Working paper for managers: 4

CAN 'CUMBERLEGE' WORK IN THE INNER CITY: THE WANDSWORTH VIEW

Gillian Dalley

King's Fund Centre for Health Services Development

PRIMARY HEALTH CARE GROUP

Gillian Dalley is a development worker with the Primary Health Care Group at the King's Fund Centre for Health Services Development. She was previously a research fellow at the MRC Medical Sociology Unit in Aberdeen where she did research on professional attitudes and policy implementation.

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

Primary Health Care Group
King's Fund Centre for
Health Services Development
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London NW1 7NF

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CAN "CUMBERLEGE" WORK IN THE INNER CITY - THE WANDSWORTH VIEW

Report of a workshop held at the King's Fund Centre,
Friday 11th December 1987

Introduction

The Cumberlege report, Neighbourhood nursing : a focus for care was published in April 1986. It was greeted with enthusiasm by the nursing world and many district health authorities (DHAs) initiated plans to examine the feasibility of introducing the approach to community nursing advocated in the report.

The main recommendations of the report can be summarised briefly as follows:

- local communities, described as neighbourhoods, should be the focus for the community nursing service, so that the needs of the population could be more easily identified and responded to, and existing community networks could be fostered.

- neighbourhood nursing teams comprising health visitors, district nurses and school nurses should be established, in order to provide an integrated and co-ordinated service to the local community.

- the team should be managed by a manager coming from a community nursing background, chosen for her management skills; thus a single manager would manage nurses from several disciplines.

- the concept of teamwork should be fostered and collaborative relationships with general practitioners be encouraged; written agreements outlining this collaboration between the teams and local GPs were to be encouraged.

- consumers should be involved as much as possible in the planning of services; health care associations should be set up to provide a consumer voice.

Although the report was generally welcomed and about half of all DHAs have proceeded with their plans to introduce the neighbourhood nursing approach, reservations have been expressed in some quarters about the report's recommendations. General practitioners have been hostile on the whole believing it to threaten the concept of the primary health care team, and some community nurses have expressed worries about the practicalities of implementation - especially in districts where there is severe under-staffing and pressure on resources. In the autumn of 1987, however, the DHSS issued a circular giving guarded approval to the report - it recognised that its approach might be particularly appropriate in inner city areas.

Since that time, DHA community units which are introducing the new style neighbourhood nursing teams have been keen to compare their experiences with each other and it was for this reason that the King's Fund and Wandsworth DHA's Continuing Care Unit decided to hold a workshop, presenting an outline of what Wandsworth had achieved over the preceding year, together with contributions from two other districts which were also on the way to introducing the new approach. Forty-three people participated, representing nineteen London health authorities. This report records the proceedings of the day.

THE WORKSHOP

The workshop was held to provide an opportunity for London DHA community units to discuss whether the approach to community nursing as advocated in the Cumberlege report was viable in the inner city. Health authorities were invited to send small teams of people from their community units (representatives, for example, of management, nursing and other functional heads) together with a GP wherever possible. The Continuing Care Unit general manager and the Community Services manager of Wandsworth Health Authority agreed to present an outline of the progress they had made towards establishing neighbourhood health care teams as a case study.

Over the past year, Wandsworth has decentralised its Community Services into three localities and within one of them (at the time of the workshop) has established a number of health care teams which incorporate the neighbourhood nursing approach proposed by Cumberlege. Although in the early days after Cumberlege was published, some measure of doubt was generally expressed as to whether Cumberlege could 'work in the inner city', the Wandsworth managers felt their own experience disproved this and wanted to share their experience usefully with other districts.

Introduction to the day.

Barbara Stocking, director of the King's Fund Centre for Health Services Development, opened the day by welcoming participants and stressing that the day was to be a 'learning day' for everybody present. Along with the team from Wandsworth, speakers from Islington and Paddington and North Kensington Health Authorities had been invited because they were developing similar, but slightly different, approaches; this, it was hoped, would provide an opportunity to compare and contrast ways of working in the three districts. In addition, the architect of the neighbourhood nursing approach, Julia Cumberlege, had been invited to contribute her views to the panel discussion which would take place after Wandsworth's presentation.

The Wandsworth presentation.

Terry Gould, continuing care unit general manager, opened the presentation by describing the challenge facing him and his management team when they came into post of achieving major changes in the quality of community health services and their delivery, within the existing framework of the NHS at the time. He was sure that change would benefit users and staff alike, but it would have to be a continuing process, subject to frequent monitoring and evaluation.

The need for an overhaul of the community health services (CHS) in the inner city had been recognised from the time of the 1980 Acheson inquiry and its report in 1981, but although recommendations were made, little effective action had been taken. Levels and quality of service had deteriorated and staff morale was low. But the advent of the Griffiths report in 1983 provided an opportunity to review the management of services; at the same time it put the community health services - by creating units of CHS management - on an equal footing with hospital services for the first time. The new managers of these units were given objectives to achieve as they came into post. In his post as continuing care unit general manager, in Wandsworth, he was asked to develop community health services in cooperation with the Family Practitioner Committee (FPC), the local authority and local voluntary organisations. In order to do this effectively, he had to draw up a new management structure, review the existing situation and ascertain the reasons for the difficulties in recruiting nursing staff. The review showed that not only were establishments low but morale amongst staff was low. There was a lack of in-service training; staff were compelled to work full-time or were offered 30 hours per week but only on temporary contracts; potentially violent situations were disregarded; and staff were having to wear winter uniforms throughout the year.

Some immediate improvements could be made: they introduced training, flexitime, permanent contracts, self defence classes and summer uniforms. Other improvements and changes were necessarily more complex and longer term.

They based their consideration of the future development of the community health services on the discussion and recommendations contained in the

Acheson report (1981), the Primary Care Green Paper (1986) and the Cumberlege Report (1986). They set the following objectives as a basis for their future plans:

- the decentralisation of their community health services;
- the need to develop multi-disciplinary services;
- the importance of health promotion;
- the identification of local needs;
- a wish to develop innovative ways of meeting need;
- well considered risk taking;
- decision-making which takes place closer to the consumer;
- a willingness to be flexible;
- good team work;
- the establishment of Health Care Associations;
- building links between statutory agencies and voluntary groups;
- the encouraging of professional development.

They believed that Wandsworth provided an appropriate setting for the implementation of Cumberlege: its total population of 180,000 could be divided into 9 neighbourhoods of between 15 - 20,000 people. The boundaries of the neighbourhoods would link with electoral ward boundaries and social services boundaries. They were able to demonstrate differences in levels of social deprivation, using the Jarman underprivileged area scores, and plotted them on the map. Neighbourhoods were determined around this information. Neighbourhoods were then clustered into 3 localities, comprising 4, 2 and 3 neighbourhoods respectively. The aim was to set up Neighbourhood Health Care Teams which would involve not only the community nurses (health visitors, district nurses and school nurses)

but other professional groups such as community midwives, community psychiatric nurses, physiotherapists and occupational therapists.

Thorough and careful discussions were conducted with the acute and mental health units, to convince them of the value of the strategy. Then it was necessary to promote the idea first with the health authority and later with local GPs and Wandsworth social services department.

Deborah Hennessy, community services manager and nurse adviser, then described in more detail how the new approach is structured. She described how a decentralised structure fitted in with Griffiths-style general management: with the appointment of locality managers it took decision-making lower down to a point closer to consumers. Greater accountability would be forthcoming both upwards to the health authority and downwards towards the consumer. It was easier to develop strategies and to monitor their success in smaller units of management; staff would feel more involved and managers would be more responsive to their needs. The aim was to ensure the provision of all necessary nursing and other skills from within the neighbourhood as far as possible. This would require as flexible as possible a use of nursing skills and other resources.

She also stressed that they were building on the strengths of good primary health care teams where they existed and encouraging new teams. She agreed with the DHSS Circular HC 87/29 when it said "Nurses are at their most effective when they and GPs work together in an effective primary health care team. This is the best means of delivering comprehensive care to the community."

She went on to describe how the structure worked. The district is divided into 3 localities each with a locality manager (a general manager, regardless of professional background). Localities are divided into neighbourhoods: there are 9 in all. Each neighbourhood has a clinic which serves as a central base for the health care team. The neighbourhood covers one or more electoral wards and social services patch teams and takes into account, as far as is possible, the traditional working arrangments of GPs. The neighbourhood boundaries would be reviewed in due course and changed if it was felt necessary.

Discussions took place with all those who were involved or had an interest in the delivery of services in the community - unit staff themselves, the local medical committee (LMC), the family practitioner committee (FPC), local GPs, the local authority, the community health council (CHC), voluntary organisations, along with those hospital based services which also worked in the community - mental health staff (community psychiatric nurses (CPNs), psychologists), midwives and paramedical staff. This was a crucial stage in the preparation for implementation; it was important to inform and consult with all those who would be involved. One aim was to accomplish a change in the philosophy underlying the services : they were to be seen not as outreach services stretching out to consumers 'out there', but they were to become local services available within each locality.

Management of the new structure was to be in the hands of 3 locality managers, accountable to the community services manager. They were appointed from different professional backgrounds and each is responsible for 2 or more generic nurse managers (all with a community nursing qualification). They in turn are managers of a mixed nursing team each - comprising health visitors, district nurses and school nurses -, responsible for clinical performance, co-ordinating team work, and for child abuse.

Rachel Scragg, one of the 3 locality managers then described how the plans for decentralisation were implemented. Some practical things had to be done: there was some modification of buildings to accommodate different groupings of staff, and more telephones had to be installed. Regular management training was initiated to prepare for change, to foster team building, to improve communication and to build morale generally. The training was important in itself but it was also beneficial because it gave the opportunity for the teams to spend time together - they were able to discuss ways of working as a multifunctional team under the guidance of an occupational psychologist. A series of 'away days' consolidated the process.

Time had to be spent working out carefully the different structures of managerial accountability and professional responsibility. Guidelines on the latter, especially in relation to child abuse, have been drawn up to ensure that appropriate professional advice is available to senior managers who do not have the relevant nursing background.

One immediate improvement that the new arrangements have achieved has been in recruitment; there is now a full establishment in health visiting. Teams are busy sharing ideas about working together, setting common team objectives and working out how to identify needs more accurately.

Everyone agreed that evaluation of the new way of working was important. Some of the ways they were trying to accomplish this were outlined. They were asking staff for their opinion; they were speaking to GPs; they planned to establish health care associations in the neighbourhoods to sound out local people's views. They believed that the number of innovations introduced and the level of staff morale were both useful measures for evaluation.

Concluding Wandsworth's presentation, Rachel Scragg looked to the future. She wondered how far the team could be extended to provide line management for staff other than community nurses. Could nurses in the future be managed at all levels by non-nurses, so that the post of neighbourhood health care team leader might be open to non-nurses? The issue of how to improve and maintain clinical standards would obviously be crucial. Another key issue was how to organise the paramedical services and how to restructure the relationship between hospital and community. And underlying everything, remained the question of how best to involve consumers in the planning of services and how to assess their needs most accurately.

The Panel Discussion

Jenny Lawrence, nurse adviser and primary care services manager from Paddington and North Kensington DHA (the workshop took place before the recent merger between Paddington and North Kensington and Brent) described her district's approach to introducing neighbourhood nursing. The district is a small one (population: 120,000). The population is mobile and there are 2500 homeless families living within their boundaries, which cover two local authorities (Kensington and Chelsea and Westminster). Four area social work teams cover the territory; there are 77 GPs practising within the district (25% of whom are single handed); most community nurses work geographically since there are only 3 group practice attachments. There are 8 clinics in the district.

They have decided to introduce neighbourhood nursing cautiously by setting up a pilot project covering the catchment area of 2 clinics (which match the area of 2 electoral wards). The population of the patch is 10 - 12,000. The project is under the leadership of a nurse manager (SN grade 5) on a 2 year contract; six months are to be spent setting up the pilot, one year for the pilot scheme to run, with a futher 6 months to be spent on evaluation.

The purpose behind the pilot is to establish whether or not neighbourhood nursing is feasible; to improve working relationships with local GPs; to develop good links with local community groups; and to encourage staff to examine their roles with a readiness to change where necessary. All the staff involved in the pilot scheme have chosen to be part of it. The manager has been in post since mid October (1987) and at present is spending time developing contacts with GPs and social services and drawing up a health profile of the patch.

Geoff Shepherd, unit general manager of Islington's community and continuing care unit, described his unit's progress towards decentralisation and the introduction of neighbourhood nursing. The aims of decentralisation were to maximise inter-agency working through establishing coterminous locality boundaries with the local authority; to strengthen primary care team working and improve links with GPs; to improve access and quality of service for consumers; and to establish effective team working based on high professional standards.

The population of Islington is 157,000 and the district covers an area 2 x 4 miles. They have divided the Unit into 5 localities each with a population of around 30,000, each locality coterminous with a cluster of the Borough's neighbourhoods. A locality manager heads each locality, responsible for nursing and administrative staff. Paramedical staff are aligned to localities but managed by district heads. The locality managers are from various backgrounds, graded at A & C 14, and SN5.

There are to be 2 neighbourhood nursing teams in each locality, each covering a population of about 15,000. A paper outlining the general principles of the approach was agreed by the Health Authority in June 1987. Workshops have been held with community nursing staff to discuss the ideas and implications of the proposals. Each team will comprise

around 20 members, which is close to Cumberlege's recommendations. Each neighbourhood nursing team leader will have particular responsibilities, for example, for homelessness. They were all very aware of the training needs and the importance of preparation for staff at a time of such major organisational change.

General discussion

Much discussion centred around the need to establish good relationships with local GPs, and a number of contributors described what steps they had taken in relation to this. Wandsworth, for example, had been in contact with every GP in the district, Paddington and North Kensington had written to every GP; Islington had tried to involve them at all stages - by having a GP and the FPC administrator on the steering group which drew up the proposals, by giving a presentation at the GP forum and by individual contacts. One GP in the audience said she felt that contacts and links had improved since her district had introduced the neighbourhood approach.

A CHC representative said that her CHC was very much in favour of the consumerist orientation of neighbourhood nursing and liked the idea of the health care association which should be able to have closer contact with local consumer groups than the CHC which had to cover a wider area was able to. The importance of linking in with the voluntary sector was stressed especially as a means of getting information about available health services across to the local population.

Wider level issues were also raised : what was the government's long term position on the relationship between health authorities and GPs for example. Julia Cumberlege was keen for FPCs to take a more active role in planning and joint working but recognised that they were still under-resourced and over-stretched. Concern however was expressed that GPs were being encouraged to take on greater numbers of staff which might undermine community unit staffing and managerial structures - and in the long term lead to the privatisation of primary care under GPs.

Managerial issues were also discussed. A number of participants were worried about how to clarify the differences between the management role and professional leadership within teams, given that neighbourhood nurse managers would be managing a multi-disciplinary team in which individual

members were at the same time being expected to work more flexibly. Islington saw an important part of training as being the sorting out of these issues at the individual level, so that each team member knew clearly what was expected and exactly where first and second line professional support was located. This would be written down in a letter for each member of staff. Wandsworth was satisfied with its arrangements for professional support, (especially for child abuse matters) through 'twinning' managers of teams from different disciplines (HV and DN) to give professional support to each other's team members and the development of the existing procedures.

No-one present saw neighbourhood nursing as a threat to good primary care teams where they worked effectively. They could be integrated into the wider neighbourhood teams and benefit from increased contact and support. One of the aims of the approach was to break down the barriers which had grown up between the nursing disciplines in the community. It would also provide an opportunity to break down some of the rigidities of the old style nursing management hierarchies.

Questions were asked about extending the scope of the neighbourhood nursing teams to include other nurses besides health visitors, district nurses and school nurses and even, it was suggested, non-nurses. Several districts were hoping to link more closely with mental handicap teams which were also going into neighbourhoods; in others specialist nurses (diabetic and incontinence nurses for example) were relating to particular localities. The longer term aim for some was also to include paramedical staff (OTs and physios) in the teams as well. In addition, as the neighbourhood nursing approach became established, many saw the benefits of flexibility coming to be recognised. Team mix and team size would be able to be related to the needs of the neighbourhood in question.

DISCUSSION GROUPS

A. How the district-wide specialist and paramedical services fit in

Terry Gould (Wandsworth UGM) led the discussion by outlining the issues as they faced Wandsworth. The initial problem was to find a place for the paramedics. They were used to working in the community, but were nevertheless attached to the hospital although

somehow never wholly part of the hospital. In addition, since the advent of general management, the relationship between paramedical heads (with their responsibility for professional advice and leadership) and general managers had never been worked out properly.

In the immediate future, he hoped that paramedical staff would see themselves as providing an integrated service, moving with patients from the hospital into the community and relating to particular patches in the community - they would be linked to neighbourhood health care teams but not managed in them.

However it was difficult to get the acute unit to think in community terms; the community unit wanted discussions with the hospital services to look at the implications for the community of more day surgery and greater throughput. There had to be a change in philosophy but it was difficult to achieve.

Discussion.

A number of participants had found similar difficulty in trying to promote a change in attitudes towards the community. Some wanted the hospital to be more conscious of the community needs of patients, but this was difficult when throughput was so rapid. It was often difficult for paramedics who had responsibilities both in and outside hospital to reconcile different demands being made on them.

Fears were expressed that if paramedics were ultimately to be managed by locality managers or neighbourhood nurse managers, it would weaken professional standards and professional leadership. However others argued that if the structures and lines of accountability were worked out properly, this need not be a problem. It was also recognised that the specialist skills of some paramedics had to be available to the whole of the unit, so mechanisms had to be set up whereby a specialist paramedic might be based in one locality but used as a resource by other localities.

Fears were expressed relating to long-term developments in the family practitioner services; it was felt that community unit structures would be destroyed if GPs employed more staff, and different types of staff (including paramedics). The challenge in the immediate future

was to find out how best the GP could be involved in current strategy and planning. After all, the patient became a GP responsibility on discharge from hospital, so it was important to involve him/her.

Problems surrounding the process of discharge from hospital were also discussed. Even where procedures were established, for example where the ward sister filled in a 'going-home' card - with a diagnosis and recommendation for all services needed - to be sent to the GP, too often there was too great a dependence on the informal passing on of information which was unreliable. The problem of records was raised, especially where an individual patient might be in receipt of a number of services. Some suggested the use of a single card (often the district nursing card) which was filled in by each visitor to the patient. The focus was on the patient, and it should be seen as the patient's card. But the question of how the GP fitted in to this remained - should the GP have a separate record? A further issue was how much clinically sensitive information could be recorded. The problems of co-ordination of services and of information were clearly seen as central for services delivered in the community.

B. **What staff preparation and training is needed**

Rachel Scragg (Wandsworth locality manager) described the training and preparation which had been organised in Wandsworth for neighbourhood health care. It was important to make sure that all staff understood what the philosophy was behind the new structures and to recognise while there were important advantages in the new system, there might also be some problems. Staff should be given the opportunity to express their fears and to feel that their views are being listened to. Forums where this takes place should not be too large, or else participants feel overwhelmed.

The importance of good training for management was stressed. Nurses have tended in the past to cling to very rigid, hierarchical forms of management. This was an opportunity to change. Neighbourhood nurse managers could perhaps learn from being 'paired' with general managers for a time. District resources for training had to be identified and used.

A comprehensive training programme had to be established. This must be carefully planned, taking into account for whom it was planned, what its intended outcome was and what resources it could call upon. District resources should be identified and used; training in multi-disciplinary working and team-building were essential. The training process should include clerical staff as well as nursing and paramedical staff. Assertiveness training in some instances might be appropriate - this would be helpful in building skills for constructive and clear negotiation within teams and in approaching other agencies. If budgets were going to be devolved, then training in budget management would be essential.

Discussion

The timing of any training programme was seen as crucial, likewise the timing of the introduction of any major change. The two processes should go hand in hand so that the relevance of each for the other was recognised. It might be better and cheaper to buy in training from outside if district capacity and resources were insufficient.

Other aspects of change were also discussed: how can existing staff be fitted into new structures; was it appropriate to slot people in to new posts, or should they have to apply for the new jobs? Some individuals cope with the challenge of change better than others. Time should be given for staff to plan and meet each other; recruitment is often a problem at times of major change.

Some worry was expressed about the position of nurses in locality management. There were fears that they might get bypassed in the scramble for general management opportunities. However, neighbourhood nurse management could be seen as a 'springboard' to further management opportunities.

C. **How to work as a common team**

Elizabeth Atere-Roberts, a neighbourhood nurse manager, started the discussion on working in the common team by describing the composition of the neighbourhood health care team in Wandsworth.

District nurses, health visitors, school nurses and general practitioners form the core of the team, whilst the wider Neighbourhood Health Care Team includes paramedics, CPNs and midwives although in a less close working relationship. The neighbourhood nurse manager is managerially responsible for the nurse members of the core team but the NHCT on a whole operates on a collegial basis. The health visitor, district nurse and school nurse members of the care team now work from the same offices and this facilitates the sharing of ideas about patient care and the developing of joint ventures in relation to the neighbourhood as a whole.

In discussing what seemed to make for effective teamworking, Elizabeth Atere-Roberts underlined the importance of setting - and sharing - common goals and objectives. Along with this, an understanding of each other's roles was important as was a common commitment to the team and its aims. Team-building was best achieved by meeting regularly and by being ready to discuss issues openly without reluctance to express feelings and opinions freely. It was recognised that consensus was not always going to be achieved, but where there were disagreements, it was important they should be brought out into the open. Opportunities for time out for training and preparation were essential to develop the team.

Dr Sian Job, a general practitioner in Wandsworth, said how impressed she was with the way the 'neighbourhood health care team' approach was working. Working relationships between a number of GPs and community health services staff had improved significantly since the introduction of the new way of working.

Discussion

Whilst participants liked the idea of common team working, some said pressure on resources and accommodation made it difficult for some units to introduce the mixed team approach. They recognised that sharing the same base or offices was an important part of building the team, but this was difficult to achieve in practice. Others were worried about how to ensure sound professional advice and accountability in child abuse cases, although the Wandsworth experience seemed to prove that this was not a problem. Neighbourhood nurse managers of different disciplinary backgrounds

Neighbourhood nurse managers of different disciplinary backgrounds were able to support each other - and develop each other's skills.

There was general agreement that the common team provided community nurses from mixed disciplines working together and sharing ideas, with a tremendous opportunity for improving the quality of care and advice to people living in the neighbourhoods where this approach operated.

D. How to research and appraise practice and health outcomes

Deborah Hennessy, (community services manager, Wandsworth) led the discussion on research and appraisal. She drew a distinction between research which was about investigation and appraisal which was about measurement. In any appraisal, it was first necessary to define structures and expectations, and then these could be assessed by using a structure/process/outcome model. She then went on to describe how this could relate to looking at neighbourhood health care. First it was necessary to draw an accurate picture of how things were at present - this would include a profile of the population, by age and sex, morbidity statistics, clinic attendances, social service and housing department statistics and so on. As there was very little hard information about health, they were presently conducting a survey to look at health needs - asking about lifestyles and perceived health needs. It was important to collect information in a manner which was usable - by postcode in their case. The survey will be repeated at a future date taking into account changes during the meantime.

Discussion

A number of participants said they were doing similar studies in their district often involving departments of community medicine (Hillingdon, for example). In Tower Hamlets they were administering the Nottingham Health Profile (of self-assessed health status). Haringey was drawing up locality profiles and basing their planning on the information in them. Deborah Hennessy suggested it would then be possible to adjust staffing ratios on the basis of such locality information - for example where there were high levels of child abuse, they would be able to increase the numbers of health visitors.

The question was raised as to how far field staff's views and knowledge were being taken into account in drawing up information profiles. In Wandsworth, staff had been involved in discussions about boundaries and in Hillingdon, clinic steering groups had been set up to choose targets for some clinic services.

One problem which was aired was how to make sure certain activities did not get squeezed out once mixed team working had started - prevention, for example. The need for monitoring was crucial to make sure this did not happen. One participant remembered that this had happened in the past where there had been triple-working.

The need for outcome measurement was recognised; it was also acknowledged that this presented problems for those areas of the service where outcomes were unclear. Wandsworth suggested that the quality of professional advice and leadership was important in those cases; they had appointed a professional development officer who would develop a continuing education programme and work closely with the quality programme. Standard setting and performance review were key issues of the day and progress in these would have a beneficial effect in the long term.

Referral patterns and referral rates were also discussed. Norwich was documenting referral patterns and Wandsworth planned to do so. Finally, the question of how to involve consumers was considered. Some had tried neighbourhood meetings but they tended to be poorly attended; others contacted local voluntary organisations. Targeting particular groups known to be interested in particular issues was also suggested. Julia Cumberlege suggested that professionals were not always good at listening to clients and hoped that this would change eventually. Wandsworth reported that one of their neighbourhoods had decided to set up a bi-monthly stall in the local market feeling that this would attract a good deal of interest and in another neighbourhood a health care association was being piloted.

CONCLUSION

There is no doubt that the Cumberlege report has fired the enthusiasm of many community units up and down the country. Wandsworth's progress, which this report describes, certainly reflects that enthusiasm. Starting from a point two years ago where staff morale was low, recruitment and retention poor, the Continuing Care Unit has developed a structure and an approach to service delivery which has gained the commitment of its staff and of associated professionals from outside the unit.

Insights to be gained from Wandsworth's experience and from the other districts participating in the presentations - Islington and Paddington and North Kensington - can be summarised as follows:

* the community health services have been vastly undervalued in the past, with a consequent lowering of morale and commitment amongst staff.

* the neighbourhood nursing approach, or the 'Cumberlege approach', has provided an opportunity to rebuild staff morale and to introduce innovative thinking.

* the introduction of innovative change has provided managers with the chance to communicate with staff and to show that they are valued.

* neighbourhood nursing has offered the means of making general management 'work' well at the sub-unit level.

* neighbourhood nursing does not have to work against the idea and practice of the primary health care team; it can be the means of establishing good relationships with GPs.

And some lessions to be learned about implementing neighbourhood nursing successfully can be listed as follows:

* the importance of careful preparation in terms of building an accurate picture of the population, its distribution and its needs.

* the need to talk and listen to staff.

* the importance of providing training and preparation for staff at all levels.

* the need to set clear aims and objectives and to timetable implementation appropriately.

* the importance of contacting GPs individually and collectively whenever possible and to include them in planning and preparation.

* the importance of the consumer's voice and viewpoint in all aspects of service planning and delivery.

There are many initiatives going on all over the country which are seeking to introduce new ways of working in the community health services. The value of sharing ideas and learning from others' experiences (and mistakes) is widely recognised. The Wandsworth workshop provided just such an opportunity for the nineteen districts represented on the day; there was general agreement that it was a worthwhile occasion.

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

Can 'Cumberlege' work in the inner city - The Wandsworth view

A workshop to be held at the King's Fund Centre on
Friday 11 December 1987, 9.30am - 4.30pm

PROGRAMME

9.30am REGISTRATION and COFFEE

10.00am Introduction: *Barbara Stocking*, Director of Health Services Development, King's Fund Centre

10.05am Neighbourhood Health Care in Wandsworth

Terry Gould, Continuing Care Unit General Manager
Deborah Hennessy, Manager Community Health Services/Nurse Adviser to the Unit
Rachel Scragg, Locality Manager

11.30am Panel discussion

The Wandsworth team will be joined by:

Julia Cumberlege, Chair of the Community Nursing Review team
Jenny Lawrence, Nurse Adviser and Manager Primary Care Services, Paddington & North Kensington HA
Geoff Shepherd, General Manager, Community & Continuing Care Unit, Islington HA

12.30pm LUNCH

2.00pm Workshops

How the district-wide specialist and paramedical services fit it: *Terry Gould*

What staff preparation and training is needed: *Rachel Scragg*

How to work as a common team: *Elizabeth Atere-Roberts*, Neighbourhood Nurse Manager and *Sian Job*, General Practitioner

How to research and appraise practice and health outcomes: *Deborah Hennessy*

3.15pm TEA

3.40pm Plenary session

4.30pm FINISH

Can 'Cumberlege' work in the inner city - The Wandsworth view

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PARTICIPANTS LIST

Chair: *Ms B.Stocking, Director of Health Services Development, King's Fund Centre

Mr Z Arif	Sector Manager, Ealing HA
Ms J Dawson	Merton & Sutton HA
Mr N Brady	Service Manager, West Lambeth HA
Dr S Brown	Specialist in Community Medicine, City and Hackney HA
Mrs A Burton	Superintendent Physiotherapist, Riverside HA
Mrs H Butler-Gallie	Director of Nursing Services, Camberwell HA
Miss J Buxton	Health Visitor, Islington HA
Mr C Chapman	Locality Manager, Haringey HA
Mrs M Codjoe	Senior Nurse/Child Health Adviser, Ealing HA
Miss M Colyer	Community Services Manager, Tower Hamlets HA
Miss M Comerasamy	Community Mental Handicap Nurse, Riverside HA
Mrs J Cumberlege *	Chair of the Community Nursing Review team
Miss M Dinwoodie	Unit General Manager, Harrow HA
Mrs E M Eley	Assistant Unit General Manager, Hampstead HA
Dr A Fairey	GP, Barnet HA
Mrs P L Freeman	Director of Nursing Services and Operations Manager, Richmond, Twickenham & Roehampton HA
Ms A Goodbrand	Primary Care Administrator, City & Hackney HA
Mrs P Gosling	Community Services Manager/Director of Nursing Services, Harrow HA
Dr T Gould *	Continuing Care Unit General Manager, Wandsworth HA
Ms J Harwood	Decentralisation Project Worker, Riverside HA
Dr D Hennessy *	Manager Community Health Services/Nurse Adviser Continuing Care, Wandsworth HA
Mrs M C Holden	Service Manager, Waltham Forest HA
Mr B Howard	Community Services Manager, Enfield HA
Dr S Job *	GP, Wandsworth HA
Mr K Jones	Development Officer, Tower Hamlets HA
Ms M Jones	Head of Planning and Administration/Deputy General Manager, Barnet HA
Ms C Langridge	Unit General Manager, West Lambeth HA
Ms J Lawrence *	Nurse Adviser and Manager Primary Care Services, Paddington & North Kensington HA
Miss B Lawrie	Acting Director of Community Nursing Services, Tower Hamlets HA
Mrs M C Lewis	Head of Nursing Services, Barnet HA
Mrs M Mitchell	Locality Manager, Haringey HA
Miss E D Morris	Senior Clinics Manager, Barking,Havering & Brentwood HA
Mr K Mullins	Locality Manager, Haringey HA
Miss M Murrell	Unit General Manager, Enfield HA

* Denotes speaker

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Miss M Parker	Assistant Director of Nursing Services, Riverside HA
Mrs B Patterson	Locality Manager, Haringey HA
Ms H Cooper	Enfield HA
Mr G Roff	Unit General Manager, Hampstead HA
Mr M Rodger	Head of Administration/Service Development Officer, Camberwell HA
Ms R Scragg *	Locality Manager, Wandsworth HA
Mr G Shepherd *	General Manager, Community and Continuing Care Unit, Islington HA
Ms J Smaje	Divisional Manager/Deputy Unit General Manager, Hillingdon HA
Ms E Atere-Roberts *	Neighbourhood Nurse Manager, Wandsworth HA
Ms A Taket	Lecturer in Health and Health Care, Tower Hamlets HA
Dr T H Toosy	GP, Merton & Sutton HA
Mr A Treasure	Unit General Manager, Newham HA
Mrs W Vlok	Director of Nursing, Merton & Sutton HA
Ms J Cowley	Riverside HA
Mrs M S Whyte	Superintendent Physiotherapist, Tower Hamlets HA
Mrs M Whitton	Chairperson, Barnet CHC
Dr K Zahir	Community Services Manager, Haringey HA

King's Fund

Ms P Brown	Development Worker
Ms G Dalley	Development Worker
Ms C King	Secretary