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Chelsea, Pimlico and Belgravia District Nursing Association 1930-1939: A Case Study

Introduction

This paper utilizes a case study of the Chelsea, Pimlico and Belgravia District Nursing Association (CPBDNA, hereafter the Association) during the 1930's, to explore how the expansion of the health services during the interwar period and being a voluntary service influenced district nursing. An understanding of district nursing historically is helpful to inform the current debate regarding district nursing (Holme 2015). A range of primary sources were used, these include the Association Annual Reports, the Medical Officer for Health Annual Reports for the Borough of Chelsea, the Ministry of Health records and the archives of the Queen's Nursing Institute (QNI). In 1961 it was noted that 'regular spring cleaning of the [QNI] records and dispos[al] of what is never likely to be of further value ... is, in fact, already being done' (Dixon 2000 p253) This housekeeping of records may have led to the disposal of documents which could add to the case study, and is an inherent difficulty when researching in the archives. Additional data was also sought by examining the Borough of Chelsea Council Minutes held in local archives.

In 1861, following his experience of employing a nurse to care for his wife at home, William Rathbone set up a district nursing association which employed nurses to work with the poor in the districts of Liverpool (Dingwall et al 1988). The value of home nursing associations was recognised when the Queen Victoria Jubilee Institute for Nurses (QVJIN), later becoming the Queen's Nursing Institute (QNI) was established in 1887, using money raised to celebrate Queen Victoria's Golden Jubilee

(Bliss and While 2000). Prior to the inception of the NHS voluntary health care provision, such as district nursing, was supported by a range of funding sources including charitable contributions and contributory schemes. The London County Council Survey identified that 65% of district nurses were affiliated to the QNI (Hogarth 1930). Following the 1929 Local Government Act local authorities were required to provide health services previously included in the Poor Law, many local authorities chose to provide home nursing via the QNI (Baly 1987). The ongoing delivery of district nursing under the auspices of district nursing associations was only possible as a result of the funding received from local authorities, thus linking district nursing more closely to the state (Kelly and Symonds 2003).

The delegation of health services to local authorities resulted in local variation. Municipal medicine accounted for the largest proportion of local authority expenditure, and whilst Treasury Grants were distributed, the dependence on local taxation resulted in variation according to the wealth of the area (Levene et al., 2011, White, 1978). A review of expenditure per 1000 of the population identified an increase in expenditure between 1922 and 1929; ranking found that Reading and Oxford ranked low with regards to expenditure (Levene et al., 2011). It has been suggested that this reduced expenditure by local authorities was the result of thriving voluntary organisations, with effective income generation resulting in less demand for local authority services (Levene et al., 2011).

The number of district nurses increased following the 1929 Local Government Act, suggesting that legislation provided an impetus for service development (Sweet and

Dougall, 1998). Current health policy drivers to provide more care outside the hospital and Sustainability and Transformation Programmes provide an opportunity to raise the profile of district nursing. Despite the strengthening links with the local authorities, district nursing remained a voluntary service, collecting money from recipients of care who could afford to pay, with additional funding from fundraising efforts and donations (Baly 1987). Although avenues of revenue were a constant concern, the QVJIN was clear that nursing care was not dependent upon the ability to pay and by prohibiting the distribution of charitable donations it was reducing the potential of exploitation of the service (Fox 1996). District nursing remains free at the point of delivery.

The 1929 Local Government Act also enabled public health to be planned as a whole, providing an opportunity to connect preventative and curative medicine (Levene et al., 2011). District nursing services were well placed to contribute to this combined approach to healthcare, for Florence Nightingale

“home nursing ... was a civilizing occupation, reforming and redirecting the lives of its patients, not just caring for them” (Dingall et al 1988 p177).

Public health at an individual and community level remains a core tenant of the district nurse’s role (QNI/QNIS 2015). The contribution of home nursing to public health was acknowledged in the London County Council (LCC) survey of district nurses

“From what I have seen of the work of these nurses in the home I do not consider that the educational and preventative effect of a nursing visit can be overestimated. In this connexion I am of the opinion that for any domiciliary nursing of patients under the new arrangements the services of these nursing organizations should be retained and that a district nurse should be present at each medical session of the district offices or dispensaries” (Hogarth 1930 p16).

Advances in medicine such as insulin and penicillin, treatment of war wounds leading to advances in wound care, orthopedics and plastic surgery provided increasing opportunities for nurses to specialize. Recruitment to general nursing and, by inference, district nursing, became more challenging. There was an expectation of increased participation for all, that health and education should be available for all according to need rather than ability to pay, heralding an era of universality and individual rights (Baly 1995, White 1978). The poor pay, rigid discipline and lack of status, made it difficult for nursing to compete against the increasing job opportunities for women. However, caring work remained the domain of the women. In the early 1930s the majority of cases seen by district nursing associations across London were women, reflecting the fact that women were the main care providers in the home (Hogarth 1930).

The migration of people to the cities, in particular to work in the munitions factories, had resulted in the aged and younger families living as separate units (White, 1978). Set within the context of the number of people aged 65 years and over in London

increasing by 55% between 1898 and 1928, the reduced number of long stay beds and the length of stay reducing from 63 days in 1919 to 53 days in 1928 (White 1978). These changes may have led to an increased demand on district nursing.

The London Borough of Chelsea

The Association provided home nursing for the Borough of Chelsea and part of the Borough of Westminster. The demographics of the Borough of Chelsea (hereafter the Borough) influenced the work of the Association, both with regards to delivery and funding of home nursing provision. The 1931 Census identified that the proportion of retired people in the Borough was higher than any other metropolitan borough, the Borough also had a higher death rate than that of London (Beattie, 1934). This reflects the location of the Royal Hospital Chelsea, home of the Chelsea pensioners, retired British army soldiers, within the Borough.

The Ministry of Health Public Health Survey noted the change in the demographics of the Borough in the previous 20 years and the increased value of the housing (Beattie 1934). Over 20,000 residents, mainly small trader and working class, had left Chelsea in the previous 35 years. Despite these figures suggesting comfort and affluence there were areas of deprivation within the Borough. In 1926 the Chelsea Housing Improvement Society had been established to provide housing for the poorest tenants, in particular those living in slum tenements (Croot, 2004). The work of the Association increased as a result of the “large blocks of working class dwellings being built at Ebury Bridge” (CPBDNA 1931 p5). The continuing impact of

the changing nature of the housing stock within the Borough was commented upon in the 1935 Annual Inspection by the QIDN who felt that the Association committee 'need careful consideration' with regards to the expansion of the service (CPBDNA 1935 p5). The Borough was not unique in this regard, Dr Margaret Hogarth reflected on the

'state of continuous flux, residential housing being converted into flats, and factories and offices being introduced into areas previously occupied by dwelling houses' in the London County Council survey of district nursing services (Hogarth 1930 p7).

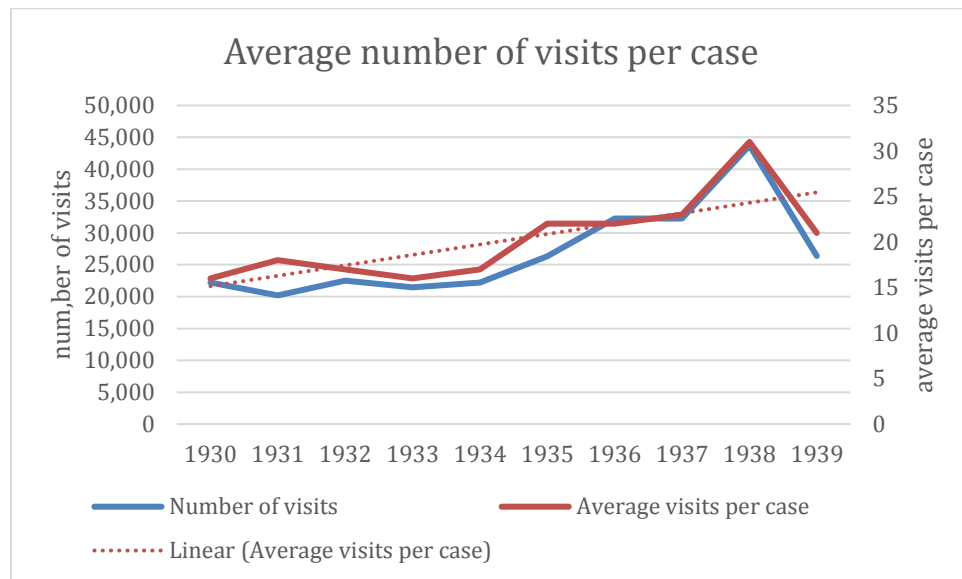
Serving one of the smallest metropolitan boroughs had potential advantages for the Association, for example reducing time travelling. Furthermore, it could be argued that the increased value of property and the changing demographics in the preceding twenty years would result in a lower level of need for municipal health services and that voluntary organisations such as the Association would be well supported by the residents.

Home Nursing Provision

The Association was nonsectarian with regards to home nursing delivery. In its first year, 1888, the Association made 10,155 visits to 471 patients (CPBDNA 1938 p4). The amount of work had increased considerably by the 1930s. The increased number of visits did not reflect an increase in cases but was the result of the increase number of visits per case suggesting that individual cases had greater need, see figure one.

Figure one: Chelsea, Pimlico and Belgravia District Nursing Association Average

Number of Visits



CPBDNA 1930-1939 Annual Reports

The increase in visits despite a reduction in cases in 1935 suggests that the severity of the cases influenced the workload. Constant increase in demand and the need to provide increasingly complex care continues to be reflected in current district nursing caseloads (Robertson et al 2017). The Annual Inspection by the Queen’s Institute of District Nursing conducted in February 1936 noted that the nurses were undertaking an average of six hours per week above their contracted 45 hours (CPBDNA 1936 p5).

The shortage of district nurses was reflected in the 1934 Survey of District Nursing in England and Wales (Queen’s Institute of District Nursing, 1934a). The fact that nurses were working additional hours to ensure that those who required home nursing received it despite staff shortages is evidence of the altruistic attitude in the London County Council Survey of District Nursing

“the altruistic attitude of the district nurse who remains at work for any length of time is strikingly apparent. For her the work, distasteful and revolting on some of its aspects, becomes more a vocation than a profession, and for this reason alone it is important that her devotion should not be exploited even in the interests of the general public ” (Hogarth 1930 p 17)

Workforce shortages currently experienced by district nursing teams continue to impact on care delivery for individuals and their families as well as other components of health and social care delivery (Maybin et al 2016). Despite the shortage of nurses the Committee decided to open a branch home in Pimlico, the choice of location was because it was the further outlying district and the number of poor people living in Pimlico at the time. It was felt that it could be described as ‘rash to the point of foolishness’ but that it was not possible to refuse nursing care to the poor who lived there (CPBDNA 1936 p5). As a result of opening the branch home it was identified that another £100 per year in donations and subscriptions would be needed.

In the early 1930s the Association had not been providing midwifery care, this changed following the 1936 Midwives Act which permitted public funds to be used to provide midwives (British Journal of Nursing Supplement 1936). A midwife was employed and alterations were required to the nursing home to provide a separate room, which required funds, for ‘care, sterilization and cleaning of district bags used for midwifery and maternity cases’ (CPBDNA 1937 p5). By 1938 the work of the

District Nursing Association had expanded, despite the staff numbers being the same as they had been in 1933; at this point the Committee noted that 'nursing does not include care which would ordinarily be given by members of the household' (CPBDNA 1938 p3).

In sharp contrast it was noted in the Annual QIDN Inspection that the 'luxury flat-dwellers are using the service and paying very inadequately' (Queen's Institute of District Nursing Records 1938). In the case of the Association it cannot be assumed that sufficient funding was available to support the delivery of home nursing without recourse to the local authorities and local taxation. This offers a different perspective to the proposition that where voluntary organisations were thriving there was less need for local authority spend (Levene et al., 2011).

By 1939 the Pimlico Branch home had been closed because of 'reasons of economy', the brief 1939 Annual Report noted that work continued despite the war and identified that as hospitals were evacuated out of London there was every possibility that the work of the Association would increase (CPBDNA 1939 p3).

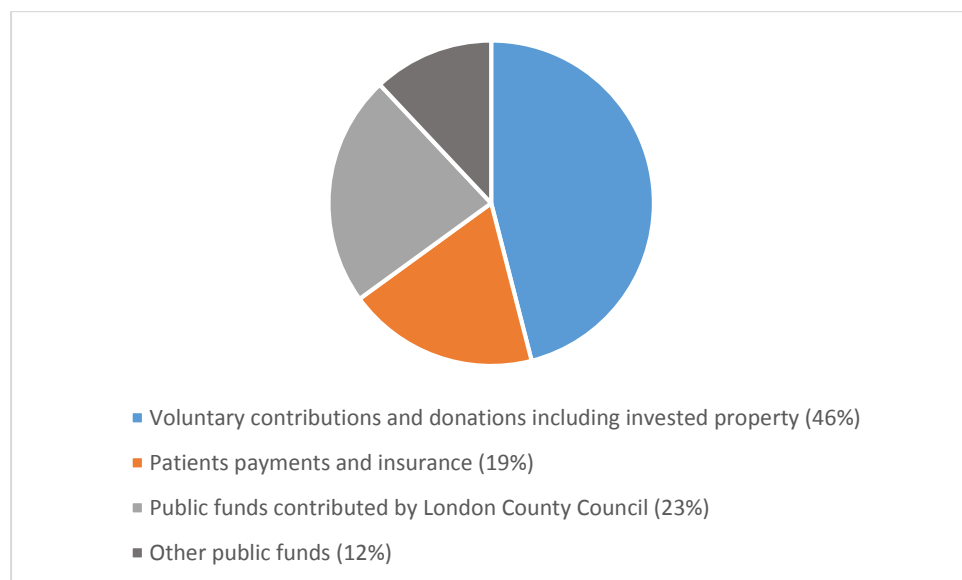
The Funding Imperative

A key driver for the Association as a voluntary organization was the need to secure funding. This was mirrored across the London district nursing associations with nearly half of income being from voluntary funding see figure two. The Association started working for the Borough of Chelsea in 1916. Prior to 1930 Chelsea Poor Law Authority had donated £30 to the Association in acknowledgement that if the

nursing services had not been provided institutional care may have been required (Hogarth 1930). Whilst the donation is to be commended it made a small contribution to costs. In 1929 the Association undertook a total of 22,010 visits during the year, if 23 % of these visits had received the 1s 6d per visit as agreed for 1930 the Association would have received an additional payment of £379 14s (CPBDNA 1930 p16).

Figure two

% of Sources of Income to District Nursing Association Pan London



Hogarth 1930 p16

The funding structure from the Borough of a block grant, £50, plus a fee, 1s 6d, per visit resulted in the revenue fluctuating each year dependent upon the health of the local population. Consequently 1931 'a year of comparative good health' which saw a shortfall of £125, the report noted that it was still necessary to maintain the staff despite the decrease in income (CPBDNA 1931 p7). In contrast 1934 saw a good deal of illness, as indicated by the increase in visits despite the decrease in cases. Current

arrangements for commission district nursing services via block contracting, where funding is not linked to activity levels, continues to impact on district nursing services ability to deliver care, this is compounded by the lack of visibility of care which take place in the home (Robertson et al 2017). Funding by the local authorities also increased administration by the Association to provide the information required to calculate the annual grants. This information was in addition to the figures the district nursing associations were required to provide each calendar year for the Medical Officer of Health Annual Report for each Borough. Miss Wilmshurst, superintendent of the QIDN spoke to the Ministry of Health regarding the QIDN concerns.

‘She wished to represent to the Ministry that the local superintendents of the QIDN found the amount of clerical work necessitated by their work for local authorities very heavy and that comparatively few of the CNAs etc could afford to supply regular clerical assistance. ... I informed her that in the existing circumstances I hardly saw how the present position could be altered’ (QIDN 1934b)

The importance of accurate reporting cannot be underestimated. As part of the NHS Improvement safe staffing workstream a consultation has recently taken place regarding an improvement resource for the district nursing service. This includes a recommendation that caseload management tools include classification of complexity/dependency and patient acuity in a standard format (NHS Improvement 2017). This will support national benchmarking with the development of national

data (QNI 2016). In some instances, district nursing associations were not receiving the correct payment from the local authorities. The General Purposes Committee QIDN wrote to the Ministry of Health in 1936 on behalf of affiliated associations to raise this difficulty:

‘It appears that in some cases the powers given by the Ministry of Health to make grants for home nursing of notifiable and other diseases is not understood, and the payment is therefore withheld.’ (QIDN 1936)

In 1938 the funding arrangements changed, and as a result the Association received a block grant of £250 per annum plus a £50 fee for work done. Consequently, the Association knew what the income would be and provided ‘a minimum remuneration in years of good health’ (CPBDNA 1937 p3).

Within this context of complexity, the Committee endeavored to support and develop the district nursing service. The Committee membership included Katherine Duchess of Westminster as Patroness and Lady Gray as Chairman, reflecting the tradition of lady volunteers when the district nursing services were first developed (CPBDNA 1930 p2). Members of the Committee were not just providing time and expertise but also financial support. Lady Gray stepped down as Chairman in 1932, in 1938 she left a legacy of £500, significantly more than the £379 13s 11d received in block grants and fees from the Borough Councils of Chelsea and Westminster (CPBDNA 1938).

It was suggested that the personnel of district nursing association committees should reflect the mix of classes within the population, thus removing any 'condescension and patronage' and that district nursing should be seen as 'a desirable social service to be made available to all in accordance for their need for it' (Braithwaite 1938 p315). However, it would appear that the donations of the committee members may have been pivotal in maintaining home nursing in the area.

The focus in the Annual reports on income and expenditure demonstrates the impact of being a voluntary organisation on the delivery of home nursing. In 1931 the Treasurer, reported a balance of £200 less at the end of the year, the result of decreased income rather than increased expenditure (CPBDNA 1931). In 1934 he reported that the expenditure was lower than in 1933 however this would change because of 'the necessity of repairs and replacements which cannot be delayed longer' (CPBDNA 1934 p8). Efforts were put into place to increase the number of subscriptions, in 1938 the Treasurer reported that there had been a minimal increase in subscriptions and set out to

'remind our readers that if the well-to-do-dwellers in Chelsea, Pimlico and Belgravia would *each* give us 5/- or 2/6 a year, their poorer neighbours' needs could be relieved with the greatest of ease' (CPBDNA 1938 p4).

The work of the Association Committee and the apparent non-engagement by some of the more 'well-to-do' appears to suggest a dichotomy of approaches to the

nursing needs of those less able to pay. The plea to well-to-do dwellers to subscribe supports Braithwaite's (1938 p9) suggestion that philanthropy is motivated by 'pity and sympathy with distress of all kinds'. Braithwaite (1938) identifies that for some the sympathy is restricted to people they have met, therefore not possible to meet the welfare of other others by relying on philanthropy based on sympathy and pity

The precarious nature of funding by voluntary means is illustrated by the Sunday Cinema money, a percentage of Sunday takings donated to local charities. The 1932 Association report set out concern regarding the 1932 Sunday Entertainments Act, which amended the amount donated to charity and the impact it would have on revenue. This resulted in a decrease in Sunday Cinema money from £72 6s 3d in 1932 to £34 12s in 1933, a reduction of £37 14s 3d (CPBDNA 1933). To put this into context in 1933 the Association employed seven Queen's nurses and a candidate in training, the salary for the Superintendent was £120 and for the candidate £55 (QIDN 1933). By 1935 four cinemas, the King's Picture Playhouse, the Gaumont Palace, the Royal Court Theatre and the Classic King's Road, were to 'continue to offer a valuable source of help' resulting in a revenue of £270 1s 11d (CPBDNA 1935 p6). This increase in revenue, now voluntary rather than legislated, and a donation enabled the Association to undertake the repairs that had been delayed at the nurses' home at 10 Sydney Street.

Conclusion

This case study has shed some illumination on the impact of the expanding health services and the voluntary status of the Association. There appear to have been a contradiction regarding the esteem and value placed upon district nursing associations providing home nursing and constant challenge of income generation. Many of the challenges faced by the Association in the 1930s are mirrored in current district nursing services. These include increased activity within the context of budgets which have not expanded to accommodate increased demand, interestingly in 2017 once again within the context of block contracts, and staff working additional hours (Robertson et al., 2017).

The case study demonstrates that the Association acted as an advocate for those in need of the service, for example identifying the need for all in the Borough to contribute financially to the running of the Association. The imperative to advocate for individuals and their families remains core to district nursing in the twenty first century. Despite the challenges experienced by district nursing associations the inclusion of home nursing in Section 25 of the 1946 NHS Act is a testament to the value placed upon home nursing provided by district nurses of during the first half of the twentieth century. Similarly at a time when district nursing in under pressure the value of the service to families and cares should not be underestimated (Maybin et al 2016). The tenacity of district nurses prior to the NHS provides a role model for district nursing in this the 130th anniversary of the QNI.

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