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# Neighbourhood Nursing

## Report of a conference edited by Rosemary Rogers



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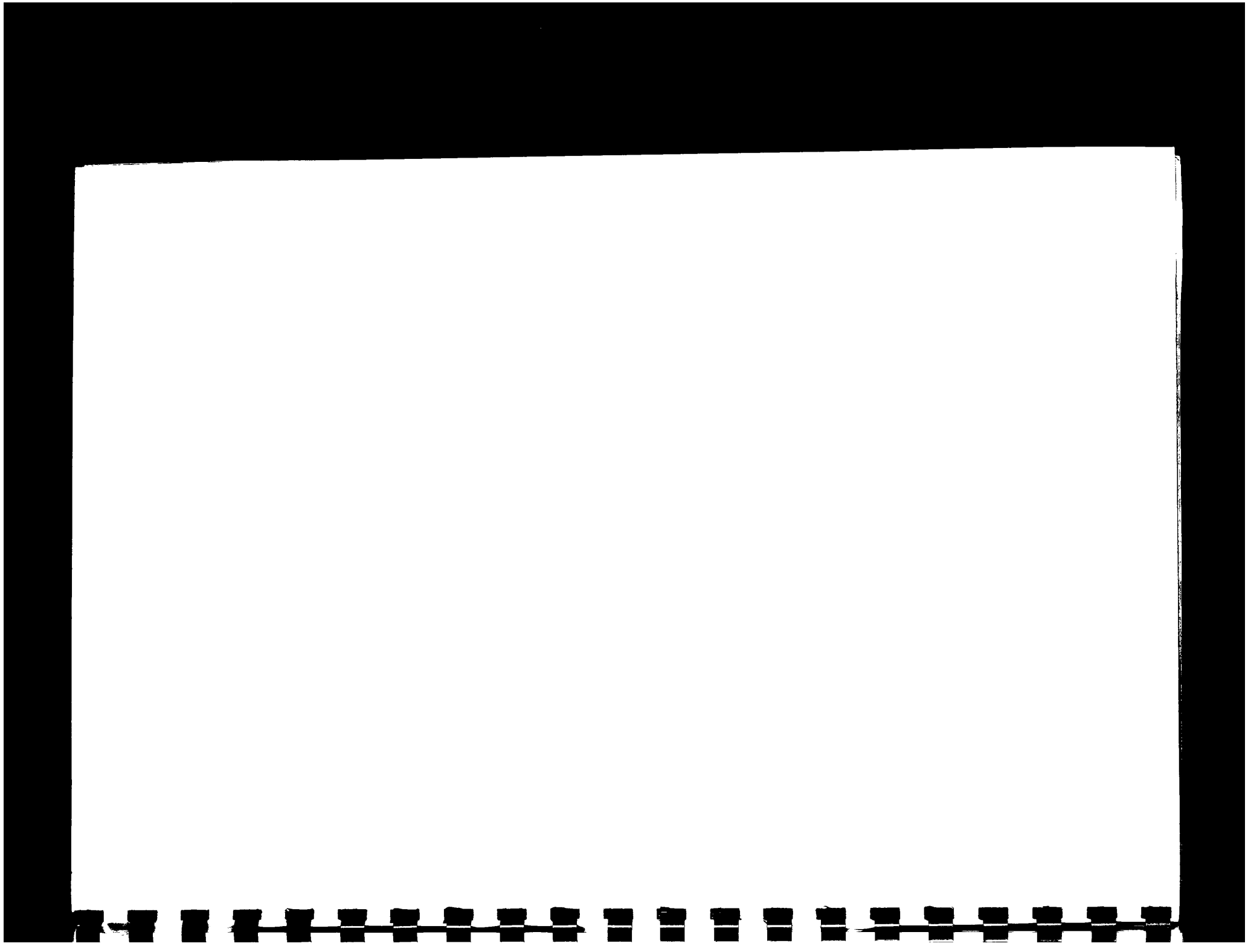
# NEIGHBOURHOOD NURSING

Report of a conference held at the King's Fund Centre

on 5 June 1986

Edited by Rosemary Rogers



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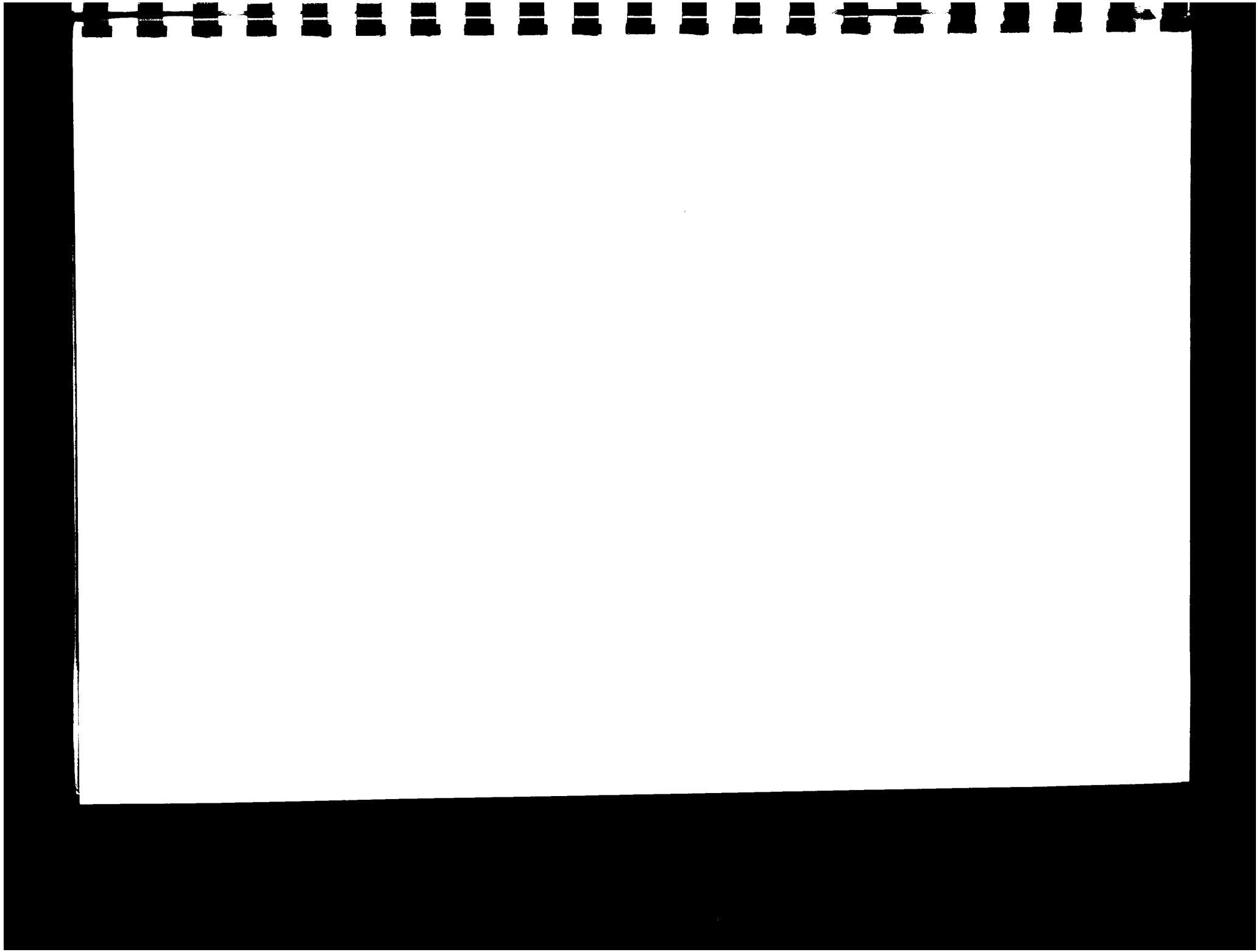

## INTRODUCTION

### The Conference

On 5 June 1986 a national conference was held at the King's Fund Centre to discuss the report of the community nursing review, **Neighbourhood Nursing - a focus for care.** One hundred and twenty delegates attended, including district nursing officers, directors of nursing services, unit general managers, health authority members, general practitioners, representatives from higher education, social services, voluntary organisations and professional organisations. The conference was heavily oversubscribed - four applicants for every place available - a reflection both of the enthusiasm and interest the report has generated and of the impetus for change.

Chaired by John Dunwoody, chairman of Bloomsbury Health Authority, the morning began with a presentation of the review's methods, findings and main recommendations from the four members of the review team: its chairwoman Julia Cumberlege, chairwoman of Brighton Health Authority; Anthony Carr, nurse member of the review team who until recently was Chief Nursing Officer for Newcastle Health Authority; Peter Farmer, a management consultant; and Edward Gillespie, the lay member of the review team.

Four speakers from fields directly affected by the report then looked at some of its implications, asking the question 'can it work?' Elva Barnie, a director of community nursing services, Greater Glasgow Health Board, looked at the implications for nurse management; while Christine Hancock, district general manager for Waltham Forest Health Authority, examined the recommendations in relation to general management. Donald Irvine, a general practitioner from Northumberland, looked at the implications for his own profession and Usha Prashar, Director of the National Council for Voluntary Organisations, discussed the proposals for greater consumer and voluntary involvement in primary health care.

In the afternoon, participants chose to attend one of five workshops to pursue in more depth some of the recommendations of the report. Key points were brought back from the discussion in each workshop to the final general session of the afternoon, which was chaired by Pat Shephard, chairwoman of Norwich Health Authority.

The following topics were explored in the workshops:

- the recommendations for the management of community nursing services: why they were made; how they fit in with the 'real' world; and how they might relate to Griffiths structures.

- the emphasis on merging the roles of community nurses: do the recommendations mean the abolition of health visitors, district nurses and school nurses or will their roles be developed and enhanced?

- the introduction of the nurse practitioner: is this following too closely a medical model or is it an exciting challenge for community nurses?

- the reality of more consumer involvement in community health services: just a token involvement or a vehicle for change and local participation?

- the possibilities for teamwork, both among community nurses and between nurses and other disciplines.

This report of the conference proceedings is not a direct narrative. The introduction describes the background to the review, the team's methods and main findings, and provides a summary of their recommendations. The subsequent five sections draw together the material discussed during the day, based around the key recommendations of the report on neighbourhood nursing services, the primary health care team, nursing skills, community nurse training; health care associations.

## The Community Nursing Review

Although commissioned by the then Health Minister, Kenneth Clarke, the review was, Julia Cumberlege was careful to emphasise, an independent report. The team had been given a free hand in their investigations.

Its terms of reference were 'To study the nursing services provided outside hospital by health authorities, and to report to the Secretary of State on how resources can be used more effectively, so as to improve the services available to client groups. The input from nurses employed by general practitioners will be taken into account'.

The review team had a support staff of four nurses: Susan Carpentier Alting, Pearl Brown, Paul Beard and Carol Files. The secretary was Michael Brown; and Roger Silver, a former journalist, wrote the final report. The team was given six months to complete its brief - a timescale which raised cries of outrage from the nursing profession, but which in the end had not proved a disadvantage. 'It gave our work a sense of urgency', Julia Cumberlege said. 'We had to stick to motorways with no time to explore the bridleways and the dead ends. Even if we had had two or three years, we would still have reached the same broad conclusions.'

The team spent the first three months out in the community talking to consumers, to nurses in all specialties, to GPs and to social workers. 'The general public image of nurses is terrific', Julia Cumberlege said. 'But we wanted to get behind the rhetoric and discover what Mr and Mrs Average really think.' A Marplan survey revealed a very high level of public acceptability of community nurses:

- 2/3 of the sample said they would be prepared to see a nurse rather than a doctor

- over 60% said they would actually prefer to see a nurse for certain purposes

- for the care of babies, this figure rose to over 80%.

The team looked at all types of primary care provision and in particular, at innovatory schemes in community nursing which included twenty-five severely demented people in Liverpool being maintained at home; a 'hospital at home' scheme in Peterborough where patients recovering from major surgery were being cared for at home; one patient, for example, was back home with full support six days after a hip replacement; health visitors in Gateshead promoting understanding about child care and development, amongst first time parents. 'We were searching out the best', Julia Cumberlege said. 'We knew these were not typical but we felt we had to build on the best that we could find.'

The team visited districts in every health region in England and examined in detail community nursing services in three specific districts - Croydon, Kettering and North Manchester. They also invited written evidence from interested groups and received 330 separate submissions, from organisations and from individuals. From this evidence the team identified three broad categories of need: dependent people at home, sick people at home and healthy people at home.

Community nursing services, they concluded, must be sensitive to the needs of individuals, families and the community as a whole. They formulated six main aims for future community nursing services:

To provide more basic information, ranging from surgery hours to information on diet and exercise

To promote health and prevent illness

To foster independence

To forge a partnership with carers - family, relatives or friends

To form part of a network of care, involving GPs, social services, housing organisations and voluntary organisations

To involve the local community

Summary of recommendations

1 Each district health authority should identify neighbourhoods for the purposes of planning, organising and providing nursing and related primary care services.

2 A neighbourhood nursing service (NNS) should be established in each neighbourhood.

3 Each neighbourhood nursing service should be headed by a manager, who would also be a community nurse, chosen for her management skills and leadership qualities. She should be based in the neighbourhood.

4 Community midwives, community psychiatric nurses and community mental handicap nurses should ensure, through their respective managers and the neighbourhood nursing manager, that their specialist contributions are fully coordinated with the work of the neighbourhood nursing service.

5 All other specialist nurses who work outside hospital should be based in the community and managed as part of the neighbourhood nursing service. Each specialist nurse should be assigned to one or more neighbourhood services and have the commitment of her time to each service specified.

6 The principle should be adopted of introducing the nurse practitioner into primary health care.

7 The DHSS should agree a limited list of items and simple agents which may be prescribed by nurses as part of a nursing care programme, and issue guidelines to enable nurses to control drug dosages in well-defined circumstances.

8 To establish and be recognised as a primary health care team, each general medical practice and the community nurses associated with it should come to an understanding of the team's objectives and individuals' roles within it.

That understanding should be incorporated into a written agreement signed jointly by the practice partners and by the manager of the neighbourhood nursing service on behalf of the relevant health authority.

The agreement should name the doctors and community nurses who together form the primary care team and should guarantee the right of the team members to be consulted on any changes proposed in its composition.

The making of such an agreement should be a qualifying condition for any incentive payments which may be introduced to improve quality in general practice (as suggested in the recent policy statement of the Royal College of General Practitioners).

9 The government should invite the Health Advisory Service, with its established reputation, credibility and acceptance by the professions, to take on responsibility for identifying and promoting good practice in primary health care.

10 Subsidies to general practitioners enabling them to employ staff to perform nursing duties should be phased out.

11 Within two years the UK Central Council for Nursing, Midwifery and Health Visiting, and the English National Board should introduce a common training course for all first-level nurses wishing to work outside hospital in what are now the fields of health visiting, district nursing and school nursing.

12 The provision of nursing services in the community should remain the responsibility of district health authorities. We would urge, however, that in due course the government should give consideration to amalgamating family practitioner committees and district health authorities and so bring all primary health care services under the control of one body.

13 A short but thorough manpower planning exercise on a practical (as distinct from purely academic) basis should be undertaken to ensure that the training and supply of community nurses is, and remains at, the appropriate level. The study should be supported by the NHS Management Board as an essential task in reviewing the adequacy and consistency of regional plans.

14 Health Care Associations should be formed, each covering one or more neighbourhoods.

## NEIGHBOURHOOD NURSING SERVICES

As its title suggests, a key recommendation of the Cumberlege report is the establishment of **neighbourhood nursing services (NNS).** These must, above all, be 'sensitive to the requirements of individuals, their families and the community in which they live', Julia Cumberlege said.

### The Neighbourhood

Every district has different needs. It should therefore be left to each health authority to identify neighbourhoods within their district, each with a population of between 10,000 and 25,000 - 'small enough to be sensible, big enough to be viable'. These neighbourhoods should be easy to identify. They already exist informally in every district, defined by social, geographical and environmental characteristics. The current location of general practices and health centres is an important guide.

When neighbourhood boundaries have been agreed, a population profile for each neighbourhood should be drawn up, showing demographic trends, patterns in morbidity and mortality, and social and environmental characteristics. It should also include census data on people living alone, people in poor housing, the size and structure of households and social class. Unemployment rates, and the provision and uptake of statutory and voluntary services could also be included.

### Nursing Services

Existing teamwork is 'fractured and piecemeal', the Cumberlege team found. District nurses and health visitors are separated in their practice both from each other and from school nurses and other specialists. As a result roles become set and traditional working methods tend to prevail.

A neighbourhood nursing service, **NNS,** should be established in each neighbourhood, bringing district nurses, health visitors and school nurses together. It should be sensitive to local needs and would form the basis for much more effective collaboration between all community health care workers.

Members of the **NNS** would be able to share their expertise with each other and with GPs, either jointly or individually, while GPs would have access to more nursing skills than are normally available. They would work closely with specialist care teams and social workers, preferably covering the same geographical areas, and determining joint priorities where health and social services meet. Community nurses, including school nurses, would be able to exploit their range of skills more flexibly and more fully. The consumer would gain a greater choice.

### Organisation

There are two community nursing workforces at present: those employed by health authorities (district nurses, health visitors and school nurses) and those employed by GPs (practice nurses). The team recommends that both these groups be incorporated into one structure, the neighbourhood nursing service, and employed by health authorities. They envisage in the future an amalgamation of health authorities and family practitioner committees but for the time being recognise that this is unlikely.

Management

Good management is crucial. The **NNS** would have to meet regularly to plan their work together, jointly set objectives and priorities, and monitor the quality of services. The crucial link in the team would be the **NNS** manager, whom the review team recommend should be a nurse with a community training. The nursing background is thought to be vital, although the individual must also have had some management training. 'To expect people to be managers if they don't speak the same vocabulary is impossible', Julia Cumberlege said. But as some participants pointed out, current management training is not always appropriate and this would have to be carefully thought through. Other management tools such as information back-up are equally important. The manager may also retain some clinical nursing responsibilities.

For the **NNS** concept to work properly, the review team envisages increasing the number of nurse managers. Current community nurse managers who are personally responsible for providing support and direction for up to 30 staff at a time have an impossible task, according to management consultant, Peter Farmer. This span of control should be drastically reduced, giving the **NNS** manager 15 staff at the most. Each **NNS** manager would report to a senior manager, with responsibility for no more than 10 neighbourhoods.

Peter Farmer believed that it should be possible to meet the additional costs incurred by these changes from efficiency savings. Increasing the numbers of nurse managers by the figures envisaged would add 2% to the nursing salary bill. But this increase should become self-financing as a result of better management and use of resources.

Can it work?

Elva Barnie, a director of community nursing services for Greater Glasgow Health Board, gave her reaction to the proposals 'from a nurse manager's point of view'. She was 'delighted' with the concept of the neighbourhood nursing service, a direction in which health care was already moving in her own area with the establishment of primary health care services based around 10 health centres. Each health centre now had one senior nurse responsible for all the nursing disciplines, giving the community nursing staff in each locality a common base, with a single clearly identified manager. The health centre was seen as 'the health hub of the community', its staff operating well together in teams and sharing common objectives.

Elva Barnie welcomed the recommendation of a written agreement between the **NNS** and GPs, a concept that was not altogether new, she said. When reorganising Glasgow's community health services, nursing policies had been discussed and agreed with the GPs beforehand and defined communication networks and team membership structures established. But she warned against the agreements being too prescriptive. 'It is important to have room for manoeuvre at local level', she said.

Clearly the neighbourhood nursing service could work, although Elva Barnie did have reservations about the size of the nursing teams - which the Cumberlege report recommends should contain no more than 15 nurses responsible to each **NNS** manager - and the increased numbers of nurse managers this would require. Unless the resources were made available, the proposals could not work, she warned. Success depended on: 'a broader span of vision, a greater understanding of community services, and a willingness to channel resources into the community'.

Elva Barnie concluded with a quotation from the 16th century writer, Richard Hooker. 'Change is not made without inconvenience, even from worse to better'.

Other participants shared her reservations about resources, and wondered whether health authorities could be easily persuaded to take on the extra nurse managers the proposals would require, particularly in the current climate. They were sceptical as to whether these recommendations would be self-financing, particularly as they would require greater clerical support. The salary grade of the **NNS** manager would also have to be resolved. If she were to maintain a clinical role, her **NNS** team would have to be small. But this would affect the salary scale and consequently the calibre of candidates. The review team, however, envisaged the scale would be that of the present senior nurse/nursing officer grade.

Another concern was how the proposed management arrangements, with a geographical rather than a professional focus, and with cross-professional teams, could be reconciled with the need for staff to have professional supervision. This could prove a transitional problem, however. The current, separate training programmes for health visitors and district nurses yield managers with a narrow professional background, it was suggested. If new common core training programmes were introduced, as the proposals recommend, these would in time produce managers with a broader professional background. And if their span of control were reduced, managers would be more able to provide better professional support to their staff. But cross-professional management could cause rivalries when new management structures were being implemented and managers appointed. The conference agreed that it would be essential to pick the best person for the job, regardless of inter-professional rivalry.

General management

How does the proposed structure fit in with general management? Christine Hancock, District General Manager for Waltham Forest Health Authority, welcomed the proposals. 'The report is clear, inspiring and encouraging to read', she said. 'It leaves you impatient for action.'

She had found 'concern and confusion' in her district about what community services were and where they should be going. Nurses must give a lot of thought to explaining to general managers what they were trying to achieve. 'General management is right for health care services but this must be demonstrated in terms of better care. This report is one way of doing that.'

It was important that the managers of nursing services had a clinical nursing background, she said. They should not be general managers or administrators. 'General managers cannot manage professional services.' She believed that general management had not so far really been applied to community services. But the setting and consideration of objectives - a central plank of the Griffiths philosophy - was an important issue addressed by the Cumberlege report.

Ideally neighbourhoods should be kept as small as possible, Christine Hancock said, possibly arranged around political wards. She welcomed the proposed written agreement between the members of the primary health care team.

The organisational and structural issues had been addressed well, she said, welcoming in particular the conclusion that there should be no separate employment arrangements for community and hospital nurses. The proposals also offered the first real opportunity since the introduction of general management to tackle consumerism.

Participants felt that while on one level the proposed model conformed to the Griffiths philosophy (the emphasis on consumerism, the identification of a single manager across professional boundaries, etc.), there could be practical problems in implementing it. Would unit general managers be prepared to delegate authority down to neighbourhood level? What would be the specific tasks of the neighbourhood nurse manager? How could overall district-wide objectives be set in regard to resource deployment?

## THE PRIMARY HEALTH CARE TEAMS

'The neighbourhood nursing teams should not be seen as substitutes for primary health care teams. They should be seen as a comprehensive reinforcement where primary health care teams already exist.' (Cumberlege report)

The review team firmly believe in the primary health care team as the way forward, Peter Farmer said. 'All the recommendations are geared around strengthening that.'

### The written agreement

To that end, the report recommends that a written agreement is jointly prepared and signed by the manager of the **NNS** and the neighbourhood GPs. It should name the doctors and nurses who together form the primary health care team and should guarantee the right of team members to be consulted on any changes proposed in its composition.

The agreement would cover the aims of the team, annual targets, meetings of the team, referral protocol (between members of the team and to outside agencies), patients' access to nurses, team membership, sharing of information, annual review.

### Can it work?

Donald Irvine, a GP from Northumberland, said the Cumberlege report was 'an excellent document, an extremely exciting and valuable contribution to current thinking on primary health care at a time when this subject is under the microscope'.

We are living through a period of enormous change, he said. 'The sorts of illnesses, problems and needs that patients had when the NHS began have altered beyond all recognition.' The changing trends in health and illness radically alter the way professionals practise. The decline in life-threatening infections has led to greater concentration on 'the multiple infirmities of old age and the need for effective prevention and surveillance'. This in turn has caused a shift in the balance from hospital to community-based care.

How the providers of that care make the necessary adjustments is not a party political matter, he said. Formerly, doctors had no need to practise in teams. They responded to what the patients said was wrong with them rather than seeking to manage chronic illness and prevent ill health.

The primary health care team was the best way of responding to changing trends, bringing primary health care to patients in their own homes or neighbourhoods. But it was a revelation to clinicians, 'brought up in the practice of individualism'. 'From a fundamental change of attitude, solutions to problems begin to flow,' Donald Irvine said. 'The key is an understanding of the nature of the task, a willingness to sit down and listen, to see what skills people have, and to be explicit in what we are trying to do.'

Participants wondered whether the achievement of such a partnership, and specifically of the written agreement, was really possible. They pointed to existing difficulties in achieving agreement between GPs, let alone between GPs and other workers.

Should the written agreement be held with the family practitioner committee in order to ensure greater commitment? Or would it be better kept locally as FPCs have little power to direct GPs or to sanction them?

Doctors who preferred not to negotiate a written agreement would receive only those nursing services which the neighbourhood nursing managers decided to provide, the report suggests. The nurse manager would give the GPs concerned a written statement of what those services would be.

Pat Shephard, chairwoman of Norwich Health Authority, pointed out that the Norwich community care scheme (which has established teams of health professionals within identified localities) was receiving very good cooperation from GPs. Other participants felt that achieving cooperation with local authorities, especially social services departments, would be just as important and probably more difficult.

Participants still felt there would be problems in reconciling primary health care teams and neighbourhood nursing schemes. One delegate described how, in Worcester, GPs take patients from all over the city and say they will not consider zoning their services. The idea of zoning was welcomed by the nurses present who obviously prefer this system of working, especially in group practices. Not all the doctors present were convinced however. One GP said patients must not be encouraged to re-register simply to fit into a new zone and the review team had accepted this as an unrealistic expectation. Overall, the view of the conference was that the written agreement would be helpful in resolving these problems but the need for the agreement to be flexible was stressed.

## NURSING SKILLS

District nurses, health visitors and school nurses are in a rut in their work, Anthony Carr, nurse member of the review team said. To change all this the team hoped to be able to bring the three branches together, blurring the roles, and allowing for a fuller and more flexible use of nursing skills. This could be achieved through neighbourhood nursing services with the development of nursing teams.

Enrolled nurses and auxiliaries also have a place in the team. There would be 'clear and important roles' within community nursing for the enrolled nurse. 'Their training enables them to carry out a wide range of duties which can be delegated to them after proper assessment by the fully qualified community nurse', the report says. Similarly, nursing auxiliaries could carry out certain basic nursing care under the direction of a trained community nurse. 'We believe the work of many auxiliaries could be developed into a combination of home help and nursing aide duties.'

There are three broad groups of specialist community nurses: community midwives; community psychiatric and mental handicap nurses; and other specialist nurses working in the community such as stoma care nurses, diabetic nurse specialists, continence advisers, nurses for people who are terminally ill and health visitors for elderly people. The contributions these groups can make should be fully coordinated with the work of the **NNS** in order to use their skills to the best advantage.

Community midwives, for the time being, should remain in an integrated hospital/community setting, Anthony Carr said, but their role would be negotiated within the written agreement. They should work to the same boundaries as the neighbourhood nurses and attend meetings when appropriate.

Community psychiatric nurses and community mental handicap nurses should remain outside the **NNS** at present because of the great benefits they derive from being part of multidisciplinary teams. A review of their position should be undertaken in five years' time. In the meantime it was hoped that community psychiatric nurses and community mental handicap nurses could be linked to Neighbourhood Nursing Teams and attend their meetings.

Other specialist community nurses should be based in the community and managed as part of the NNS - each specialist nurse attached to one or more neighbourhoods with the commitment of time to each service specified.

Elva Barnie, from the Greater Glasgow Health Board, said she would welcome the inclusion of the specialist nurse within the primary health care team. 'It would make sound sense to integrate these nurses into the community and to highlight their common objectives', she said.

Would the proposals lead to the eventual abolition of district nurses, health visitors and school nurses as such, or would they mean an enhancement and development of their roles? Participants were strongly against the creation of a generic community nurse, although in principle they favoured the idea of greater flexibility in the use of nursing skills and the loosening and blurring of roles.

Some concern was expressed over the need for professional supervision and the possible professional implications if health visitors were managed by non-health visitors and district nurses by non-district nurses. Would the neighbourhood nurse manager have the appropriate clinical skills to manage both health visitors and district nurses? The review team agreed that professional support would have to be built in and could be provided by an adjacent neighbourhood nursing manager or a clinical career grade adviser with the team.

The nurse practitioner

The nurse practitioner is still rare in the UK, although the number of practice nurses is increasing rapidly. In the course of their review the team visited the Birmingham practice where Barbara Stilwell has worked as a nurse practitioner for several years. They came away convinced that this role should be developed.

> 'We believe that community nurses who have, or acquire, the necessary skills in health promotion and the diagnosis and treatment of disease among people of all ages, should have the opportunity to practise those skills in the setting of a clinic in the neighbourhood.
>
> Her key tasks would be to interview patients and diagnose and treat specific diseases in accordance with the agreed medical protocols; refer to the general practitioner patients who have medical problems which lie outside the written protocols; be available for all patients who wish to consult the nurse practitioner; give counselling and nursing advice to patients consulting her direct or referred to her by a general practitioner; conduct screening programmes among specific age or client-groups; maintain patient-care programmes, particularly to the chronic sick; refer patients for further nursing care to the neighbourhood nursing service.' (Cumberlege report)

Participants were concerned about the legal implications if nurse practitioners were introduced on a widescale basis, particularly the insurance requirements. They were careful to draw a distinction between practice nurses and nurse practitioners - a practice nurse is currently employed by a GP to carry out certain delegated tasks. The GP is therefore legally responsible. A nurse practitioner on the other hand is a practitioner in her own right and must therefore have personal indemnity insurance.

From her own research into the role of the practice nurse and the nurse practitioner, Barbara Stilwell said there was a huge variation in the tasks these nurses performed. If there was a common core to be identified at present it was very small. The so-called 'extended role' often meant no more than taking on a few extra tasks. She also pointed out that whatever their employment position, nurses remained subject to their professional code of conduct and the disciplinary procedures of the UK Central Council.

Clearly a precise definition of the role of the nurse practitioner would have to be carefully worked out in advance - something participants felt nurses traditionally found hard to do. Some felt that her role would vary so much according to the specific needs of a particular area, that it would be difficult to agree on a definition and draw up a training programme to meet individual needs. But Barbara Stilwell pointed out that health visitors face the same variations in their different places of work but still have an adequate training course.

Access to patients is an important issue and again one in which there is great variety around the country. In some practices the nurse has open access to the patient - the patient can simply choose if and when he wishes to see the nurse rather than the doctor; in others access is through the doctors' agreement, either via a true triage system or simply a delegation of the more menial tasks.

Are nurses qualified to carry out specialised clinical examination and capable of determining when to refer the patient to the doctor? 'Nurses can be that competent,' responded Barbara Stilwell. 'I am not saying that they already are, or even necessarily that they should be; but with the extra training the report envisages, including specific training in diagnostic skills for practice nurses after community training, they certainly can be'.

**TRAINING**

> 'Bringing district nurses, health visitors, school nurses and other nurses working in the community together into neighbourhood nursing services would we believe, have a major impact on the way nurses are trained in these fields.'

The Cumberlege Report recommends the introduction of a common core training for first-level nurses wishing to work outside hospital in what are now the fields of health visiting, district nursing and school nursing, leading to a Diploma in Community Nursing and Health Care. This would be based largely on the present health visiting course and would involve one year's academic study in a university or college of higher education, followed by a year's supervised practice, including a wide variety of experience and the completion of a specialist module.

Opportunities should also be created for masters degrees and higher diplomas in community nursing. This would enable community nurses to carry out research in their own neighbourhoods, Anthony Carr said. Most of it was currently being carried out by sociologists.

The team emphasised that they are not proposing the introduction of a generic community nurse. 'But we do see common training as the one way to break down the rigid roles these nurses have at present.'

Welcoming the concept of common core training, Elva Barnie was concerned about the timing. Would the 'new' community nurses bring sufficient experience and maturity to their work? One participant suggested that training courses should include assertiveness training and Julia Cumberlege agreed. Much of nurse training concentrates on acquiring straightforward skills in preparation for what is essentially a task-oriented role.

Judith Bryant, chief nursing officer of Riverside Health Authority, said that although nurses trained in the 1950s and 1960s had been prepared for a task-oriented role, current training programmes were very different. 'Nurses are now trained for problem-solving roles,' she said, 'and they are frustrated by the traditional systems they find when they come out of training school. These proposals will offer them new systems.'

Participants generally welcomed the proposals for a common basic training programme, feeling it would increase flexibility and enhance the potential of community nurses. But retraining and reorientation for existing community nurses was considered just as important. Anthony Carr suggested that bringing outside consultants in to help with training might be more effective and efficient than sending individual members of staff on courses in a piecemeal way. It might also be necessary for districts to employ 'change agents' to work with staff and show how change could be introduced. This method is widely used in industry and could be one way of speeding up developments.

But again the question of resources was raised, with participants pointing out that some districts are not able to give nurses secondments for basic training courses. Could the elimination of 'wastage' in the way community services were currently organised, together with greater efficiency, really yield the necessary resources? One way of finding the extra cash for new posts and more training, it was suggested, was to use the underspending on nursing budgets in health authorities.

Project 2000

The review team welcomed many of the proposals in Project 2000 - the UKCC's proposals for the restructuring of nurse education - particularly the emphasis on community experience during the initial two year common foundation course.

But at the post-basic level the two reports differ. Project 2000 suggests separate health promotion and clinical care roles within the primary care team. The Cumberlege report suggests that it is this separation which has led to the present rigidity of roles between community nurses. Individuals, families and communities would benefit from a more flexible approach.

## HEALTH CARE ASSOCIATIONS

The review team looked for ways of encouraging greater consumer involvement in community health services and recommended the establishment of Health Care Associations **(HCAs)**, more locally based than the current consumer health watchdogs, the Community Health Councils **(CHCs)**. **CHCs** are based at health district level, whereas the idea of **HCAs** is that they would be neighbourhood-based, backing up the work of the neighbourhood nursing service. Edward Gillespie described **HCAs** as a two-way relationship between the public and primary health care services - dealing with complaints and suggestions and identifying gaps in services, but also providing the patient with information about treatment options and helping him to make an informed choice: 'telling the patient what to look for on the shelves'.

Membership would vary according to the character and perceived needs of the locality, but **HCAs** would be small. They might include the neighbourhood nurse manager, a 'talented and tolerant' GP, a social worker, a representative from the CHC, a representative from the voluntary sector as well as local citizens.

'Society is going through a time of enormous change. People are questioning what health services are offering, challenging professional judgment and looking for alternatives', Julia Cumberlege said. 'Professionals are only effective when they are wanted as well as needed.'

Usha Prashar, Director of the National Council for Voluntary Organisations, welcomed the proposals. There were 'some very positive things in the report', she said, and it was encouraging that the role of the voluntary organisations and local networks had been recognised. When defining new networks for the involvement of voluntary groups, it was important to establish the links already in place, the scale of the numbers of informal carers and the range of voluntary organisations in existence.

She suggested that the voluntary organisations should have some input into nurse training to help nursing services understand more fully the nature of the voluntary sector, and to recognise and respect the huge range and diversity of organisations in existence. 'If it is recognised that the voluntary sector is to make a full contribution in planning services, it is important that its qualities are recognised and its independence respected. The structure of the voluntary sector must be understood for it to be consulted and involved in a real sense', Usha Prashar said.

When setting up **HCAs**, the resources needed must be taken into account. Voluntary agencies should be seen as complementary to, rather than substitutes for, statutory services, particularly at a time of financial constraint. It was also important to recognise the difference between voluntary workers recruited by the NHS - recruited on the understanding that they would undertake certain tasks - and those who came directly from voluntary organisations. 'Volunteers should not necessarily be asked to perform tasks that should be done by professionals', said Usha Prashar. 'They must not be regarded as a cheap alternative to the statutory services.'

Participants voiced other concerns about the relationship between users and providers of neighbourhood services. Where would the money come from for **HCAs,** particularly when **CHCs** are under-funded? Would **HCAs** be representative of the people in their neighbourhood? What power would **HCAs** have to influence decision-makers? Many of the potential problems associated with **HCAs** are also apparent in **CHCs** at the moment. However, some participants felt that **HCAs** were likely to foster professional alliances, and might hinder some of the more imaginative development work that is currently taking place. It was also suggested that the emphasis on the 'commercial' consumer model might stifle the role of the **HCA,** limiting it to handling complaints and grievances rather than encouraging and facilitating the involvement of the community in deciding how services should be provided and run.

**In Conclusion**

The discussion throughout the day was lively and stimulating. Strong views were expressed in favour of the Report's recommendations and equally strong reservations were expressed about the practicality of implementing some of them.

Particular difficulties were envisaged in aligning general medical practices with neighbourhood nursing services, especially where GPs resist the idea of zoning. Cross-professional nursing management in a geographically-based team was seen as another problem. Legal implications over insurance for nurse practitioners, finding resources for more nurse managers, more clerical support and for Health Care Associations were also potential problems. But several participants spoke of Cumberlege-type experiments already taking place and there was considerable interest in learning more about these. Above all, there was enthusiasm for the spirit of the Cumberlege Report with its emphasis on a more flexible use of nursing skills, and a breaking down of traditional barriers within community nursing.

**King Edward's Hospital Fund for London**

King's Fund Centre
126 Albert Street London NW1 7NF

## NEIGHBOURHOOD NURSING - A FOCUS FOR CARE

Conference at the King's Fund Centre on Thursday 5 June 1986

Those due to attend:

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|---|---|
| MRS M ACLAND | Vice President, District Nursing Association |
| MISS E L ALEXANDER | Isle of Wight HA |
| MRS M ALEXANDER | Community Nurse Specialist, Bath HA |
| MS T ANDERSON | Principal, DHSS |
| MR R F ASHMOLE | Chairman, Bromley HA |
| MS J BAILEY | Director of Nursing Services (Community), Paddington & North Kensington HA |
| * MISS E BARNIE | Director of Nursing Services (Community), Greater Glasgow Health Board |
| MR P BEARD | Director of Nursing Services, Bloomsbury HA and Nurse Advisor to Review Team |
| MRS C BEECH | Unit General Manager, East Hertfordshire HA |
| MR P R BETHELL | Chief Nursing Advisor, Calderdale HA |
| MRS R BLAKEY | Location Manager, East Hertfordshire HA |
| MRS M BREW | Lecturer, Croydon College |
| MRS M J BRITTON | Community Unit General Manager, South Tees HA |
| * MS P BROWN | Development Worker, King's Fund Centre and Nurse Advisor to Review Team |
| MRS J BRYANT | Chief Nursing Officer, Riverside HA |
| MRS P BUTCHER | Director of Nursing Services (Community), N Devon HA |
| * MR A CARR | Nurse Member of Review Team |
| MISS M COLYER | Director of Nursing Services (Community), Tower Hamlets HA |
| MRS K M CONWAY-NICHOLLS | Chief Nurse/General Manager Community Health Unit, Brent HA |
| MISS S M CRAWSHAW | Director of Nursing Services (Community), St Helens & Knowsley HA |
| * MRS J CUMBERLEGE | Chair of Review Team |
| MRS L I CUTLER | Director of Nursing Services, W Berkshire HA |
| MRS J H CUTTING | Assistant Director of Nursing Services, Liverpool HA |
| MS G DALLEY | Development Worker, King's Fund Centre |
| MISS E E DARGUE | District Nursing Officer, Sheffield HA |
| MRS A J DAVID | Senior Lecturer, Croydon College |
| MRS M B DEAKIN | Unit General Manager (Community/Mental Handicap), W Suffolk HA |
| MISS D DENNEHY | London Project Executive Committee, King's Fund |
| MISS D J DOLMAN | Regional Nurse, South Western RHA/Gloucester HA |
| * DR J DUNWOODY | Chairman, Bloomsbury HA |
| MR D DURHAM | Unit General Manager, Paddington & N Kensington HA |
| MRS F M DU TOIT | Chief Nursing Officer/Unit General Manager Priority Care Services, Worthing HA |
| MISS C EGAN | Director of Nursing Services (Community), Newham HA |
| * MR P FARMER | Management Consultant on Review Team |
| MISS C FARRELL | London Project Executive Committee, King's Fund |

* denotes speaker/facilitator

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| MR M F FENN | District Nursing Officer, Huntingdon HA |
| DR L F FISHER | Unit General Manager Community/Mental Handicap, Macclesfield HA and BMA representative |
| MR J P FITZSIMONS | Assistant Director of Nursing Services, Manchester HA |
| MRS P FREEMAN | Assistant Director of Nursing Services, Richmond, Twickenham & Roehampton HA |
| MRS C GAMBLE | Director of Nursing Services Community/Midwifery, Scarborough HA |
| MR N T GERRARD | Unit General Manager Community, Oldham HA |
| MISS P M GILBERT | Director of Nursing Services, Grimsby HA |
| * MR E GILLESPIE | Member of Review Team |
| MR GODFREY | General Medical Services Committee of BMA |
| MISS S GOODWIN | General Secretary, Health Visitors Association |
| MS P GORDON | Programme Coordinator, King's Fund Centre |
| MR T E GRADY | Unit General Manager/Chief Nursing Officer, Exeter HA |
| MS H GRAHAME | Chair, Bloomsbury Community Health Council |
| MISS J GRANT | Nursing Advisor, Chichester HA |
| MRS GREENWOOD | Nursing Officer, Lewisham & N Southwark HA |
| MS K GREENWOOD | Secretary, Paddington & N Kensington CHC |
| MR J GRIFFITHS | Unit General Manager, Richmond, Twickenham & Roehampton HA |
| MS P GUNN | Assistant Professional Officer, Royal College of Midwives |
| * MS U GUSTAFSSON | Research Fellow-Teamwork Project, Centre for Study of Primary Care |
| MISS C HANCOCK | District General Manager, Waltham Forest HA |
| MRS C HARDING | Secretary, Hillingdon CHC |
| MR E A HARGREAVES | District Nursing Officer, Bradford HA |
| MRS J H HENCHER | Director of Nursing Services, Worcester HA |
| MR J HENLY | Unit General Manager, Portsmouth & SE Hampshire HA |
| MR E C HERBERT | Unit General Manager Community, Plymouth HA |
| MR M HOLDSWORTH | Director of Quality Assurance/Chief Nursing Advisor, Haringey HA |
| MR A HOLBOURN | General Manager Community Health Services, Merton & Sutton HA |
| MRS D A HOPKINS | Senior Nursing Officer-Health Visiting, Eastbourne HA |
| MISS D HORRIDGE | Nursing Officer, DHSS |
| MS J HUGHES | Programme Coordinator, King's Fund Centre |
| * DR D IRVINE | General Practitioner, Northumberland |
| MRS S J JONES | Assistant District Nurse, Herefordshire HA |
| MR J C KIRKMAN | Unit General Manager, Leicestershire HA |
| MS C LANGRIDGE | Secretary, Wandsworth CHC |
| DR C M LEON | Associate Advisor in General Practice, Regional Postgraduate Institute for Medicine & Dentistry |
| MRS J LIVERSEDGE | Primary Care Services, Medway HA |
| MRS J MACKAY | Senior Nurse Child Abuse/Training Officer, Hillingdon HA |
| MRS P MASON | Unit General Manager Community, Brighton HA |
| DR E J MCGUIRE | District Medical Officer, Tunbridge Wells HA |
| MRS M MERRICKS | Manager-Community Services for Adults, Cambridge HA |
| MR J MILLETT | Chairman, Macclesfield HA |
| MISS J A MOORE | District Nursing Advisor/AGM Quality Promotion, Southampton & SW Hampshire HA |
| MISS M G MORRIS | Director of Nursing Services, Chester HA |
| MISS S MOWAT | Unit General Manager, Hillingdon HA |
| DAME ALISON MUNRO | Chair, Chichester HA |

* denotes speaker/facilitator

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| MRS M J NORMAN | Assistant Chief Nursing Officer, E Suffolk HA |
| MRS P O'CONNOR | Director of Nursing Services, Bexley HA |
| MS E O'KEEFFE | Bloomsbury CHC |
| REVD B ORMEROD | Chair, Northallerton HA |
| MISS M J PACKWOOD | Unit General Manager, Tunbridge Wells HA |
| MRS M A PERCIVAL | Director of Community Nursing Services, Kettering HA |
| DR U N PHILLIPS | Unit General Manager, Worcester HA |
| * MS U PRASHAR | Director, National Council for Voluntary Organisations |
| * MISS C PYKE-LEES | Priority Care Group General Manager, Lewisham & N Southwark HA |
| MISS J REDDINGTON | Director of Nursing Services, Torbay HA |
| MRS J REID | Chair, NW Surrey HA |
| MRS J REYNOLDS | Hon. Secretary, Health Visitors Association (Shropshire Branch) |
| MISS E A RIDLEY | Acting Director of Nursing Services, Gateshead HA |
| MISS B M ROBOTTOM | Professional Officer (District Nursing), English National Board for Nursing, Midwifery & H Visiting |
| MR M D SCOTT | Senior Nurse, Community Nursing Review for Wales |
| * MRS G P SHEPHARD | Chair, Norwich HA |
| MISS K G F SPILLER | Director of Nursing Services, Tunbridge Wells HA |
| MRS M STANHOPE | Chair, SE Staffordshire HA |
| MS P STEVENS | Regional Nurse, Manpower Planning & Information, SE Thames Regional Health Authority |
| MRS M P STEWART | Community Nurse Manager, Winchester HA |
| * MS B STILWELL | Nurse Practitioner, Department of General Practice, University of Birmingham |
| MR D W SWARBRICK | Chairman, Hillingdon HA |
| MR A TAYLOR | District Nursing Officer, Northallerton HA |
| MR A C TAYLOR | Chairman, Newcastle HA |
| MRS M TAYLOR | Assistant Director of Nursing Services, Southend HA |
| MISS M THWAITES | Professional Officer (Health Visiting), English National Board |
| MISS H TRAYLEN | Information & Planning Manager, Bath HA |
| MISS D M WAGNER | Chief Nursing Officer, N Bedfordshire HA |
| DR C WAINE | Royal College of General Practitioners |
| MRS J M WALDEN | Chief Nursing Advisor, Bloomsbury HA |
| * MISS M WANN | Development Worker, National Self-Help Project at National Council for Voluntary Organisations |
| MISS M WARD | District Nursing Officer, Leicestershire HA |
| MISS H WATTS | Director of Nursing Services, Macclesfield HA |
| MS K WHITE | Lecturer in District Nursing, Polytechnic of the South Bank |
| MS S WHITE | Acting District Nursing Officer, Newham HA |
| MISS C M WHITEHEAD | Unit General Manager/Chief Nurse, Maidstone HA |
| MRS P J WILLIAMS | Director of Nursing Services, Peterborough HA |
| MISS K E WINN | Project Officer, King's Fund Centre |
| DR I G YULE | District Medical Officer, Aylesbury Vale HA |

## NEIGHBOURHOOD NURSING - A FOCUS FOR CARE

A day conference to consider the findings and implications of the Community Nursing Review (England) - Thursday 5 June 1986.
10.00 am - 4.00 pm

### PROGRAMME

The morning session will be chaired by **Dr John Dunwoody**
Chairman of Bloomsbury Health Authority.

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|---|---|---|
| 10.00 am | Registration and COFFEE | |
| 10.30 am | Chairman's Introduction: Dr John Dunwoody | |
| 10.35 am | The Way Forward: Mrs Julia Cumberlege<br>Mr Anthony Carr<br>Mr Peter Farmer<br>Mr Edward Gillespie | ) Review Team |
| | The Way Forward - Can It Work? | |
| 11.40 am | Miss Elva Barnie, Director of Community Nursing Services, Greater Glasgow Health Board | |
| 11.50 am | Miss Christine Hancock, District General Manager, Waltham Forest Health Authority | |
| 12.00 noon | Dr Donald Irvine, General Practitioner, Northumberland | |
| 12.10 pm | Ms Usha Prashar, Director, National Council for Voluntary Organisations | |
| 12.20 pm | Discussion | |
| 12.45 pm | LUNCH | |

The afternoon session will be chaired by **Mrs G P Shephard,**
Chair of Norwich Health Authority

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| 2.00 pm | Workshops with the Review Team and facilitators - see enclosed list. |
| 3.00 pm | TEA |
| 3.20 pm | Discussion with the Review Team |
| 3.50 pm | Chairman's Summary |
| 4.00 pm | FINISH |

## NEIGHBOURHOOD NURSING - A FOCUS FOR CARE

Conference at the King's Fund Centre on
Thursday 5 June 1986 from
10.00 am - 4.00 pm

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***Which workshop would you like to join?***

**Workshops**

In the afternoon there will be the following five workshops. Please be thinking about which one you would like to join. Places will be limited to 20 in each, so making a second choice is also a good idea. The workshops will provide an informal structure for pursuing in more depth some of the recommendations of the Review Team.

**WORKSHOP I**

Peter Farmer, the management consultant on the Review Team, will be joined by Celia Pyke-Lees, Priority Care Group General Manager in Lewisham and North Southwark Health Authority, to discuss such issues as how the management recommendations fit in with the real world, why they were made and how they might relate to Griffiths structures, etc.

**WORKSHOP II**

Anthony Carr, the nurse member of the Review Team, will be joined by Kate White, lecturer in District Nursing, Polytechnic of the South Bank, to discuss what type of community nurse we might expect in the future as a result of the emphasis on merging the roles now and the new training in the future. Are health visitors, district nurses and school nurses being abolished or having their roles developed?

**WORKSHOP III**

Barbara Stilwell, the experienced nurse practitioner, will be joined by Pearl Brown (nurse advisor to the Review Team and Development Worker at the King's Fund Centre) to discuss the recommendations that nurse practitioners be introduced, what this means for the consumer/primary health care team - is it following too close a medical model or is it an exciting new challenge for community nurses?

**WORKSHOP IV**

Edward Gillespie, the lay member of the Review Team, will be joined by Mai Wann, Development Worker at the National Self Help Project based at NCVO, and will look at the reality of more consumer involvement in community health services of the future. Will Health Care Associations be just an excuse for the health authority to say they are involving the consumer after all, or will they prove an exciting vehicle for change and local participation?

**WORKSHOP V**

Julia Cumberlege, Chair of the Review Team, will be joined by Ulla Gustafsson, Research Fellow - Teamwork Project at the Centre for the Study of Primary Care (NE Thames Region), and will discuss the implications that the Report has for team work among nurses and between nurses and other disciplines, particularly in the primary health care teams. Is the proposed agreement between nurses and GPs an idle fantasy or can it be seen as a tool for enhancing good teamwork?