

The first line of defence

Last week we published the first part of an address given in May by Anthony Carr, ANO, Newcastle-upon-Tyne, to an annual study conference in Cheltenham. After a close examination of the meaning behind the term 'primary health care team', he now goes on to develop his view that, for there to be a reduction in infant and perinatal mortality rates in this country, a major revolution in thinking, the way we live and the way we apply social security benefits, will have to take place

It must be agreed that better health of mothers and improved medical care, together with improved living standards, have contributed to the overall decline of the perinatal mortality rate.

However, when some analysis is made of inner-city areas, deprivation of good housing, medical facilities, shops, and employment, all combine to keep up this death rate.

As an illustration of this, a midwife was recently appointed to review the situation relating to pregnant women in an inner-city area. Out of the first 20 mothers visited, 15 were found to be at risk. Several were either one parent families or about to become one, had histories of previous light weight births and/or the social conditions were poor.

It is also found that women in these areas avail themselves less of the appropriate medical services, either because they are not provided near enough to home, the service itself is inadequate, or because of lack of personal incentive.

I would seriously recommend a major change in policy regarding payment for antenatal care. Many of the mothers at greatest risk, as already indicated in this paper, are as follows:

- 1) in the younger age group,
- 2) unmarried,
- 3) if married, the husband, if in employment, is in a low social class,
- 4) have had at least two previous births.

Most of those factors, and certainly a combination of them, may lead the mother to be disinterested in her own care. To motivate families to use the services available to them I would like to propose a change in the way child benefits are paid.

Payment, I suggest, should start from the date of confirmation of pregnancy by the general practitioner, and the payment be continued up to and including the first birthday of the child. Payment would be subject to a nationally agreed programme of antenatal and post-natal care and this

would have to be followed by the mother. This, in my opinion, would have two important effects.

First, the woman would, generally speaking, seek to follow the programme, and secondly, the area health authority would be required by the public to provide an adequate service. I make that statement deliberately brief so that it can be further explored in discussion later.

Shared responsibility

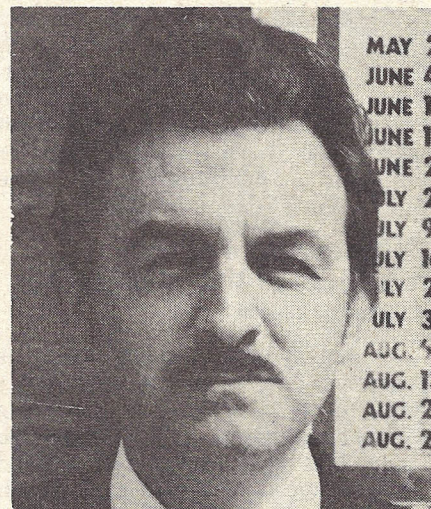
Before I leave this aspect of care I would just wish to make two further comments. First, to me, it makes sense that the midwife keeps contact with the mother and child for the first 28 days, even though health visitor contact will have been made ideally in the antenatal period. As nurses we do enjoy having set times in which we 'take command' of a situation. Can we not agree to share responsibility? I am sure we can and do.

My last point here relates to the number of community midwives in post. In many areas there needs to be consideration given to increasing the number of midwives available. In some areas of the country, prior to 1974, a reduction in the number of community midwives took place in line with the reduction in the number of home confinements. It is obvious that some local authorities over-reacted to this situation and forgot, or misunderstood, the very important health education role played by the midwife when the mother is discharged from hospital, and the support given by teaching practical skills.

Health visiting

I have stopped asking health visitors what is their role within the health service. Professor Court offered the health visitor a new role, one of a child health visitor. It is said that the health visiting profession rejected the idea.

In talking to health visitors personally, however, I still find that they would prefer to have continuing



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contact with the child and his family and in fact treat this as their first priority. If we want to make a real impact on the perinatal mortality and infant mortality rates in the country, then certainly more concentration of health visiting staff has to be agreed for the country as a whole.

Should the health visitor concentrate and become specialist, particularly with children, or continue to be the generalist? It is not easy to decide. Perhaps the way I see it is this.

There should be, and I am sure there is in most areas, a policy of surveillance

of children from birth up to school age. If that system operates well, and each aspect of the programme is seen to work, then other age groups can be reviewed. Until that time I would rather see the basic service put right for children.

Do we care enough about school children? What proper post basic course which is nationally approved do we have for the school nurse? How does she properly carry out her duties in supporting children, identifying potential battered children, alcoholics, those on drugs?

We console ourselves with the fact that the school nurse has contact with the health visitor or nursing officer. Where is the expertise based on knowledge and training? Again, is it not wise to ask 'have we got it right for children?', particularly in this International Year of the Child.

Extended role of the members of the community nursing team

In many nurses' minds there is confusion and a certain amount of uncertainty when considering extension of their role. We all have the advice that the particular task in mind must be approved by the area health authority, that the nurse must be trained and found competent, and lastly, that the nurse must be willing to undertake the new task.

The question I always have asked is how does it affect the relationship with the patient? Does carrying out a vaccination and immunisation programme in a family improve the health visitor's chances of acceptance by that family?

Is the nurse or health visitor assisting the patient in his care? Does it enhance the nursing contribution? If it does, can we please do the particular procedure without endless local discussion and claim and counter-claim, and the setting up of working parties?

District nursing

This branch of nursing is entering upon a new and exciting phase of development. It was pressure from the district nurse tutors, district nurses, and the Panel of Assessors that finally persuaded the Department of Health to give permission for the setting up of the working party on the education and training of the district nurse (SRN) at the end of 1974.

Yes, it is as long ago as that. Our report was completed in late 1975 and most of our main recommendations published in October 1976.

As you all know, the new training commences in less than two years' time, in 1981, and at the same time the work of a district nurse is acknowledged in that from the same date a qualification to practise is required.

What will this new training do? Update the new entrant in district nursing? More than that.

The district nurse of the 1980s will be competent by education, training, and experience, to assess the needs of not only the patient but those of his family. Not just physical needs in terms of a wound needing dressing but the social, psychological, emotional, and spiritual needs which we recognise that people may have in today's society.

Is the nurse or health visitor assisting the patient in his care? Does it enhance the nursing contribution? If it does, can we please do the particular procedure without endless local discussion and the setting up of working parties?

As I gently suggest that the role and work of the health visitor should be aimed primarily to the child under 16 years, so the new type of district nurse should take to herself the more embracing responsibilities of caring for the family. What is so attractive to me in this concept is that the district nurse is so readily accepted in most homes. She is called in to help because of an identified need that already exists. Once with the patient and his family she will be exercising her new skills for caring and supporting people.

In this new role it is essential that the district nurse can not only diagnose correctly the care to be given, but define a plan in writing, decide on levels of care to be given, and allocate certain parts of that care to other staff, monitor its effects, and replan as necessary.

Let me raise another problem. Seemingly little attention has been given to the team within a team principle. I understand much research has been undertaken in relation to the working of the primary health care team, but very little on the nursing team within that primary health care team. I am able to announce that the working party set up by the Panel of Assessors on the education and training in district nursing for the state enrolled nurse has

now completed its work and held its last meeting. The final draft is being prepared in readiness for submission to the new reconstituted Panel of Assessors when appointed later this year.

What we have recommended must, of course, remain confidential but I can say that much time has been spent on considering the role and function of the SEN with particular reference to her working within the nursing team.

Those of you familiar with the 1976 report will know that the approach known as the 'nursing process' is proposed for the district nurse. This in turn naturally leads to defining levels of care and allocating to others parts of the programme. As the number of nursing auxiliaries increases it is important to define clearly the duties and responsibilities of all the members of the nursing team. Ratios of staff within the nursing team are also important to determine both locally and nationally.

I believe that there are persons in the community who need care and attention but are at present not receiving it. Maybe as night service has yet to be instigated, very few staff are available in the evening to give care. It is very important for all health authorities to consider introducing at an early date a 24-hour seven-day service for all their clients both in district nursing and health visiting.

Our aim in caring in this way must be to allow as far as possible all people who are terminally ill to die in their own home with dignity, surrounded by their loved ones, and supported, if required, by professional staff.

Ratios

Finally, I believe the time has come when it should be considered seriously if minimal ratios of midwives, health visitors, and district nurses per head of population should be agreed nationally and enforced. At present, national figures are guidance only.

If we wish to have a uniform high standard of care throughout the country then ratios have to be set and achieved. I know all the arrangements about control being delegated by the DHSS to region, to area, to district and so on. In this case the improvements, from the care of the child to the care of the dying patient in the community, can only be achieved if the staff are there to do the work.

I hope you feel I have been controversial and stimulated you in thought or to action, not to agree necessarily with my views but at least to have better alternatives to offer.