the Balance' (1968)[2.] with its emphasis on communication between the hospital and domiciliary services, was in its final stage, the 'First Green Paper' was published in 1968.[213.] Its main theme was the unification of the health service under one new administrative body. Its proposals were related to changes in the administration of the personal social services, being discussed at the same time by the Seebohm Committee (1968)[214.] and also to changes in local government, also a current concern being handled by a Royal Commission.[215.]

For a variety of reasons the First Green Paper did not gain acceptance and was followed by the Second Green Paper, entitled 'The Future Structure of the National Health Service'.[216] It was a significant document in being the product of the first Secretary of State for Social Services in the new Department of Health and Social Security. As a result of a change in the ruling political party in 1970, a further delay occurred. It was not until 1972 that the final 'White Paper',[217] preceding the reorganisation of the National Health Service was published. The National Health Service Reorganisation Bill of the same year received Royal Assent on 5th July, 1973, and the new structure became operational on 1st April, 1974.[218] Thus, it can be seen that debate and uncertainty extended over a considerable period.

A brief summary of the new structure of the National Health Service is presented below, attention being drawn to those features of it which have the potential of dealing with the problems highlighted in the research programme.

The main feature of the reorganised health service is the abolition of the tripartite structure resulting in unification. The unique, but slight variations in the administrative structures of Wales and Northern Ireland are omitted from this cursory overview. At the heads of the respective government departments are the Secretaries of State with overall responsibility, aided by ministers with responsibility for health and for social services respectively. A sizeable body of administrative and professional civil servants with appropriate advisory machinery complete the central government framework.

Attempts were made, both within the Department of Health and Social Security (DHHS) and the Scottish Home and Health Department (SHHD) to promote relationships between the health and social services which, though operating under the general guidance of the Secretary of State,

were separately administered. Thus, there is provision for some collaboration between staff of the Government Health Departments and Directors of Social Work Services and a range of social services are supervised by DHHS and SHHD respectively. As far as the district nursing service is concerned the removal of the home help service from the responsibility of health authorities to local authorities controlling social services, is particularly important.

In the structure for the delivery of health care at local level again there are some differences between the constituent countries of the U.K. which are merely alluded to as they do not contravene the main principles of the legislation. In England, a three tier structure was created, the tiers being organised at regional, area and district levels. Scotland, Northern Ireland and Wales have a two tier structure, the countries themselves being, on average, no larger than the English regions. The importance for nursing lies in the fact that a Nursing Officer is a member of the top management team of each tier in all countries. A line management structure of nurses underpins top management resulting in all nursing services being administered by nurses. Nursing policy, which cannot be divorced from health care policy is formulated at top management level through concensus between the professional heads and ratified by the corporate bodies of the regional and area health authorities or boards.

Thus, unlike the situations described in the early stages of the research programme where the Medical Officer of Health controlled the community nursing services the new structure provided for nursing control. There is, therefore, a greater potential for nursing to assert itself as a profession which can state its own claims, objectives and policies, thereby taking greater responsibility for its own destiny. Regarding the relationship between district nurses and general practitioners, the major concern of the first study in the

research programme, the unified structure in itself has not made a fundamental difference. General practitioners, though ostensibly absorbed in the new structural framework, have retained their independent contractor status and identity through the Family Practitioner Committees as sub-entity of the health authority structure. They are, however, much more closely involved in the general health care policy of regions, areas and districts through representation at all levels, which should ease collaboration and reduce the possibility of direct conflicts.

The success of attachment of nursing staff to general practice which was established before the 1974 reorganisation and of all aspects of team work at local level will always ultimately depend on individuals concerned, but the new structure removed a number of obstacles.

The second and third study in the research programme had their focus on collaboration between the hospital and community services and continuity of patient care. In this area, the new health service structure has the greatest potential of making a significant contribution. No longer is the cost of health care in hospital separated from that provided in the community. More rational planning in manpower and other resources is, therefore, possible. The decision to discharge a patient 'early' will not be made merely on the basis of reducing hospital costs but the possibility of incurring greater district nursing costs will enter into the same decision making process; clearly, such an example can also be pursued in the opposite direction of cost transfer. Moreover, cost is not so likely to be the only factor in planning the long-term care of patients in a system where professionals within the hospital structure and outside it can engage in direct and personal discussions related to patient welfare. Regarding the organisation of the nursing services the new legislation

has created the possibility of integration between hospital and community nursing services at district and at divisional levels, making direct contact an inherent part of its implementation.

The importance of the home help service in maintaining a patient in his own home was stressed by the district nursing staff in all projects. Clearly, the administrative separation of the home help service from the health service structure, by transferring it to the social services, may generate new problems in achieving continuity of care and will require vigilance.

The other set of legislative changes which 'over-shadowed' the latter part of the research programme were those related to the education and training of nurses. The Committee on Nursing reported in 1972, two years after being set up by the Secretary of State with the following terms of reference: -

> 'to review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service'. 219.

The recommendations made by the Committee are, therefore, directly related and relevant to the reorganised 'integrated' health service and also to many of the issues discussed in the national study, particularly in Chapter 12 of the thesis, which identified dilemmas and conflicts. Some of the conflicts between enrolled and registered nurses should be reduced and, in addition, the acceptance of mandatory training for district nurses by the Secretary of State in 1978 [220.] should reduce the major anomalies identified in the national study. The Report of the Committee on Nursing refers to all four studies comprising the research programme defended in this thesis. It is not claimed that the research programme made a major impact or that it influenced the Committee on Nursing. Reference to the programme

suggests, however, that the Committee were aware of it, that they used some of the findings as supportive evidence and that empirical studies, such as these, generated by service needs rather than mere academic aspirations, have a place in the total spectrum of research.

The Royal Commission on the National Health Service was appointed in May 1976.[221] Its terms of reference:-

> 'To consider in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service'

predict yet another period of legislative and administrative changes.

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