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Cumberlege in Action

A directory of good practice that influenced the Community Nursing Review Team

Edited by Pearl Brown and Pat Gordon
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King's Fund Centre
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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.

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FOREWORD

The NHS is well known for its "not invented here" syndrome, dismissing ideas which have not been pioneered in their particular health district. However I have been impressed that since the publication of the Community Nursing Review Team's report "Neighbourhood Nursing - a focus for care" one of the most frequent questions asked at meetings and through the mail has been - have you got an index of the good practice that you saw and think we could emulate? My answer has had to be no, but thanks to the King's Fund that is no longer the case.

This excellent paper presents a fund of good schemes which impressed the Review Team due to the way they had been carefully planned and implemented showing sensitivity to consumer demand. Although some of these schemes will need to be modified to meet local circumstances they all have a practicable base and improve beyond doubt the quality of life of those they seek to serve.

Here is an opportunity to learn from others, to save the effort and waste of time re-inventing the wheel and hopefully in some cases the flat tyre as well.

People's expectations of health visitors, nurses and midwives working in the community are very high and they are right to expect good service from a highly trained professional body of committed men and women. I wish you every success in your endeavours.

Julia Cumberlege

INTRODUCTION

The Report of the Community Nursing Review* was published in April 1986. During the six months in which they gathered evidence and visited each Region in England, the Review Team saw and heard of many examples of good practice. These helped shape their thinking about the way community nursing services could develop. For while their diagnosis may have been that in general community nursing is "in a rut", they were in no doubt at all that throughout the country there are shining examples of imaginative services.

In the last twelve months, since the Report was published, there has been enormous interest in and debate about its recommendations. There have also been requests for more information about experiments in different districts and 'how to do it' questions at the many workshops and conferences which have taken place. This directory has been compiled in response to these requests. It contains brief descriptions of twenty projects which for one reason or another impressed the Review Team. More importantly perhaps it gives the name of a contact in each case so that colleagues can get in touch with each other and discuss the pros and cons of new ways of working, the pitfalls as well as the successes. It is intended as a working paper.

The Review Team found examples of good practice in every Region. Some are included in the Report* itself, others are threaded through the check lists in Part II. This directory is by no means comprehensive but its contents are intended to illustrate a little more fully how the Review Team saw services developing to become "more sensitive and responsive to the needs of consumers". This is the underlying theme of the whole report, the end result to which the recommendations are directed.

The work described here is grouped into three categories, three means towards the same end:-

- managing resources effectively;
- extending traditional nursing services;
- collaborating with other agencies.

Some of the schemes have common characteristics to which these broad headings do not do justice and an index is therefore included to make the directory easier to use.

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* Neighbourhood Nursing - A Focus for Care: Report of the Community Nursing Review. DHSS, 1986.

GLASGOW: MONITORING THE HEALTH OF CHILDREN AND THE WORK OF HEALTH VISITORS

Health visitors visit all new born babies several times in the first five years of life. Their records hold a great deal of information about the health status of children. In **Glasgow** a simple computer programme has been developed to extract this information in a form which is useful for managing the service.

Since 1982 returns have been made for children in Glasgow at the ages of one, nine, eighteen and 46 months. 98% of children have been followed through and important information analysed about developmental delay, breast feeding, hospital admissions, clinic attendance and other factors. The data is used to understand the caseloads of individual health visitors. It is also used on a postcode basis to map the health status of children across the city. This allows 'black spots' to be identified and enables managers to redistribute resources and target their work. The data also allows comparison over time.

The work is based on the national child health record system being developed in Cardiff. The first two modules (the child register and immunisation modules) have been adopted in Glasgow, but it was felt that the pre-school module did not give the kind of effective monitoring system which was wanted for health visiting; and so an additional module was developed for domiciliary health visiting. It is fully integrated with the national system and has been in operation since January 1982. Health visitors complete a set of four computer returns for each child between birth and five years. Staff time to complete the returns is minimal and the computer programme is simple. Items can be analysed by individual health visitor caseload showing, for example, the number of hospital admissions or referrals to GPs or domiciliary visits. They can also be analysed by postcode as a map, showing at a glance the geographical spread throughout the city of hospital admissions or clinic attendance or immunisation uptake. Examples of the maps and the computer returns are given in the Community Medicine article referenced below[1]. In it, McIntosh and Womersley refer to the computer programme as a "modest development" which has enabled 98% of children born in the city to be kept under surveillance, despite a highly mobile population.

Most important perhaps is that the data collected is turned into information in a usable form[2]. It enables health visitors to manage their caseloads more effectively, and it provides managers with the information they need to direct resources. For example, when the postcode analysis revealed one small sector of the city with a particularly high incidence of hospital admission of babies with gastroenteritis, managers decided to redistribute resources and put an extra health visitor into the patch to

work on an intensive programme of home visiting. This had the desired result of reducing the infection rate and the admissions. It also had the result of enhancing job satisfaction. The Glasgow managers are in no doubt that the 'evidence' from the computer returns not only makes their task easier, it makes the health visitors' work more satisfying. It also allows a clearer picture to be presented to health board members and officers of the work being done by health visitors.

This project is thought to be so successful in assessing the health status of children and providing an excellent management tool that it is hoped to develop a similar programme on the health status of elderly people in the care of district nurses.

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NEWCASTLE: NEGOTIATING AGREEMENT BETWEEN A SPECIALIST COMMUNITY TEAM AND PRIMARY HEALTH CARE TEAMS

The 'Care Team for the Elderly' in the city of **Newcastle** is a centralised team of community nurses who offer a health assessment service for elderly people on a practice basis, on terms agreed with general practitioners and attached nurses. Their aim is to offer a service to clients regardless of whether they are known to the primary care team, social services or voluntary organisations; and having made an assessment, to establish a routine surveillance programme within each general practice. In so doing, they aim to support elderly people at home and to offer a preventive service rather than a treatment programme. Their work has been described as "a highly popular service to practices which could not do this for themselves - an outstanding example of nurse managers actually managing[1]".

The background to the project is that in 1984, a survey of nurse managers in 49 health districts revealed that although 90% of them thought that helping elderly people to remain independent was primarily the health visitor's remit, in fact very few elderly people were visited. The centralised care team in Newcastle was set up as a way of offering community nursing services to elderly people before they become ill or need crisis intervention or regular treatment. Resources were released to fund this team by streamlining the school nursing service and discontinuing the geriatric visiting service.

The team comprises three leaders - one district nurse and two health visitors - and seven staff nurses each of whom has some expertise in working with elderly people.

After investigating many screening trials, the care team devised a screening card which met their requirements. From the 1981 census data, wards with the highest number of elderly people were identified. Community nurses attached to GPs in those wards were asked to approach the practices (twelve in all) to offer the services of the team. Within a week, three practices requested a meeting with the care team, and within six months these practices had been screened, a further two were under way and four were awaiting the team's services. The work has now spread throughout the city.

The organisation of the work starts with the care team meeting with GPs and attached nurses to agree screening standards, access to records and domestic arrangements. The Family Practitioner Committee provides lists of patients over 75 years and the primary health care team identifies recent deaths, housebound people, hospital patients, etc. Appointments are sent for either clinic screening or home visits. Those failing to attend clinic sessions are followed up with domiciliary visits. Elderly people with

immediate needs are identified, referrals are made, equipment obtained, etc. They are then placed on a rota to be visited at regular intervals according to identified 'at risk' criteria. When the screening of all people over the agreed age limit is completed, records are handed back to the district nurses and health visitors working in the practice. Each person has an individual visiting plan and shared screening clinics are then established. The team then withdraws from the practice to work with another one.

Negotiated agreement between the care team and general practitioners and other members of the primary care team is central to the success of this project. The impact of the specialist team going into a practice, setting up the system and then withdrawing, appears to be effective in establishing the surveillance of elderly people as a permanent part of practice work.

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1 STEEL, R. Pros and cons of five ways to screen the elderly. Geriatric Medicine. June 1986, pp 63-66.

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KETTERING: SHORT-TERM TARGETED HEALTH VISITING TO CONTROL AN OUTBREAK OF HEPATITIS B

Following an outbreak of hepatitis B in Kettering, a short-term programme of targeted health visiting was set up as part of an epidemiological investigation. The aim was to trace known cases and their contacts, and use health visiting skills to increase the knowledge and awareness of those at risk and thus contain the outbreak.

Between January 1984 and April 1985, 105 cases of hepatitis B were notified in Kettering health district, 70 of which were from the town of Corby. Prior to this, one to five cases were notified annually. It was suspected that the outbreak was associated with drug abuse among adolescents, not a group with whom health visitors usually work. Their task was threefold: to trace the 70 known cases in Corby and their contacts; to persuade them to attend a clinic for blood tests; to explain the nature of the disease and how to avoid the spread of infection.

The two health visitors worked closely with specialists in microbiology and community medicine. There was some scepticism about the chances of success in persuading the vulnerable group to attend for blood tests since all that was on offer was health education. The results show, however, that all 70 cases were traced and interviewed and 95% attended the clinic for a blood test. 300 contacts were interviewed and 83% attended for a blood test. Those with positive results were offered support and three monthly follow-up. Eighteen months after the project only twenty further cases had been notified, twelve of whom were close contacts of the original 70.

There seems little doubt of the success of the interviews and the opportunity they afforded for health visitors to discuss a variety of health related issues with a population of young people normally outside their caseload. Among the topics raised in addition to hepatitis and the spread of infection were AIDS, family planning, sexually transmitted diseases, housing and welfare benefits. Referrals were made to other agencies as required.

Short-term targeted work may be unusual for health visitors, but it offers a way of extending their role in the promotion of health and prevention of disease, which in turn may lead to greater job satisfaction.

Reference: BROOKBANKS, M.P. and HEMPSTEAD, A.L. Positive Health Visitor Intervention: Controlling an epidemic. Kettering Health Authority Report, 1986.

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PORTSMOUTH AND SOUTH-EAST HAMPSHIRE: STRUCTURED HEALTH VISITING AS AN AID TO INFANT SURVEILLANCE

The aim of this programme in **Portsmouth** and **South-East Hampshire** is to identify at birth children at risk of sudden death and child abuse and to offer close surveillance and structured visiting by health visitors to reduce that risk. The work has been described in several articles[1,2].

Between 1977 and 1981 in the town of Gosport, there were 49 sudden infant deaths. Because of this high incidence (7.8 per 1,000 compared to a national average of 2.3 per 1,000) it was decided to undertake a restrospective study using the Sheffield scoring system[3] to find out whether the Gosport babies could have been identified as at risk. Although only six out of the eight Sheffield factors could be used in Gosport, it was found that 40% of the 49 SID babies scored 'high risk' compared to 28% of the control group. This evidence, backed by information from health visitors, led to the setting up of an infant surveillance programme in 1982.

The organisation of the programme rests on all babies being assessed at birth and at four weeks, and an intensive health visiting programme being implemented for babies scoring a high risk. Structured visiting is recommended, with the pattern used by Sheffield health visitors, on the evidence that where there is intervention, fewer children die. At four weeks, the baby is weighed naked and a questionnaire completed. Questions are asked which help to select children at risk of child abuse or at risk of deafness. The answers to the questionnaire are fed into a computer and the GP and health visitor receive information on whether the baby is low risk, high risk, or very high risk. All parents who have had a previous infant death are scored high risk.

Three home visiting patterns have been developed, ranging from almost weekly for the high risk groups to the normal four or five in the first year of life for the low risk group. Health visitors experienced the biggest change in their work as a result of the surveillance programme which was extended in April 1983 to cover all babies born in the district.

No extra finance was needed for health visitor staff. Weight monitoring is regarded as vital to the success of the work and money was raised from several sources to buy scales for each health visitor. Wall thermometers were also bought for high risk babies. The computer was financed initially from charitable sources.

In addition to the changes in health visitor working patterns the programme has produced other benefits: accurate records, sharing of accurate information, closer cooperation between GPs, clinical medical officers, paediatricians, midwives and health visitors, baby charts for each baby used by both parents and professionals, more accurate monitoring of caseloads by nurse managers, improved teaching sessions with student health visitors and midwives.

Although the debate continues about the evidence that increased structured health visiting can affect the life chances of high risk babies, the Sheffield and Gosport experience suggests that this is so[4,5,6]. This routine also provides a tool for measuring the effectiveness of health visiting while at the same time providing job satisfaction for health visitors.

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3 PROTESTOS, C.D. et al. Obstetric and Perinatal Histories of Children who Died Unexpectedly (Cot Death). Archives of Disease in Childhood. No. 48, 1973, pp 835-41.

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6 CARPENTER, R.G. and others. Sheffield Cot Death Project. The Lancet. 7 June 1986, p 1331.

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GATESHEAD: STRUCTURED HEALTH VISITING WITH FIRST TIME PARENTS

The 'first parent visitor' programme in **Gateshead** is an example of health visitors adopting a specialist approach to try and reach a target population in an effective way. The target in this case is first-time parents who live in areas of multiple deprivation where poverty, unemployment and poor housing make it difficult, if not impossible, to assess the effectiveness of health visitor interventions.

The aim of the programme is to build up parenting skills by working cooperatively with parents. To do this, a health visitor is released from other casework to work only with first time parents, and a series of carefully structured visits is carried out beginning with an antenatal visit followed, after the birth, with a weekly visit for six weeks and then a monthly visit for six/eight months. Each visit is planned by appointment so that the mother knows the health visitor is coming. The programme of visits focuses on seven areas of development: language, social development, cognitive development, pre-school education development, nutrition, health, general development. The health visitor has considerable resource material for use during the visits ('programme tools') and a development card and progress form are held by the parents. After eight months the family is handed over to the generalist health visiting service unless there are particular reasons for continued intensive support.

The programme in Gateshead is part of a national intervention study based on the work of Dr. Walter Barker at the University of Bristol. This is aimed at promoting new parents' understanding of their child's early development and how they can enhance that development. It is no longer concentrated in areas of multiple deprivation. Because of their unique entree into the homes of parents of young children, health visitors are in a key position to support and encourage them. This programme offers a way of doing it which seems to improve confidence and parenting skills even though home surroundings may not change.

Reference: Child Development Programme. Health Visitor. January 1985, vol. 51, pp 5-7. (A report of a conference.)

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NEWCASTLE: PATCH-BASED CHILD HEALTH SERVICES

The aim of the Riverside project in Newcastle upon Tyne is to provide preventive health services for children on a local and accessible patch basis. The key elements are a geographically based multidisciplinary team; better integration of services within the NHS and between the health, social and educational services; greater participation by service users. The work has been described in articles and reports.

The project started in 1979 when it took over responsibility for all school and baby clinic medical services in four electoral wards in the west of the city. The population of the chosen patch was 40,000 with 9,000 aged under 16. This patch had the highest levels in the city for perinatal mortality, low birth weight babies and child abuse registrations. The project team originally included doctors, a health visitor, community workers and administrative staff. A local base was set up in a school. The idea was to provide the medical services for pre-school and school age children with a new perspective by involving the local population in deciding which services should be provided, and by assessing how to make the best use of these services. The advantages and disadvantages of working on a patch basis were also to be assessed.

In 1987 the team now consists of six doctors (two full-time, one part-time, and three in training); two community workers; one information worker; two speech therapists; one speech therapy aide; and two secretaries (one part-time). The team meet weekly and work closely with school nurses and health visitors. In the area there are four nursery schools, thirteen primary schools, two secondary schools, one special school, fourteen group practices. Three child health clinics are held jointly with three practices.

All the usual services are offered to parents and children through the pre-school and school health services. How, when and who gives them is where the difference lies between this and the more orthodox delivery of services found elsewhere. The project has attempted to deliver a service more finely tuned to what families need. For example, staff meet and discuss all the children they have seen following a child health session - sharing information and teaching. The five year old on entering school does not automatically have a medical examination. If the child has been seen regularly by a health visitor in the preceding years and there are no immediate problems, this is thought to be unnecessary. Instead health staff, school staff and parents are involved in a review of the child and only following this might a child be referred to the school doctor. As well as listening to and involving parents, the form teacher (not the Head

as in many other areas) is closely involved in helping to review the health needs of the child. This process has helped to break the myth ,that the doctor can discover every child's health problem simply by a single examination. This process of selective screening has released medical and nursing time to be spent with children and families who need more support.

Because the team works in a geographical patch they are in a good position to help local people focus on health issues wider than those of their children; for example, on the Tyne and Wear Well Women's project and the need for an Asian Women's Centre. The community workers are able to support local groups and campaigns and have also helped parents to produce their own leaflets on subjects such as bedwetting, talking to the doctor, children's infections. They have helped to bridge the gap that is often found between professionals and their clients.

Different ways of working have been tried out and documented during this project. Ways have been found of demystifying health care and enabling parents and teachers to help assess their children's health needs and decide appropriate services. The local community as a whole has had more opportunity to become involved in health issues.

The project was originally financed by the University Department of Child Health, health authority, Sainsbury Fund, Inner City Partnership and Save the Children Fund. Staff are now funded entirely by the health authority, except for the community workers who are funded by the health authority, Inner City Partnership and Save the Children Fund.

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PEARSON, P. An inner city child health project. Health Visitor. August 1985, vol. 58, no. 8, pp 223-224.

PLATT, D. Cultivating a child health patch. The Health Service Journal. 11 September 1986, p 1198.

Further reports of the project are available from the Riverside office.

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DONCASTER: PAEDIATRIC DISTRICT NURSING

Services for nursing sick children at home are not as common as services for adults. In **Doncaster** in 1982 a paediatric district nursing service was started with the aim of allowing earlier discharge of children from hospital to home and, wherever possible, preventing admission in the first place.

The service is staffed by three sisters (two part-time) and one part-time staff nurse. The sisters are qualified district nurses and sick children's nurses. Their work is mainly with children with medical conditions, discharged early from paediatric wards. Most of the nursing takes place in the daytime, but evening visits are also made. Joint working is encouraged with health visitors and the paediatric liaison health visitor. Salaries are paid from the community nursing budget.

The paediatric district nursing service does not cover the care of premature babies discharged early; nor does it cover surgical cases and young people over 16, who remain under the care of district nurses.

Since the scheme began the length of stay of children in hospital in Doncaster has been cut by almost 50%, and outpatient visits reduced by 25%. The choice of care for sick children and their families has been increased and good working relationships between health visitors, district nurses and the specialist team enable them all to offer a more comprehensive service.

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PADDINGTON AND NORTH KENSINGTON: FROM CLIENT-BASED HEALTH VISITING TO COMMUNITY DEVELOPMENT

In 1983 the community nursing service in **Paddington and North Kensington** funded an experimental project in which a health visitor worked not with individual clients but with community groups. The aim was to promote awareness of health issues, to examine the use of community development methods in health visiting, and to document the resources that would be needed to work in this way. A full report of the project has been published[1] along with several articles[2,3].

During the fifteen month 'active' period of the project, the health visitor worked with 23 community groups, although she met with 40 groups altogether. These included youth clubs, pensioners' associations, estate coffee mornings and community centres. Her approach was to act as a catalyst on health issues, initiating discussions, organising courses, but above all responding to matters raised by group members. She adopted three ways of working: once only interactions in which she was asked to lead a discussion on some aspect of health; joining in with groups in which she spent time establishing rapport and working with the group over a period of time; organising public events such as a pensioners' health course and a menopause group.

Evaluation of the project was built in from the start with the object of providing continual feedback in order to modify working methods; assessing the appropriateness of this way of disseminating health visitor knowledge to local residents; and assessing the consequences of such a role for health visitors. A steering group supported the project with members from health visiting, community work, research and health education. There was close and productive work between the project and the district's health education department.

The project demonstrated the demand that exists in this inner city district for opportunities to discuss health matters in an informal, non-threatening environment. Many people were found to lack the confidence to find out more about health or to try to obtain services. It became clear that informal access to a health professional and the sharing of information and experiences among group members could begin to build that confidence.

The success of this experimental work has led to the establishment of a permanent post for a health visitor to work full-time with community groups. The district has recognised that it is not the kind of work which can be done on top of a conventional caseload, and that community work techniques have much to offer in trying to provide effective health promotion. Gathering people together over issues they themselves have identified is likely to be a new way of working for most health visitors, but with support and encouragement could be both stimulating and productive.

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3 DRENNAN, V. Working in a Different Way. Senior Nurse. Vol. 6, no. 1, January 1987, pp 11-13.

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PETERBOROUGH: HOSPITAL AT HOME

The hospital at home scheme in **Peterborough** has been in existence since 1978. Its aim is to offer all patients of any age and suffering from any condition the opportunity of acute hospital-level care in their own homes. It is a superb example of the kind of service which can be provided by primary health care teams backed by a coordinated, imaginative community nursing service.

The only criterion for admission to the scheme is that without hospital at home the patient would be admitted to, or remain in, hospital. Prior to the patient's admission the GP and the attached district nurse must accept medical and nursing responsibility respectively. Patients are referred to the scheme either by:-

> the GP and district nurse agreeing to the patient's wish to remain at home rather than be admitted to hospital; or by
>
> early discharge from hospital when the patient no longer requires acute hospital resources but still needs more intensive care than the district nursing team can provide unaided. The ward team, including the liaison sister, will discuss the possibility of admission to hospital at home with the patient and carer, who have the right to choose whether they are admitted to the scheme or remain in hospital. If the patient wishes to be admitted, the consultant will ask the GP to accept medical responsibility and the liaison sister will discuss the case with the district nurse, who will undertake a home assessment if the family is not known to them.

Once it is agreed to admit a patient to the scheme, the district nurse will liaise with the nurse manager responsible for the day-to-day management of the scheme, to identify the quantity and quality of extra nursing care required to nurse the patient safely at home. Any nursing equipment required will be delivered on the planned day of admission. A member of the hospital at home staff will be in the patient's home to greet those patients discharged from hospital to allay any anxiety they may feel; and will continue under the guidance of the district nurse to implement the patient's care and treatment.

Hospital at home field staff who support the district nurses consist of 0.5 WTE enrolled nurse (contracted), 5.5 WTE patient aides (contracted), and a nursing bank of 30 registered nurses, 30 enrolled nurses and 54 patient aides. Patient aides undertake duties ranging from bathing the patient, and giving general care, to keeping the patient's rooms clean and tidy, collecting children from school, cooking meals, shopping, or just providing social contact.

Though time consuming to administer, the nursing bank is an effective method of providing extra nursing care as required by allowing nurses with home commitments to choose the hours they wish to work. This provides staff with employment when a regular post would not be feasible and allows them to remain in current practice ready to return to a permanent position when commitments allow. All staff new to the scheme have a five day in-service training and district nursing staff are updated on new surgical techniques before accepting post-operative patients into the scheme.

Examples of patients admitted to the service are people who have had hip replacement surgery, three to five days previously; nephrectomies, two to three days previously; people who have had strokes; and people who are terminally ill (50% of the work is with terminally ill patients). Children are now being successfully admitted to the scheme.

Each patient will have at least two visits per day by a trained district nurse, and the GP visits regularly. Peterborough has a 24-hour community nursing service, and the evening and night nursing establishment is supplemented by three extra part-time sisters (NDN) to ensure all hospital at home patients have an evening visit. Additional visits are made if night cover is necessary. To ensure patients and hospital at home staff are able to obtain help and advice whenever required, a 24-hour communication system is available through the use of two-way radios and pagers. Paramedical services are vital to the success of the scheme and regular input is available from physiotherapy and occupational therapy. A social worker, or member of the clergy can be called upon if needed. When this comprehensive care is no longer required, the patient is discharged to the district nursing service.

Hospital at home was originally set up as a separate service covering the patients of just twelve GPs. The team was somewhat isolated from other services and the GPs were reluctant to transfer their patients from their attached district nurses; so after a year the service was incorporated into the regular district nursing service. GPs now accept total responsibility for the patient's medical care, though hospital consultants will make domiciliary visits when requested and some have taken a particular interest in the scheme.

Funding for hospital at home comes partly from the health authority and partly from charitable monies. The DHSS has funded a three year evaluation of the scheme by Sheffield University, and it is anticipated that this major study will be published in 1987.

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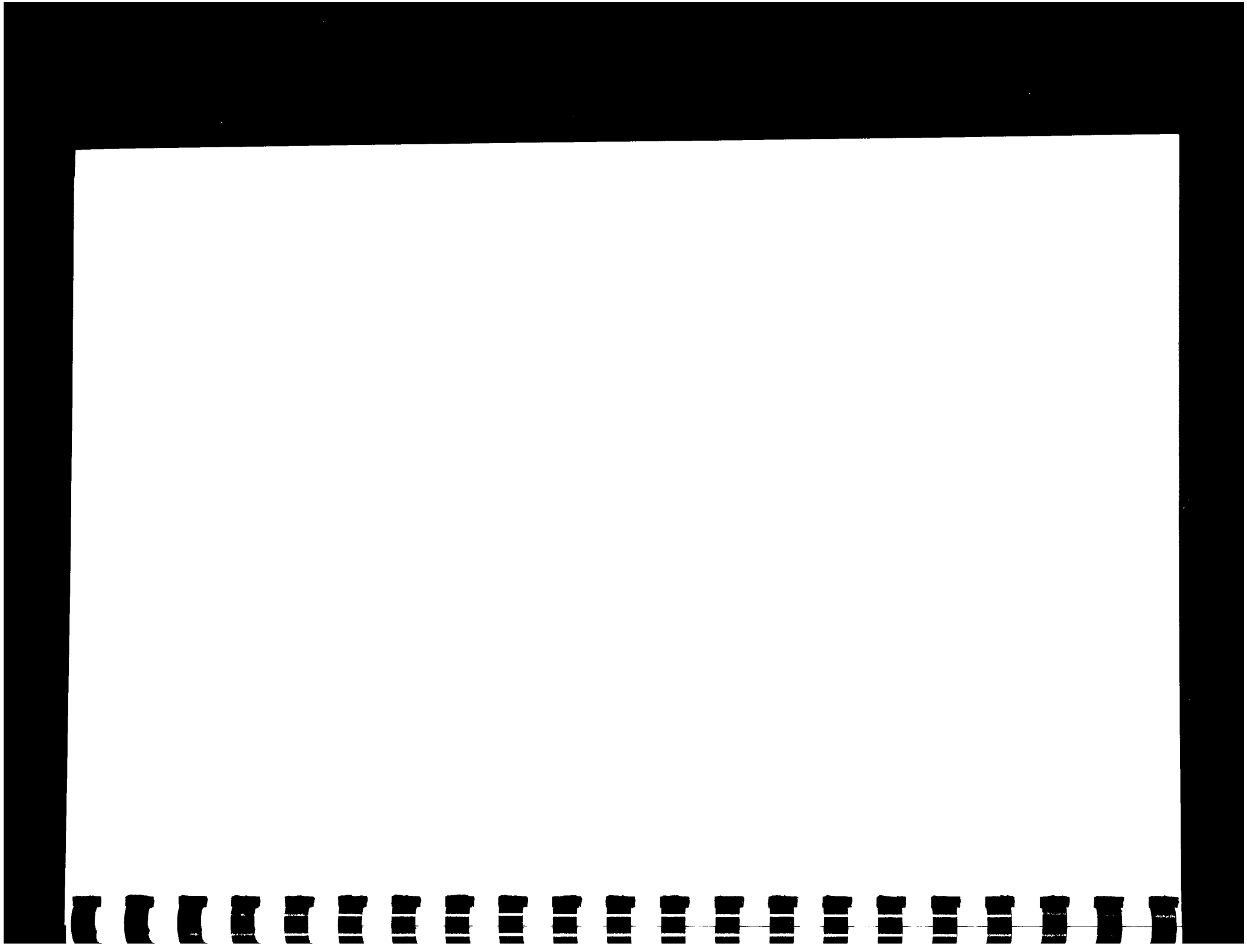

NORTH MANCHESTER: 24-HOUR NURSING TO PREVENT HOSPITAL ADMISSION

Children with gastroenteritis are frequently admitted to hospital. In **North Manchester** it was decided to try to prevent hospital admissions by offering intensive district nursing instead.

During the daytime the paediatric liaison sister is the key worker. She has a district nursing background, and as well as caring for children with gastroenteritis is able to offer advice and support to their parents. In order to offer a 24-hour service, the district nurses who cover evenings and nights have been given extra training to work with these children. Initially, health visitors expressed concern about such close involvement with families they were already visiting, but now appreciate the service and work well with it. The work is undertaken by the community nursing service without extra cost except for the additional training for district nurses.

As well as reducing admission rates and enabling children with gastroenteritis to be cared for at home, the scheme has added interest to the work of the evening and night district nurses by extending their role.

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DONCASTER: COMMUNITY NURSING BEDS

Alverley Lodge is a 10-bedded unit in the grounds of a local hospital in **Doncaster**. It is managed by the Director of Community Nursing Services and its purpose is to enable community nurses to admit patients from their own caseloads to give family carers short term respite.

The unit was opened in 1980 and has functioned well since then, partly because there has been strict adherence to admission criteria. These are that patients should be elderly people, receiving care at home from community nurses, whose carers need relief on a planned, rota basis to alleviate stress; or because of a temporary crisis; or special occasion; and that maximum length of stay should be two weeks. On average 110 men and 100 women are admitted each year, including 12 couples. Many patients require high dependency care and the unit is staffed by nurses whose salaries are paid from the community budget. Six beds are used for planned admissions, with patients admitted on a rota two or three times a year. Four beds are kept for emergencies. Patients bring their own medication and medical cover is provided by their own GP, but admissions and discharges are made by the community nurses.

The attraction of this scheme is that it provides an 'extra arm' to the community nursing service, enabling nurses to manage their caseloads more flexibly than usual and at the same time providing respite care for families.

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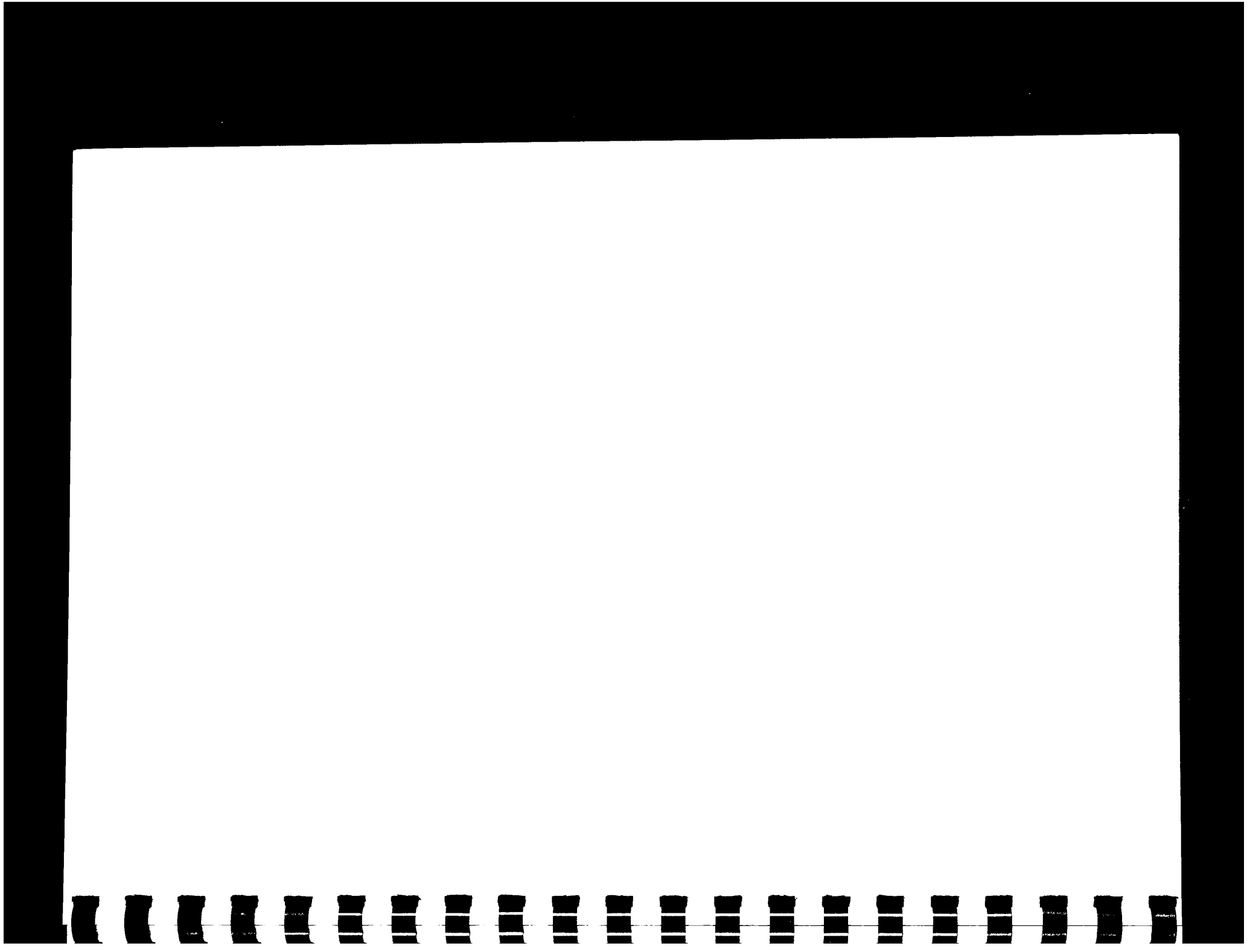

CITY AND HACKNEY: NIGHT SHELTER

The aim of this scheme in Hackney in East London is to relieve relatives caring for elderly mentally infirm people to enable them to have occasional evenings and nights without the old person.

The day unit of the local psychiatric hospital is used at night to provide 'shelter'. Beds are set up with screens for privacy. It is staffed by a psychiatric nurse from the main psychiatric unit, and additional support is available if necessary. Transport can be provided for the patients, who arrive at about 7.00 pm for supper and leave after breakfast in the morning. Patients can be up and about at night if they wish - a routine that would greatly disturb most families. Referrals are generally made by community psychiatric nurses, general practitioners, psychiatric social workers and psychogeriatricians. Requests are also accepted from relatives.

The scheme is funded from the psychiatric nursing budget. 'Soft' money was used for equipment.

The scheme shows sensitivity to the needs of carers. It would not be useful for every confused person, but for some it means that the quality of 24-hour care from family and the NHS can be enhanced. No great organisation is needed and the relatively small capital outlay provides imaginative response to need.

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LEWISHAM AND NORTH SOUTHWARK: CARE AT HOME

The aim of the scheme in **Lewisham and North Southwark** in South London is to prevent admission to hospital by offering the alternative of immediate, intensive nursing care at home.

This is a RAWP-losing district whose hospital beds are being reduced. The Community Unit General Management Group were convinced that a proportion of people admitted to hospital could be cared for at home if immediate, and intensive, nursing care were available as an alternative. Because the policy of the district is to develop primary care teams, a decision was made not to create a specialist Care at Home service, but to concentrate on strengthening the service already on offer to a defined local population. A group practice with four GPs and a population of 9,000 agreed to cooperate and the scheme began as an experiment in one part of the district. The cooperation of the Home Care Service of the London Borough of Lewisham was sought, and additional home care workers were employed by the local authority to work with the scheme.

The scheme is open to everyone over 16, but so far has been used mainly for elderly people. GPs admit patients to the scheme on the grounds that without immediate extra support they would require hospitalisation. A whole-time district nurse has been appointed and she is first on call for patients. Two night district nurses have also been appointed, along with a health visitor. A physiotherapist is available and aids and adaptations to homes are given priority and funded by the health authority.

The scheme started in 1985 and has since been extended to cover the practice's patients who present at the local accident and emergency department and, with their GP's consent, can be re-routed into the scheme.

A steering group meets monthly to assess progress and discuss policy. This has proved invaluable in ironing out problems and learning from early mistakes. Trouble spots which have needed skilful handling are the fact that intensive care has meant a number of different workers going into the home which some elderly people have found overwhelming; and, paradoxically, the handover from the intensive Care at Home scheme back to the regular community nursing service has at times caused tension. The scheme's successes include greater choice of care for patients; and closer cooperation between nursing services and GPs. There are plans to extend the scheme to other parts of the district, on a practice population basis.

The scheme was originally funded by the health authority, with the cost of the local authority home care workers being met by joint funding. After the first year, joint funding for the home care workers was withdrawn as were the home care workers. Their role has now been taken over by

auxiliaries in the community nursing service who combine the role of nursing auxiliary and home help. The cost of the scheme for the health authority in 1985-86 was £47,117. There were 60 admissions to the scheme in this period involving 908 patient days. The cost per patient day was £52 (excluding the GP costs). This can be compared with £110 per patient in the local district general hospital.

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NORTH MANCHESTER: STROKE REHABILITATION TEAM

The aim of the community-based stroke rehabilitation scheme in **North Manchester** is to keep people who have had strokes out of hospital and to work intensively with them to improve their speech, mobility and morale.

The idea of basing a team in the community was put forward to the regional health authority in 1984 as a non capital-led development bid. There was already a senior enrolled district nurse and a nursing auxiliary working with stroke patients in the district as part of the district nursing service. The proposal was to create a specialist multidisciplinary team who would greatly aid the earlier discharge of stroke patients from hospital or prevent their admission wherever possible. In this way prompt rehabilitation would be started at once. The team was expanded to include qualified district nurses (RGN), speech therapist, occupational therapist, chiropodist and health visitor. Two posts were not funded, for a physiotherapist and community psychiatric nurse, but close links have now been established with the community physiotherapists and regular meetings take place.

The scheme started in a small way in 1984 covering the population of two group practices. It is now a district-wide service. Medical cover is provided by GPs supported as necessary by geriatricians. Home assessments are carried out jointly by the community physiotherapist and district nurse. The multidisciplinary team works closely with patients, their families and general practitioners immediately following a stroke incident or on discharge from hospital. When intensive care is no longer needed, the routine nursing services take over as required.

The district nurses and health visitor are financed from the community nursing budget. Other staff are financed from a regional health authority allocation.

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ENFIELD: HEALTH VISITING IN THE EVENINGS

Traditionally health visiting services are available Monday to Friday, 9.00 am to 5.00 pm, with the occasional child health clinic and parenthood preparation class being held in the evening. Many health visitors, however, voluntarily extend their hours by giving personal phone numbers to clients or by visiting them in the evenings or at weekends. This may be particularly important in rural areas where families may live several miles from the nearest health centre or hospital. Several health authorities in cities organise out-of-hours services which usually rely on a rota of day time staff to cover the 'off peak' hours of evening and night time[1,2,3].

One of the longest running evening schemes is in **Enfield** in North London[4]. It was started in 1979 with the aim of offering similar services to those given in the day time to people who for some reason cannot take up the service during the day (approximately 1,600 in 1986). 1.53 WTE health visitors visiting staff are employed, and their work includes visits to families and children under five who are generally unavailable to day staff (approximately 153 families); early antenatal visits to first time parents; visits at the request of day health visitors unable to make contact with clients; on-call service for dealing with problems arising outside normal health visiting hours; slimmers' clinics; relaxation classes.

This scheme is unusual inasmuch as it offers almost as comprehensive a service as the day time one and has survived so long. A reason for its survival may well be that additional staff have always been employed to run the scheme rather than relying on day time staff to work on a volunteer rota basis. Other equally valuable services in other districts appear to have failed because resources in the form of extra staff have not been made available.

The service costs £30,000 per annum which covers the cost of five part-time health visitors, their car allowance and radiopaging service.

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1 DOWLING, S. Health for a change. Child Poverty Action Group and National Extension College, 1985. See chapter 5 - Out of Hours Preventive Service from Midwives and Health Visitors.

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3 DUNCAN, A., FERNANDO, M., WHYTE, N. Twilight Zone. Nursing Times, Community Outlook. April 1986, pp 14-17.

4 HAYLOCK, M. A 24-Hour Health Visiting Service. Health Visitor. Vol. 52, no. 1, January 1981, pp 16-18.

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DARLINGTON: AN INTEGRATED SERVICE FOR ELDERLY PEOPLE AT HOME

The object of the Community Care Project in **Darlington** is to provide coordinated health and social care for elderly people in their own homes as an alternative to long stay hospital care. It is based on the premise that many frail elderly people remain in hospital only because there is inadequate support in the community; that people need 'packages' of support services tailored to meet their individual needs; and that only by close cooperation between agencies can good results be achieved.

The project developed from a conference in 1984 on how to improve services for elderly people in Darlington. It was planned jointly by Darlington Health Authority and Durham Social Services Department, and is funded for three years via the DHSS "Care in the Community" initiative. One idea that came from this conference was the merging of the home help, nursing auxiliary and other therapy posts (e.g. physiotherapy helper) into one home care assistant. Other features crucial to the success of the project are that the manager holds a care budget for each patient; that each patient has an individual care plan; and that one manager is responsible for coordinating and monitoring services to individual patients from <u>both</u> health and social services.

Selection of patients is made by a multidisciplinary team. The project manager has three service managers who between them control care budgets for each patient to provide intensive domiciliary support. Individual care plans are prepared for each elderly person and reviewed regularly. Care comes from a number of sources including the specially recruited home care assistants, existing health and social services provision, and a range of support from the local community funded from the care budget. All the services are coordinated by the service manager.

Home care assistants are a central part of the scheme and are specially trained to cover domestic as well as personal work, combining the role in many other places of home help, auxiliary nurse and therapy helper. Training is provided as needed by physiotherapists, occupational therapists, speech therapists, craft instructor, stoma therapist, social worker for the deaf, rehabilitation officer for the blind, audiologists, district nursing service, environmental health department, the school of nursing, the continence adviser, and the community liaison sister. Home care assistants will at times operate under the advice of professionals visiting the home. They also act as advocates for their elderly patients in making contact with 'outside' agencies such as DHSS and the local hospital.

The budget for the third year of the pilot project is £450,000 which supports 54 people at home. Total funding over three years has been £900,000. The health authority is committed to taking over the funding in 1988.

The importance of this scheme is that it brings together health and social care at the level of the individual elderly person. The home care assistant post is an attempt to reduce the number of professionals working in one home, and the service manager has a clear responsibility to coordinate all those providing services to one individual. One outcome appears to be more productive working between professionals, for example, between district nurses and physiotherapists.

The project won a Health Management Award in 1986[1] and has been described in more detail in The Health Service Journal[2].

References:

1 Health Management Award Winners. Health Service Journal. 3 July 1986, p 887.

2 STONE, M. Keeping Care at Home. Health Service Journal. 29 May 1986, p 730.

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TOWER HAMLETS: MORE EFFECTIVE HEALTH VISITING IN A MULTI-RACIAL DISTRICT

The aim of this project in **Tower Hamlets** in East London is to improve the service to the Bangladeshi community in an inner city district by joint working between a voluntary agency and the community nursing service. Currently one in two births in Tower Hamlets is to Bangladeshi women.

The background to the work lies in the frustration expressed by health visitors working with Bangladeshi families about the amount of time spent repeating visits and work, little of which seemed to be effective. The first important step was the recognition that what the health visitors, supported by interpreters, had to offer did not seem to match what the Bangladeshi families wanted or needed. The next step was to contact a local voluntary agency, the Maternity Services Liaison Scheme (MSLS), which employs women from ethnic groups to work as advocates for pregnant women from their communities and help them make the best use of maternity services. MSLS agreed to release three of their Bengali-speaking workers to work for half a day per week with the health visitors.

The first five half days were spent in training the workers in observation techniques, home visiting, home safety, and basic health education, followed by two days on family planning. Two of the workers now work with one health visitor based in a health centre, and the third worker in a neighbouring health centre with another health visitor. The first two workers 'spread out' to work with all the health visitors in the centre, but this was found to be less satisfactory.

The Bengali-speaking workers do not make the first home visit to a new baby, but thereafter they visit whenever it is thought that a family has particular communication or other problems. Their skills and involvement have grown and they now run teaching sessions on subjects such as breastfeeding and family planning. They in turn now refer families to the health visitors.

The scheme was started in 1985 and is seen as a success. It did, however, take one enterprising health visitor to carry it through and to convince MSLS and the health authority that it was a worthwhile venture. MSLS is enthusiastic, and claim that the reason it has been more successful than some other attachments is that there was strong commitment and preparation for training from the health visitor concerned.

The health authority paid for the two-day family planning course, but otherwise has incurred no expenses other than releasing one health

visitor's time for training. The Bangladeshi workers' salaries are paid by MSLS but the future of the work is not yet guaranteed as MSLS, like many other voluntary agencies, has only short-term funding.

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KETTERING: NIGHTLINE

The object of this joint NHS/local authority scheme in **Kettering** is to provide a service for frail people at home in the evening, night and early morning, which meets their needs and supplements the nursing and home help services.

The background to the service lies in a review of the work of district nurses, which revealed that 40% of patients visited in the evening did not need nursing but did need assistance with an evening meal, bathing and going to bed. Contact was made with social services who were able to identify 25% of their clients receiving home help services who also needed help in the evenings and weekends, but were not getting it.

Both the health authority and local authority have strategic plans for "Care in the Community", but it was clear that without an evening/ night/dawn service these plans were seriously deficient. A joint working party was formed to plan a service which would support dependent elderly people and adult physically handicapped people at home, relieve family carers and, where possible, avoid hospital admissions. A crucial decision of the working party was to employ a new category of staff to be known as 'home carers', who would combine the duties of home help and nursing auxiliary.

The scheme is planned in three parts: an evening service, a night-sitting service, and a dawn service from 6.00-8.30 am. All the home carers are to be responsible to the principal social worker (care at home) and there is strong support from the district nursing service. The scheme is funded for three years from joint finance monies, with agreement by the local and health authorities to continue the service thereafter.

The importance of this scheme lies in the recognition that professionally defined services may not meet clients' needs and that by working together, pooling money and resources, health and local authorities can provide appropriate care; in this instance, sensitive 24-hour care. It is also an example of the time and energy which has to go into the planning and negotiating of a new way of working. In this case, negotiation with trade unions over the introduction of a new grade of staff has taken longer than expected and delayed the full implementation of the scheme.

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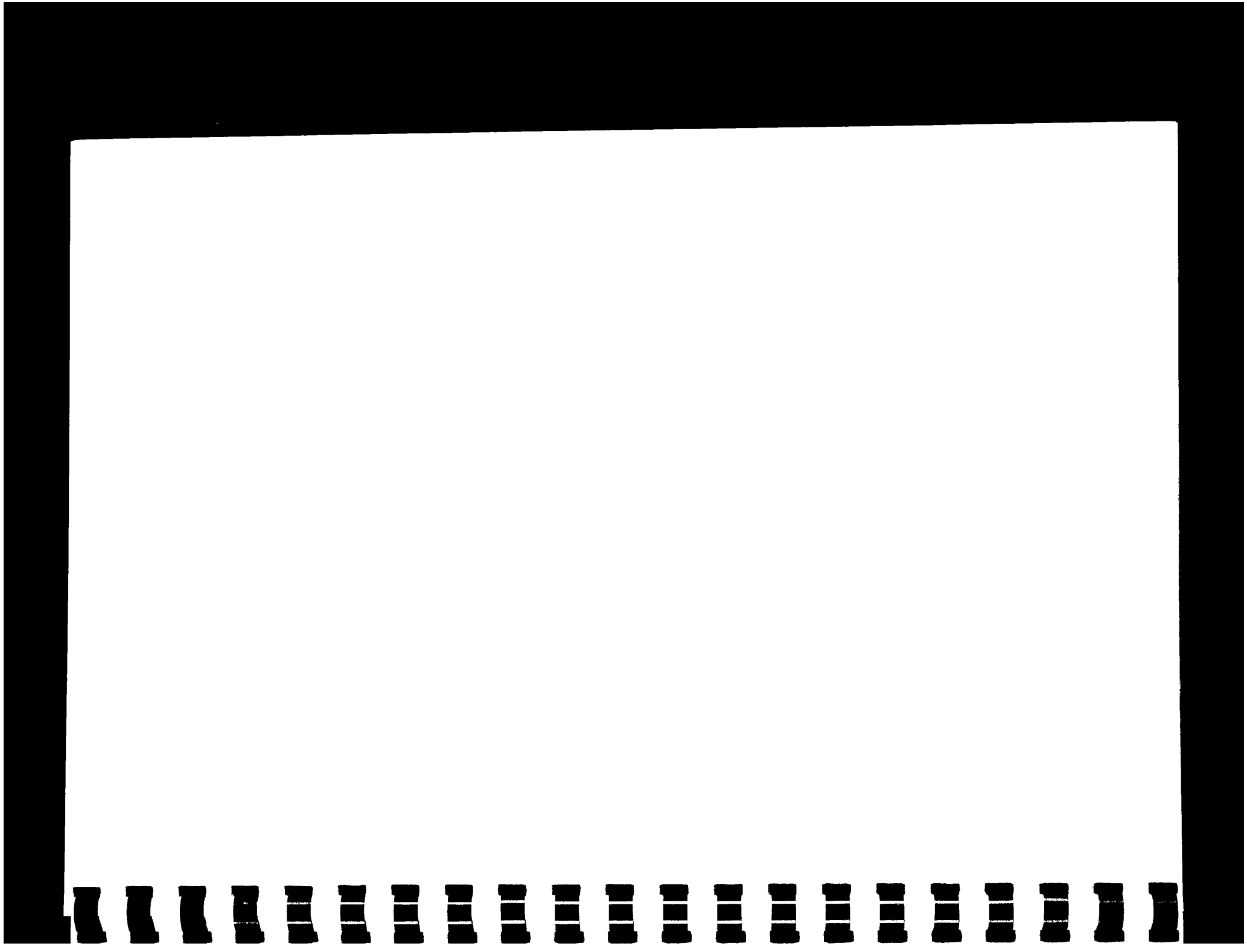

WINCHESTER: FROM LONG STAY GERIATRIC WARDS TO CARE IN THE COMMUNITY

The aim of this project in Winchester is to return patients from long stay geriatric wards to community care. It is an example of successful joint working between a health authority, local authority and voluntary agency.

An assessment of the needs of elderly people who had been in hospital for over a year showed that several were there not because they needed hospital care but because there was neither suitable housing nor support for them at home. With the cooperation of the local authority housing department and a local housing association, ten warden-controlled flats were made available. The health authority recruited home care assistants who combined the role of nursing auxiliary and home help.

The only criterion for admission to the scheme is that the elderly person does not need help during the night. The care assistants visit as often as necessary during the day and evening to help with dressing, washing, making meals and housework. They are supervised by district nurses. In this way previously institutionalised people are able to lead a more independent life in their 'own homes' rather than face the prospect of home being a hospital ward.

£51,000 for three years was raised from the DHSS "Care in the Community" scheme to pay for the salaries of the home care assistants.

Joint planning between the health authority and other agencies has made this scheme possible, along with the recognition that the services usually provided separately by nursing auxiliaries and home helps can be successfully combined in one home care assistant.

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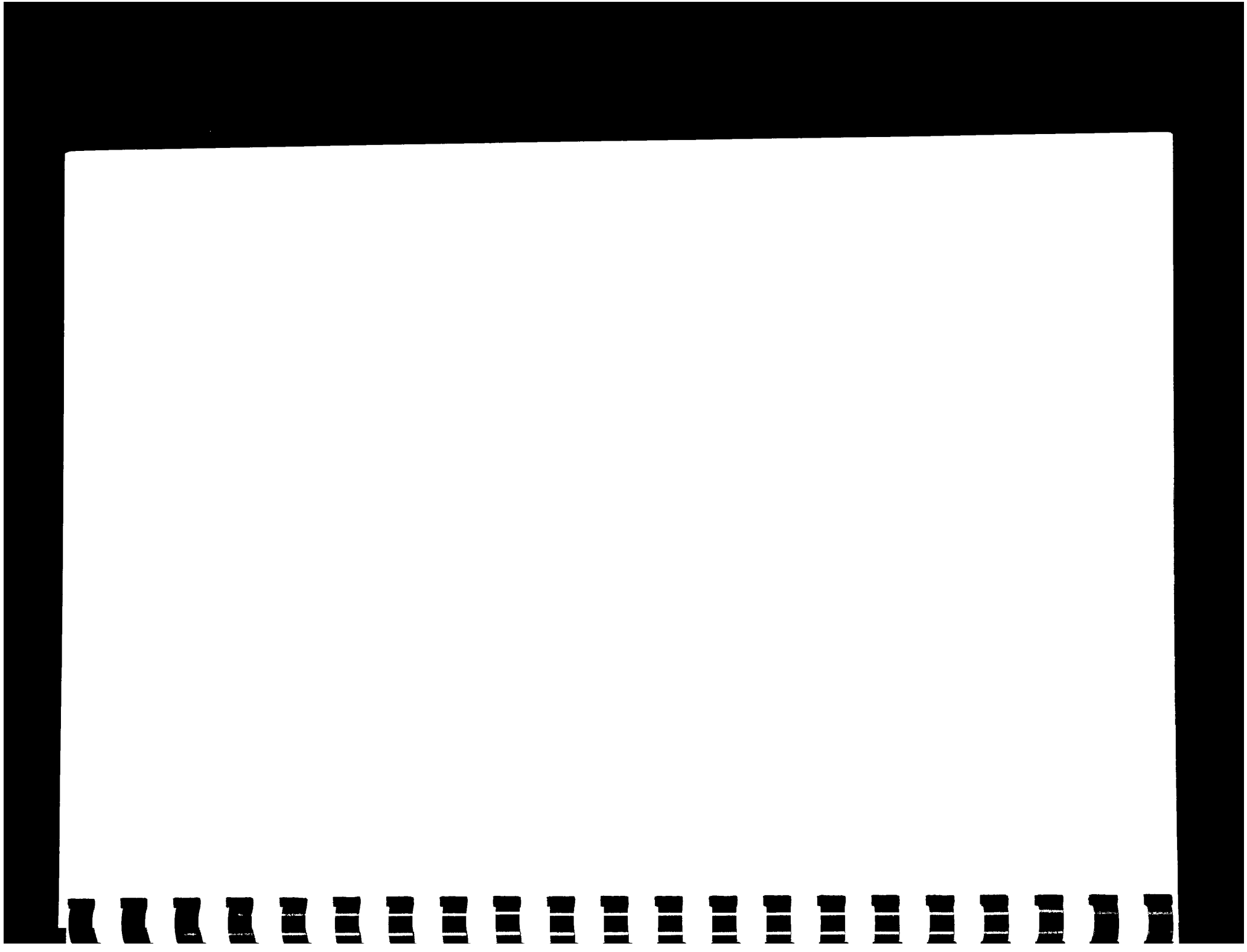

CITY AND HACKNEY: ADVOCATES, NOT INTERPRETERS, FOR NON-ENGLISH SPEAKING WOMEN

The multi-ethnic women's health project was set up in 1979 in **Hackney** in East London. Its starting point was to improve access to the NHS for non-English speaking women during their pregnancy and childbirth. From small beginnings it has become a successful experiment in helping the NHS find ways of listening to the needs of users and changing to meet those needs. Now in its eighth year it has expanded from maternity services to work in community clinics, the district general hospital and children's hospital.

Six full-time workers are employed, based in the Community Health Council. Between them they speak Turkish, Gujarati, Punjabi, Bengali, Hindi, Urdu. One worker acts as coordinator and another as an Afro-Caribbean liaison worker. Several had no work experience outside the home, but all of them have knowledge of and commitment to their communities. The first workers benefited from a special course run for them by the midwifery school, to which other community workers whose work brought them into contact with pregnant women were invited, such as teachers of English as a second language. New workers are now taught and supervised by existing staff.

Four of the workers are based in the maternity unit, where they work as patient advocates. They are always present at booking and antenatal clinics when women from their language groups are attending. They visit the wards regularly, visit families at home as necessary, liaise with both community and hospital staff. They are currently exploring ways to work appropriately in the community clinics. At the children's hospital the workers help staff to meet the child's needs in a culturally appropriate way, and ensure that the family understand what is happening to their child and why specific treatment is being offered.

One essential aspect of the project is that through their steering group (which consists of half NHS and half community representatives) the workers make recommendations to the District Health Authority, or the Medical College, or to the District Management Board about practices that are causing problems and where there is a need for a change of policy. They then help to ensure that once a policy is changed, it is implemented in practice. They also work with families and community groups to improve understanding of health and about the health service.

The project has the support of senior nurses, doctors and managers in the district; but particularly in the early days, the workers had to overcome considerable professional resistance to their work. A strong steering

group has made it possible to raise and work through difficult issues such as racism. This scheme has helped explore how a professional bureaucracy as large as the NHS can have workers within it, but not part of it, whose sole function is to find ways of ensuring that the service continues to be sensitive to users' needs.

The day-to-day manager and budgetholder is the Community Health Council Secretary. The steering group meets six weekly, and final management authority rests with a management group which represents the Community Health Council, the local Council for Racial Equality and the Health Authority.

The cost of the scheme has been met by Inner City Partnership monies (£78,000 in 1987/88). The District Health Authority is committed to taking over the funding and the Community Health Council will continue as management agent for the DHA.

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CORNWELL, J. and GORDON, P. An Experiment in Advocacy: The Hackney Multi-Ethnic Women's Health Project. King's Fund Centre, December 1984, KFC 84/237, Price £1.50.

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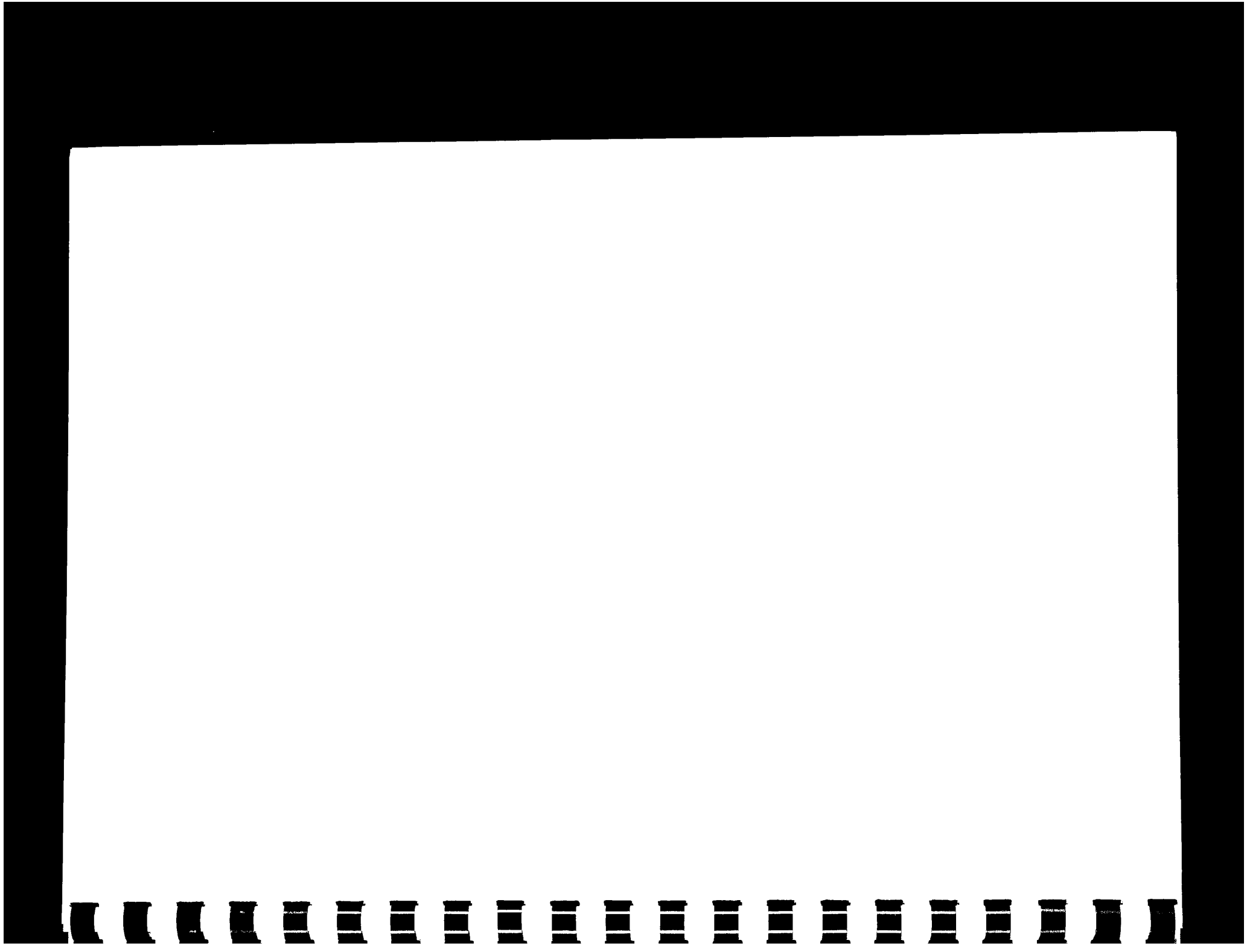

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