BREAKING NEW GROUND
The Lambeth Community Care Centre

Elizabeth Winn
Christine King

Primary Health Care Group
King's Fund Centre for Health Services Development

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And finally, our profound gratitude to John and Laura Symons who successfully confronted a large King's Fund audience and who made an essential contribution to the success of the day.

CONTENTS

Introduction

1. The Conference

In March 1987 the King's Fund hosted a conference about the Lambeth Community Care Centre. A variety of health professionals* were invited to learn about the work of the Centre, and to discuss with staff and GPs working there the practical and policy implications of their principles and methods of work. The Community Care Centre offers valuable lessons for all health professionals about patient autonomy and participation, collaborative work between professions, GP and community involvement, and imagination in environmental design. These themes and principles emerged during the day from formal presentations, group discussions, panel presentations and role play**. This report is not a verbatim transcript of the conference proceedings but attempts to illustrate key themes that were discussed. Additional material has been used to supplement some of the facts and figures presented during the conference, and a brief bibliography is included at the end of the report***.

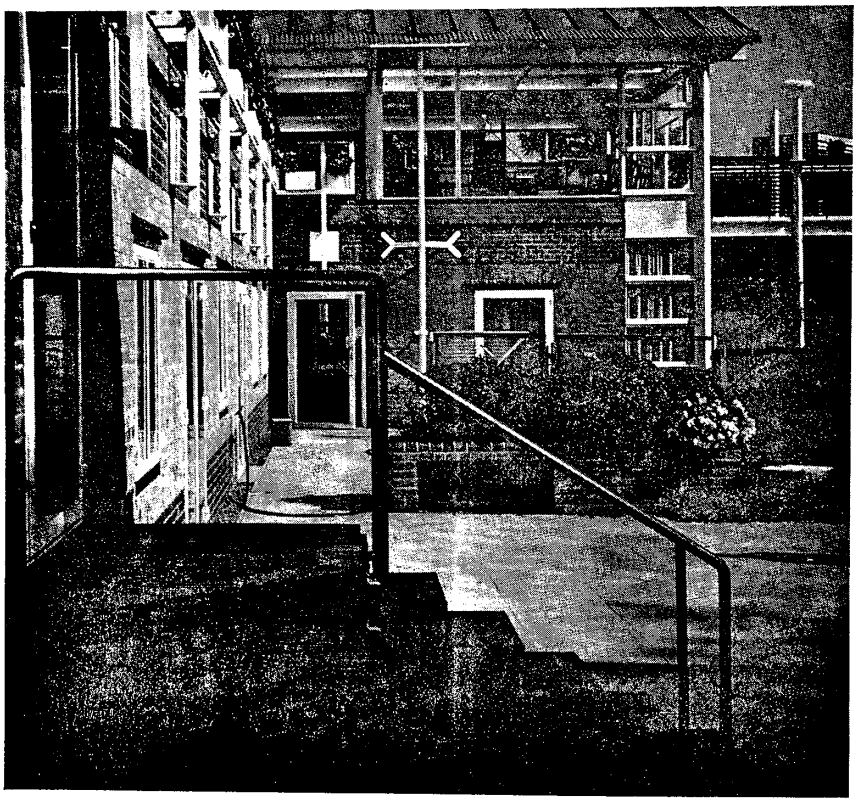
2. The Lambeth Community Care Centre

The Lambeth Community Care Centre is a small, community-based GP hospital in inner London. It was built on the site of the former Lambeth Hospital in the north-eastern part of what is now West Lambeth Health Authority; and was developed in response to a campaign led by West Lambeth Community Health Council together with local people who were committed to the idea of a small neighbourhood hospital facility which would be easily accessible to patients, friends and family. Individuals within the health authority also gave some support. Funding for the new Centre was difficult to find, but approval was finally received in July 1980 after five years of campaigning. The Centre opened in July 1985 and now takes patients from a catchment area which includes West Lambeth, Camberwell and Lewisham & North Southwark Health Authority districts. Initial capital and revenue monies for the first eighteen months came from the Inner City Partnership, and West Lambeth Health Authority took on financial responsibility from 1 April 1987. Overall running expenses are £0.5 million a year, but costs per patient at the Centre compare favourably with care in local hospitals (see Appendix IV). The Centre is currently being evaluated and the first stage report is due to be published shortly.

The Lambeth Community Care Centre aims to provide a comprehensive primary care service which can offer assessment, continuing care and rehabilitation of local patients at a level intermediate between home and hospital. Help is given to those whose needs cannot be met in their own home, but who do not require admission to, or to remain in, hospital. Care is provided

* See participants list, Appendix I
** Conference programme, Appendix II
*** Bibliography, Appendix III

in a purpose-designed building which combines inpatient wards with 20 beds in four- and one-bedded rooms; a day unit for 35-50 people, which includes consulting and treatment areas, sitting and dining rooms, a conservatory and landscaped garden; and facilities for meetings of local primary care staff and community and self-help groups. The services provided include physiotherapy, occupational therapy, chiropody, speech therapy and dentistry; social work assistance, including counselling and group work sessions, and welfare rights advice; community link work; as well as other therapeutic activities such as gardening and cheaper rate hairdressing for patients.



Referrals to the day and inpatient units may be made by any GP who agrees to abide by the Centre's operational policy and who enters into an honorary contract with the health authority to this effect. All patients on the lists of contracted GPs are eligible for treatment at the Centre if they are over 16 years of age, and do not require acute psychiatric or consultant specialist care. Clinical responsibility remains with the GP, but care is planned and carried out on a multidisciplinary basis. Initial assessment is made by the most appropriate member of the team, and arrangements for continuing treatment, discharge, and follow-up in the community are agreed between the GP and other members of the team, the patient, and relevant community health staff. A keyworker/special nurse is allocated to each person referred to the Centre, to be responsible for coordination of the patient's care, and for ensuring good communication between all those involved.

38 GPs from ten local practices work with the Centre and provide either themselves or through a contracted named deputy, 24-hour medical cover for all patients referred. Once admission has taken place, day-to-day treatment is the responsibility of the keyworker, who coordinates care of the patients in conjunction with relevant nursing and therapist staff. Members of primary health care teams (including district nurses) and social work teams working in the community with particular individuals are encouraged to continue their involvement with the patients whilst they are at the Centre. The keyworker therefore has a special role in making links with workers both within and outside the Centre. There is a multidisciplinary Centre Management Team which meets regularly to oversee the smooth running of daily operations; and a Centre Advisory Group composed of an equal number of staff and community representatives which discusses and formulates policy for use of the Centre and provides a forum for exchange of new ideas. The chair of the Centre Advisory Group (always a lay person) is also a full, voting member of the Centre Management Team.

Flexible treatment plans are drawn up for each patient which can be adapted to the needs of individuals and their families or carers. All such planning starts from the premise that the patient should be encouraged to take charge, and to participate in setting objectives for the management of his/her own care. Treatment plans must show a clear pattern of working towards identifiable short-term goals. Patients admitted to the Centre are not expected to stay for more than three months. Admissions tend to be for short periods and the average length of stay is 16 days. However, patients needing treatment lasting several months may be accepted provided that a plan for their care includes regular review.

The Lambeth Community Care Centre aims to help local people play a greater part in their own health care and in the planning and provision of services. The health authority employs a community link worker who is based at the Centre to encourage health initiatives locally; to coordinate and organise voluntary support in and for the Centre; and to develop group activities there. Health education programmes are an important part of these activities and advice and support is given both to groups and individuals from the local community, and to students of all professional disciplines.

The Lambeth Community Care Centre is highly valued by those who use its services, and by those who work in and with the Centre. Apart from its 'localness' and attractive design, the Centre has a number of other characteristics which explain its popularity. It places great emphasis on patient autonomy; a team approach to service provision is actively encouraged; patients have their 'own' doctor and nurse; GPs have a new and important contribution to make; and local people are involved in the Centre's work. These characteristics emerged as the key themes of the conference and are discussed in more detail in the following sections.

SECTION I

Patient Autonomy

One of the most striking things to come out of the conference was the degree to which patient autonomy is fostered in the Centre. The approach manifests itself in a variety of practical ways and these are discussed below. But first it is worth concentrating on the less tangible aspects of patient autonomy and how an atmosphere which encourages positive approaches is fostered.

It is unwritten policy that patients' requests are met with a positive response and that the member of staff approached is responsible for helping to ensure that "it can be done". For example, a patient might approach a nurse and request a bath in the middle of the night. The nurse has a number of options. She could explain the difference between day and night nurses; or point out that at 2.30 am everybody is asleep; or suggest that there is unlikely to be any hot water. For the nurse who has been on shift for several hours these might seem very attractive options. There is another option however: the nurse could show the patient where the bathroom is, check that all equipment required is there, and then leave her to get on with it. This is the option favoured at the Centre.

The approach requires the development of positive attitudes amongst staff, together with an emphasis on listening to what patients say. This point was illustrated negatively during the conference by describing the case of a patient who developed sore heels. It was only after three days and a number of applied 'solutions' to the problem that the patient was allowed to explain her own tried and tested remedy which proved to be successful.

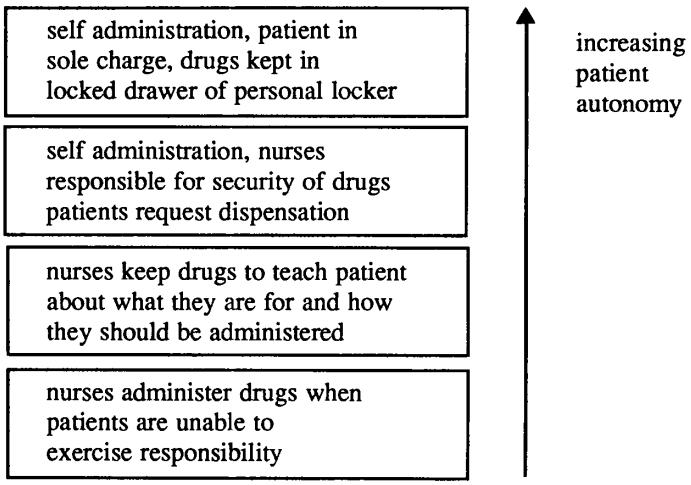
The point about listening to requests and suggestions from patients is that it acts as a foundation for developing the practical aspects of autonomy. It makes no sense to promote the idea of 'autonomy' and expect patients to take responsibility for their health and recovery, if at the same time other messages from staff give the contradictory impression that there are *no* choices and that patients have in fact only a very limited sphere of influence and power.

Patient autonomy is intended to enhance patients' confidence and ability to cope with new (or old) disabilities or illness and new regimes when they leave the Centre to go back to their own homes. The practical aspects of this autonomy are illustrated by the administration of drugs, patients' notes, choosing how to die, and decisionmaking.

Administration of drugs

In most hospitals or other institutions, the responsibility for the administration of drugs is vested in the staff *until* the patient is discharged. At that point he/she is expected not only to assume responsibility for what might be a complex daily regime, but is also meant to have some knowledge or understanding about how the drugs will help. Staff at the Centre described how this can backfire. A patient was discharged from hospital and prescribed an anti-convulsant drug. According to his relatives, he had coped for a few months but was now beginning to have vague attacks. Since the patient lived alone, it was decided to admit him to the Centre for observation, and to ask him to bring along his prescribed drugs. He arrived with an enormous supply of empty pill bottles. When his hospital supply had run out, he had been unwilling to bother his GP, partly because he did not know why he had to take the drugs. At the Centre he learnt about the purposes of the drugs and why he needed to take them. He was therefore in a much stronger postion to manage his own treatment.

The staff at the Centre have devised options for drug administration which range from nurse control to total patient responsibility:



It is the responsibility of the staff at the Centre to work out with individual patients which approach suits them. Clearly, there is considerable movement between the categories by people during their time at the Centre.

Patients' notes

Patients at the Centre are encouraged to read and contribute to their own case notes. From the beginning, it was agreed that patients should have access to their notes, which were kept originally at a central desk to be read as required. To begin with, there was caution on both sides; staff were careful about what

they wrote in case patients read their notes; yet patients seemed reluctant to ask to see them. Notes are now kept at the bottom of beds and gradually, with encouragement, patients have begun to read their notes, and even more slowly, to write in their own comments.

The policy not only reinforces ideas about choice and an individual's control over what happens, it also helps patients and their carers to understand the treatment plans that may have to be followed on returning home.

Choosing how to die

Many people want to die in their own homes. Some people choose to die in institutions. What is important is that their choice and wishes are respected, no matter if it conflicts with 'current policy'. Staff at the Centre acknowledge a patient's right to make decisions about death and, in doing so, have sometimes been able to meet unusual requests. One woman wanted to die with her hat on, which was simple enough to arrange. Another wanted to be discharged in the middle of the night so that she could die in her own home — which she did a few hours later. This was a much more complex matter for staff who had to arrange immediate transport and night nursing services, when it would have been easier to wait until the morning to arrange this kind of support.

Involvement in decision making

Discussions about the care or discharge of patients at the Centre include the patients themselves, together with their relatives and informal carers, if that is what is needed. In practice this might mean that patients who are enthusiastic about getting home are forced to think realistically about the timing of discharge if there is a spouse present who can point out practical problems or who is less confident about coping. In one example, a patient's discharge was delayed for one week after uncertainties had been expressed by the carer who wanted more time to ensure that their home was safe and properly equipped. This 'teamwork' is a natural extension of patient autonomy. The views and wishes of carers and relatives are considered alongside those of the professional staff at the Centre, and carers are encouraged to attend therapeutic sessions so that they can learn about potential changes to regimes and lifestyle once the patient returns home.

SECTION II

Teamwork

Methods of work adopted at the Lambeth Community Care Centre rely on and emphasise teamworking, and the success and effectiveness of the work depends on the strengths or weaknesses of the team approach. Teamwork is reinforced by an atmosphere of collaboration and manifests itself in a number of practical ways. Teamworking at the Centre is not only about a group of professionals working together to provide comprehensive care for individual patients. It involves professionals and non-professionals from both within and outside the Centre; and the team approach is adopted in all aspects of work — from drawing up initial care plans to discussions about discharge.

In one conference session, a group presentation was made to illustrate the team approach in relation to the care of a patient who was admitted to the Centre following a stroke. Both he and his wife took part in the discussion as members of a team. This presentation highlighted the following aspects of teamwork.

The keyworker

When a patient is admitted to the Centre, someone is assigned as a keyworker and is responsible for knowing about the details of that patient's care. The keyworker is usually a nurse, but sometimes the occupational therapist, physiotherapist or speech therapist may be selected. The keyworker provides the main focus for communication between team members and is in regular contact with the patient and carers throughout the stay.

There is no formal process for the selection of keyworkers, although if a patient is familiar with a particular member of staff it is likely that he/she will be allocated that staff member as a keyworker. Allocation also depends on the nature of the admission so that if, for example, rehabilitation is the main focus, a member of the therapy staff will be the keyworker. If problems arise — for example, a 'personality clash' — or where workloads become unbalanced, staff and patients together discuss and agree any changes. Because the system relies on the knowledge of the keyworker, it is essential that the patient's notes are kept up-to-date to provide information for use by other staff.

The nursing team

One conference participant described the Centre's approach to nursing as "primary nursing"*. In the Centre nurses are certainly given more responsibility for taking decisions and have more autonomy in their day-to-day work than traditionally. Nurses are encouraged to think imaginatively about possible solutions to problems that may arise. So the role of the nurse manager is to foster independence and encourage nurses to think and act in different ways. At the same time, there is a need to supervise and support staff, particularly where nurses new to the Centre's ideology are reluctant to transgress traditional boundaries. To help the process, and also to help patients accept the autonomy given to nurses, staff have the option of wearing not uniform, but either a standard blue overall with no indication of status, or their own clothes.

Keyworkers and team leaders

Keyworkers operate in the context of a team and, although the nursing keyworkers remain the focus for information about and involvement with patients in the Centre, at various stages throughout the care process other professionals have increased responsibilities and take the lead. The team leader is not necessarily the GP although at some point his/her role will be dominant.

* Primary nursing has been defined as a nursing care delivery system based on the premise that one person is operationally responsible for the quality of care administered to a select group of patients in a unit, 24 hours a day, seven days a week. Clark Culpepper, Rebecca et al. *Journal of Nursing Administration.* Vol. 16, no. 11, November 1986, pp 24-31.

The pattern at Lambeth Community Care Centre is for the leading responsibility for care/treatment to change according to the needs of the patient. For example, in the case of the patient who took part in the conference, responsibility shifted from him, to the GP, the nurse, the physiotherapist, the dentist, the speech therapist, the occupational therapist, and back to all of them again at various stages until the patient's discharge.

Meetings

Apart from the unwritten rule that everyone should be involved in meetings about the work of the Centre (all Centre workers had some input into the conference), there is a serious commitment to holding team meetings of everyone involved in the care of a particular patient, including carers and relatives, at stages in their treatment/care/rehabilitation when decisions are needed. Normally the patient is also involved in these meetings, and his/her comments and feelings are taken into consideration. For example, prior to the planned discharge of one patient and following a visit to assess his home environment, a meeting was held of all those concerned with his care, including him and his wife. In the event, the proposed discharge date was put back a further week because of practical difficulties highlighted by his wife: for example, carpeted stairs to the first floor bathroom, which would require a little more time for adjustment for someone unstable on his feet.

Decisions about care of patients are therefore jointly made and a spirit of co-operation fosters this from admission, through the development of a care plan, to discharge.

SECTION III

Involving General Practitioners

The Lambeth Community Care Centre is run without resident doctors. Medical input is provided by the patient's own GP who is a member of the team of health workers providing care, treatment and support to the individual patient (see section II).

The significance of the input from GPs will not be lost on those who have been involved in planning and providing primary health care, particularly in inner cities. All too often GP and district health authority services are provided in an uncoordinated way, making it difficult to plan and monitor primary care; health authority staff may not want to work in 'primary health care teams' believing that they allow the dominance of one professional over others; and there may be ignorance on both sides about activities and future plans for services. Building links between family practitioner services and community health services is not only hampered by structural blocks (separate authorities and status), but also by a long history of separate working. In West Lambeth, though, 38 GPs are now involved in the Community Care Centre. They offer medical support to patients, monitor and evaluate their own performance, and meet as peers where they did not meet previously.

Once the plan for the Centre had been formulated, it was clear that for the scheme to succeed, the support of local GPs was essential. GP involvement increased from a handful of practices when the Centre opened, to 38 at the time of writing. Ten practices, six in West Lambeth and four in Lewisham and North Southwark, now make use of the facilities at the Centre. They represent about one-quarter of the practices within a twenty minute travelling time radius, and cover 50,000 patients between them.

The three GPs who took part in the conference saw many advantages in working at the Centre and these are described below.

A clear role for GPs

One of the principles of the Centre is that it should be viewed wherever possible as an extension of the patient's home; so the GP's involvement with the patient in the Centre remains the same as it is in their home. The GP therefore retains medical responsibility for all his/her patients whether they are day patients or inpatients.

GPs attached to the Centre have to accept the operational policy and are asked to enter into an informal contractual relationship with the district health authority (West Lambeth). This contract is subject to renewal and covers:

- the GP's responsibility to the patient;
- the availability of the GP or a named deputy for 24-hour cover;
- an agreement to follow the Centre's procedures;
- an agreement to visit regularly and as required;
- an agreement to participate fully in evaluation procedures.

Although the contract is honorary, a GP who fails to fulfil his part of the agreement may have his/her admitting rights withdrawn by the district health authority via the district management board or the Centre Management Team. Where disagreements occur between a GP and a nurse, referees are called upon to intervene. Four of the GPs on the original project team for the Centre form a referee rota. To date, this safety mechanism has hardly been used.

Apart from the advantages of working as part of a team, GPs attached to the Centre have opportunities to use their skills to the full and to develop a deeper understanding of their patients' needs. Workers at the Centre comment that the confidence of both medical and nursing staff in tackling more complex health problems has greatly increased since the Centre opened. Staff feel as though previously under-used skills have been maximised by following the policies and using the facilities of the Centre.

Opportunities for reviewing work

The Centre holds monthly meetings which are carefully recorded. GP principals and trainees meet with nurses and therapists, the dentist, administrator and community link worker. Treatment of a small number of patients is analysed and discussed in the audit meeting, and referral, case management, teamwork aspects and medical screening are reviewed in a multidisciplinary setting. Apart from the educational benefits for all concerned, this performance review facilitates appropriate referrals and good quality patient care.

GPs also take part in the longer term evaluation of the work of the Centre, and collect and review information about patient activity and case mix; as well as looking at data about potential alternatives (for each patient) to care at the Centre were its facilities not available.

Audits have also been carried out in individual practices. For example, one practice reviewed the care provided during the first year of the Centre's activity for patients who had experienced strokes. The findings from this work stimulated discussion and a consultant physician from St Thomas's Hospital met with those who attend the monthly meeting to put forward criteria for good quality of care for patients with strokes.

Contact with other GPs

The Centre offers GPs a venue, pretext and opportunity for meeting with colleagues which was not available to them before. Apart from using the Centre for audit and evaluation meetings, it is also a place to have lunch and for informal contact. The value of this formal and informal contact is not only confined to the Centre and its patients. For example, because the Centre has become a focal point for professional support and development, together with opportunities for improvements in clinical competence, it has obvious spin-offs for trainees and young principals working in small practices.

SECTION IV

Community Involvement

Those working at the Community Care Centre place a lot of emphasis on its 'localness'. During the years leading up to its opening a great deal of effort was put into talking to local people to find out their ideas and suggestions. Today the Lambeth Community Care Centre tries not only to build in the suggestions and wishes expressed by the local community during the planning period; but also to maintain the spirit of consultation and cooperation with the local community on a day-to-day basis. This section describes attempts made to involve the community.

Lambeth Community Care Centre aims to serve the local population, to offer services which are easily accessible, which people feel they can attend informally, and to which they can make a real contribution. It provides a focus for the local community. The Centre acts as a meeting place for people of all ages, and encourages participation of professional and lay people, representatives from a variety of statutory and community groups, volunteers and workers. Emphasis is placed, too, on maximising the potential contribution that can be made by patients themselves, and by their relatives or friends, in helping to manage illness.

The story of the development of the Lambeth Community Care Centre is one of cooperation, and of a determination on the part of West Lambeth Community Health Council to consult fully with local people at all stages to get the kind of service they wanted. Ten years were to pass between closure of the old Lambeth Hospital, completion of the new building, and opening of the Centre. During this time the CHC played a continuing role on behalf of local people in providing representatives to debate issues such as site development and funding; and, once design and construction of the building were under way, to attend project team meetings to ensure that the community viewpoint was kept at the forefront of discussions. Local people were quite clear about the type of building they wanted, and felt strongly that it should be within walking distance so that relatives could visit easily, and with a relaxed and friendly atmosphere — "somewhere to go with your pinny on".

To help local people take part in its activities as much as possible, a Community Link Worker has been employed by the DHA to link the Centre with the community and the community with the Centre; to persuade local people to play a greater part in their own health care; to promote understanding locally of what is meant by positive health; and to exchange information and ideas. Individual patients and the community as a whole are encouraged to take responsibility for health care and planning; to identify and articulate the types of service provision they require; and to suggest areas where changes should be made. The worker also helps to define the needs of local people and carers in relation to the Lambeth Community Care Centre; to develop local initiatives

on health; and works to build up effective networks of care, supporting those that exist already and fostering new ones. She also coordinates voluntary support.

People from the community may be involved with the work of the Centre in one of two ways. There is the formal mechanism of the Centre Advisory Group, which is a multidisciplinary body made up of seven representatives from the Centre staff, and seven from amongst community groups and individuals living locally. The Group provides a forum for discussion of issues of concern, and enables local people to take a part in the day-to-day running of the Centre.

Community involvement may also be on a more informal basis. Local groups, such as tenants' associations, carers or bereavement support groups, may use Centre facilities to hold their meetings; various health education and other learning opportunities are made available; and there are special functions such as fetes, picnics and gardening days which are held in the Centre's grounds. All such occasions give an opportunity for local people to mix socially with Centre staff and with patients, and help to increase commitment to the Centre. Integration with the community is also achieved by the regular use of volunteers; and the Lambeth Community Care Centre reaches out into the community in a reciprocal way by pursuing opportunities for anticipatory and preventive care and support, by offering relief to carers, and by extending local links such as a work experience scheme which has been set up in conjunction with a nearby school.

SECTION V

Lessons for the Future

The current philosophies and ways of working at the Lambeth Community Care Centre have been described and can offer valuable lessons for those providing primary care services. Yet if learning from this way of delivering services in the inner city is to be maximised, the *processes* involved also need to be examined.

Today the Centre is a testament to what can be achieved in the inner city: multiprofessional teamwork, integration between independent contractors and health authority staff, and real community involvement. How are these things realised in a corner of West Lambeth Health Authority when they seem nearly impossible elsewhere? How significant were the processes of planning and implementation in the way the Centre works today? And can the innovation be sustained in the future?

A look at the planning process and the ways in which the Centre's philosophy about patient-centred care has been built into everyday working might help to answer some of these questions.

Planning the Centre

The Community Health Council helped to initiate discussions about what might replace the former Lambeth Hospital, and subsequently a multidisciplinary project team was set up to take forward the idea of the Community Care Centre. There followed ten years of dedicated campaigning and consultation before the Centre became a reality.

Many people have attributed the establishment of the Centre to the determination and staying power of a small number of local actors or charismatic leaders. There seem to be many examples in the NHS of enthusiasts bringing about change*, and there is little doubt that they often play a large part in influencing the development of new ways of working. Yet this might seem disheartening to others if it is the *only* factor determining success.Those involved in the establishment of the Centre have identified other important components of the planning and implementation process which they feel helped to make the idea a reality.

Strong links developed with the local community helped to sustain the effort needed to take the campaigning and negotiations forward. Not only did this close relationship with local people confer a strong sense of responsibility on

* Stocking, Barbara. *Initiative and Inertia.* Case studies in the NHS. Nuffield, 1985. In this study, enthusiasts are referred to as product champions.

the project team, it also lent legitimacy and therefore power to their work.

The project team included representatives from four local general practices and this 'core' group of GPs was important for drawing in further support as things progressed. Nearer to the time of the Centre's opening, meetings were held to which all GPs in the area of the local medical committee were invited. Additional GP interest was generated at this stage, as the plans became more nearly a reality.

The long genesis of the Centre offers two main lessons for others. First, that managing change often needs a long period of careful planning, negotiation and consultation. A large part of the Centre's future philosophy was determined during the planning stages, and this opportunity to create a responsive environment should not be underestimated. Second, because the *initiative* for the Centre came largely from outside the usual NHS planning process, those involved had to demonstrate a knowledge of health service structures (and timetables); an understanding of health authority/local authority/local medical committee/family practitioner service politics; and experience of where and when to make appropriate representations and comments. It helps if the work is coordinated by someone with this type of knowledge, who is in a position to have an overview of professional and other organisations involved.

Sustaining the innovation

Many institutions fall back into traditional, more rigid patterns after a 'honeymoon' period. So far (although it *is* early days), the Lambeth Community Care Centre continues to operate according to its original philosophy. A number of factors contribute to sustaining patient-centred care and teamwork.

Members of the original project team still have active links with the Centre. This core group has the potential to act as a reference point for the guiding principles; and the continuity has a stronger impact because the project team developed policies for ways of working *before* the building was commissioned and built. Not only did this mean that the design of the building could be developed to reflect how the Centre would be used, it also meant that, once the Centre was opened, it had both structural and philosophical foundations. From this it was possible to make relevant judgements about the initial recruitment and selection of those working in the Centre. Induction programmes for new staff communicate the need to put patients first, and ongoing teaching and counselling by senior staff offer opportunities for restating objectives, as well as for ironing out problems. Staff at the Centre meet regularly — in audit meetings, quality circles and staff meetings. Senior staff run an annual study weekend to examine and re-examine the Centre's ways of working. All of these activities help to raise questions about operational methods, and also to promote changes when things do not appear to be working in the best interests of patients.

Conclusion

The Lambeth Community Care Centre illustrates on a small scale something which is good in inner city primary health care. Yet it is clear that the innovation could not just be transplanted anywhere. A philosophy has to be developed in consultation with a wide band of professionals and local users, and enormous effort needs to be put into communicating objectives and ideals. But probably the most important lesson to be learned is that the Lambeth Community Care Centre succeeds in its work because the central tenets of Centre policy are constantly built into, and reiterated within, the day-to-day lives of all the people who are involved there.

Appendix 1

LAMBETH COMMUNITY CARE CENTRE - BREAKING NEW GROUND

Conference to be held at the King's Fund Centre on Wednesday 25 March 1987

LIST OF PARTICIPANTS

	MRS S ALLEN	Senior Nurse Manager, Elderly Care Unit, Brent HA
	MR C AMOS	Unit Administrator, Haringey HA
	MS T ANDERSON	Principal, DHSS
	MR P ARMSTRONG	Assistant Secretary, Newham CHC
	DR S ATKINSON	Specialist in Community Medicine, Lewisham &N Southwark HA
	MRS T AYLOTT	Senior Nurse, District Nursing, Enfield HA
	MISS J BARLOW	Community Tutor, Thomas, Guy & Lewisham School of Nursing
	MR H BATTYE	Joint Planning Officer, Redbridge HA
	MRS L BATES	Service Manager (Elderly), Enfield HA
	MR S BEL-BARKO	Senior Nurse Manager, Central Middlesex Hospital
	MR N BRADY	Service Manager, Community Unit, W Lambeth HA
	MRS K BUXTON	Bloomsbury CHC
	MS C CLARK	Secretary, Waltham Forest CHC
	DR J CLARK	Director of Nursing Services (Community),W Lambeth HA
	MR A COKER	Member, Newham CHC
	MS U COWELL	Director of Nurse Education, The Nightingale School
	DR S CURSON	GP and member of Project Team
*	MR S DIU	Dentist
	MS J DOUGLAS	Administrator, Lambeth Community Care Centre
	MR J EATON	District Works Officer, W Lambeth HA
	MS A EDWARDS	Community Liaison Nurse, Camberwell HA
	MS M FARRUGIA	Nurse, Leyton Green Neighbourhood Health Service
	MRS E FLETCHER	Member, Newham CHC
*	MS S FREUDENBERG	Former Secretary, W Lambeth CHC
*	MR J GARNETT	Chairman, W Lambeth HA
	MRS M GILFEATHER	Senior Nurse, District Nursing, Bloomsbury HA
	MRS T GOLDING	Chair, Hounslow & Spelthorne HA
	MRS M GOLLOGLY	Senior Nurse, Community Mental Handicap Service, Kingston & Esher HA
	MS A GOODBRAND	Primary Care Administrator, City & Hackney HA
	MR K GRIMWADE	Research Project Officer, Lewisham & N Southwark HA
*	DR R HIGGS	GP and Chairman of Project Team
	MRS B HILL	Health Visitor
*	DR J HORDER	Visiting Professor in General Practice, and Chairman of GP Teaching Group, Royal Free Hospital
	MR B HOWARD	Service Manager (Community), Enfield HA
	MR T HULL	Assistant Director of Nursing Services, Haringey HA
*	MRS M-J ILES	Speech Therapist
	DR R JONES	Association of GP Hospitals
	MRS J KELLY	Director of Planning, Brent HA

* denotes speaker

	MR G KENNEDY	Assistant Director of Nursing (Community), Kingston & Esher HA
	MS J LAMB	Principal Architect, DHSS
*	MS C LANGRIDGE	Community Unit General Manager, W Lambeth HA
	MRS M LEWIS	Head of Nursing Services, Barnet HA
*	DR B MARSON	GP
	MR J MCINALLY	Nursing Officer, Kingston & Esher HA
	MS S MORRIS	Assistant General Manager, West London Hospital
	MISS S MOWAT	Unit General Manager, Hillingdon HA
*	MR R NICHOLSON	Architect (Cullinans)
*	MS L NIXON	Community Linkworker
	MR D ODDI	Director of Planning & Information, Hillingdon HA
	MR K PAGE	Unit General Manager (Community), Hounslow & Spelthorne HA
	MISS M PARKER	District Planning Officer, Ealing HA
*	DR D POOLE	GP
	DR A QUICK	Member, Haringey CHC
	MRS A RICHARDSON	Secretary, Wandsworth CHC
	MS C ROBINSON	Planning & Development Officer, Enfield HA
*	MS H RUDDOCK-WEST	Occupational Therapist
	MRS F RYAN	Nursing Officer, Health Care of the Elderly, Royal Free Hospital
	MR G SHEPHERD	Unit General Manager (Community and Continuing Care), Islington HA
*	MRS G SMITH	Senior Nurse (Community), Enfield HA
*	MR M SMITS	Research Nurse
	MS J SPARROW	Nurse
	DR D ST GEORGE	Registrar in Community Medicine, Merton & Sutton HA
	MR J STEVENSON	Unit General Manager, Bexley HA
*	MS G STEWART	Physiotherapist
*	MRS L SYMONS	Patient's wife
*	MR J SYMONS	Patient
	MS J SYMONS	Bloomsbury CHC
	MR A TESSEYMAN	Planning Administrator, Barking, Havering & Brentwood HA
	MRS A TURRELL	Superintendent Physiotherapist, Lewisham & N Southwark HA
	MR P WARD	Assistant Chief Architect, DHSS
	MS P WEDGE	Service Development Officer, Lewisham & N Southwark HA
	MS A WEST	District Nurse Adviser, Wandsworth HA
*	MISS S WOODWARD	Senior Nurse
	DR K ZAHIR	Specialist in Community Medicine/Community Services Manager, Haringey HA

King's Fund

MS P BROWN	Development Worker
MS P GORDON	Programme Coordinator
MS J HUGHES	Programme Coordinator
MS C KING	Secretary
MS L MARKS	Project Coordinator
MS E WINN	Project Officer

* denotes speaker

Appendix II

King's Fund Centre for Health Services Development
126 Albert Street
London NW1 7NF
Telephone: 01-267 6111
Director: Barbara Stocking, BA MSc.

March 1987

LAMBETH COMMUNITY CARE CENTRE - BREAKING NEW GROUND

Conference to be held at the King's Fund Centre on Wednesday 25 March 1987

PROGRAMME

Chairman: Dr. John Horder, Visiting Professor in General Practice, and Chairman of the GP Teaching Group, Royal Free Hospital

9.15 am-9.40 am	REGISTRATION
9.40 am-9.45 am	Chairman's opening remarks: John Horder
9.45 am-9.50 am	Introduction to the Lambeth Community Care Centre: John Garnett, Chairman, West Lambeth HA
9.50 am-11.00 am	A panel discussion developing the themes of the Centre will be led by: Sue Freudenberg, former Secretary, West Lambeth CHC Roger Higgs, GP and Chairman of Project Team Robin Nicholson, Architect (Cullinans) Lesley Nixon, Community Linkworker (Caroline Langridge, Community Unit General Manager, West Lambeth HA will take part in the discussion following the presentation.)
11.00 am-11.15 am	COFFEE
11.15 am-11.45 am	The practicalities of GP working within the Centre: Bill Marson, GP
11.45 am-12.45 pm	Quality issues Martin Smits, Research Nurse and Sheila Woodward, Senior Nurse to lead discussion on quality of care in the Community Care Centre, looking at what the Centre provides from a patient's point of view, patient autonomy, and how nursing staff cope with returning control to the patient.
12.45 pm-2.00 pm	LUNCH

Continued/...2

2.00 pm-3.15 pm	Case presentation: multidisciplinary teamwork in action John Symons, Patient Laura Symons, Patient's wife David Poole, GP Jane Sparrow, Nurse Gillian Stewart, Physiotherapist Helen Ruddock-West, Occupational Therapist Shamsher Diu, Dentist Mary-Jane Iles, Speech Therapist
3.15 pm-3.45 pm	TEA
3.45 pm-4.15 pm	Panel - a further opportunity for discussion. Followed by: Caroline Langridge, who will sum up the major themes and practical issues raised during the day.
4.15 pm-4.20 pm	Close of the conference by John Horder.

Appendix III

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WEST LAMBETH HEALTH AUTHORITY

Lambeth Community Care Centre

Costs

Appendix IV

INITIAL FUNDING

The Capital and 18 months revenue costs were provided by the Inner City Partnership. From 1.4.87 the running costs will be taken on by West Lambeth Health Authority.

CAPITAL COSTS

Construction	955,000
Design Fees	141,000
Furniture/Equipment	135,000

FIRST YEAR COSTS

From July 1985-June 1986 the costs per patient were as follows:-

	In-Patient £ p	Day Patient £ p	
Dietetics	0.44	0.43	
Nursing	16.84	2.36	
Occupational Therapy	2.15	1.21	
Physiotherapy	0.59	2.96	
Speech Therapy	0.25	0.38	
Dentistry	0.71	0.57	
Chiropody	0.10	0.29	
Other	17.25	6.27	
Medical (Admin time)	0.99	0.37	
TOTAL	39.32	15.29	
COMPARISON COSTS	112.69		St Thomas' Hospital
	57.56		South Western Hospital
	41.06		Tooting Bec Hospital

1986/87 BUDGET *

	In-Patient £	Day Patient £	Total £
Dietetics	2,918	4,968	7,886
Nursing	172,380	43,095	215,475
Occupational Therapy	14,720	14,720	29,440
Physiotherapy	3,212	28,906	32,118
Speech Therapy	1,349	3,649	4,995
Dentistry	8,813	12,681	21,494
Chiropody	619	3,252	3,871
Other	140,583	75,699	216,282
Medical (Admin time)	2,604	1,402	4,006
Total	347,198	188,369	535,567

1986/87'COST PER' *

	In-Patient £ p	Day Patient £ p
Dietetics	0.40	0.39
Nursing	23.63	3.37
Occupational Therapy	2.02	1.15
Physiotherapy	0.44	2.26
Speech Therapy	0.18	0.28
Dentistry	1.21	0.99
Chiropody	0.08	0.25
Other	19.27	5.93
Medical (Admin Time)	0.36	0.11
Total	47.59	14.73

* Budget as at August 1986

NB Centre did not function fully in 1st year, there were only 10 beds available July-August, 15 beds September - November and 20 beds from December 1985.


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