
**Healthcare, Health Inequalities and the QNIS,
c. 1930-1970**



GCU Glasgow Caledonian University

Project Leads:

Dr Janet Greenlees, Senior Lecturer in Health History & Deputy Directory Centre for the Social History of Health & Healthcare

Dr Alexandra Flucker, Postdoctoral Researcher



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Title:	Healthcare, Health Inequalities and the QNIS, c. 1930-1970
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Executive Summary

Aim:

This project aimed to understand the role of the QNIS in providing healthcare for poor people in urban and rural contexts and how the role of a district nurse changed between 1930 and 1970. (The date parameters were extended to 2000 to understand changes at the end of the 20th Century and to make best use of the experiences of our interview cohort.)

Methodology:

The methodology primarily comprised oral history. However, archival research broadened the context of the study and placed it within the wider Scottish healthcare environment. We interviewed fourteen Queen's nurses about their changing experiences of nursing in different Scottish communities. While the interviews were semi-structured, they were not prescriptive. The interviewees were allowed, and indeed, encouraged to broaden the scope of their contribution.

Key findings:

Three key themes emerged from the interviews with the Queen's Nurses. Firstly, their Queen's training was important as it provided the skills and confidence to cope with any situation – health or contextual). Secondly, patient/practitioner relations were important, not simply for the job, but for making it an enjoyable job. There was mutual respect between the nurses and their communities which enhanced the nurse's ability to promote health amongst their patients. Thirdly, the nurses were very innovative in their practice (frequently taking the form of adaptability or 'making do').

Conclusions:

The preliminary conclusions are threefold (archival work is ongoing with the Wellcome Trust matching funds):

Firstly, similarities were found in the work practices of both urban and rural nurses, in that the environments necessitated nurses taking initiative and responding creatively to many unforeseen situations. While all nurses were equally dedicated to their patients and their job, for the most part, and notwithstanding individual personalities, rural nurses had a broader remit of practice responsibility.

Secondly, all nurses stressed the importance of positive patient/practitioner relations. Not only did this make their job more enjoyable, but the mutual respect allowed them to perform their tasks more simply. The positive relationships contributed to creating a positive, community context for work. Moreover, these relations enhanced the nurse's ability to engage in health education in deprived communities which, historically, have had the poorest health outcomes. While this was part of their Queen's remit, it was unofficial in that it did not form part of the government public health campaigns and remains marginalised in the literature.

Thirdly, the nurses stress the importance of their Queen's training in enabling them to manage the varied situations in which they found themselves. The extra training in district nursing not only



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enhanced their practice skills, but was targeted at the specific needs of being 'on the district', including education about potential community specific nursing and social challenges which they could face. Such training not only made their first position easier to handle, but provided them with the skills and confidence in dealing with challenging medical and environmental situations.

Implications for Practice:

Nursing in urban and rural communities hold different remits of responsibility related in part to the nature of the patients, but also the environmental context. Consequently, nursing responsibilities and roles need to allow for the varied demands that the different contexts entail, rather than working with a 'one-size fits all' model.

What next:

This project emphasised the importance of the context of healthcare provision in defining nursing roles and responsibilities, but also for the development of healthcare provision. Community healthcare systems need to progress in accordance with the priorities, needs and cultures of that particular community. While a generic framework can perhaps provide the parameters of provision, locally specific needs are core to effective service provision at a local level. Hence, the project team are currently seeking additional funding to conduct further interviews with Queen's Nurses to increase our understanding of the development of healthcare systems in different communities and the role of Queen's Nurses in growing these systems. At the same time, we are seeking to further disseminate our findings, particularly surrounding the importance of informal public health education.

Aims & Objectives

- To understand how the role of a Queen's Nurse in poor Scottish communities changed between 1930-1990 by capturing their experiences in oral interviews.
- To contextualise the welfare provision of Queen's Nurses within current historical debates by utilising secondary literature and archival material to understand the broader context of care.
- To provide the QNIS with oral histories (and transcriptions) to help preserve the importance of their work.
- To present the research findings in a variety of formats, including conference/workshop papers, journal articles and poster presentations.



Findings

Background and Aims:

In 2007, King and Stewart argued that there might be a case for charting the regional, rather than national, development of welfare systems. We have good accounts of national welfare structures (eg. Stewart, 2004 and 2004 in Ellison, et al.; Lowe, 2005; Cousins, 2005; Harris, 2004), English working-class health culture (Beier, 2008; 2001) and poverty and welfare (eg. Levitt, 1988; King and Tomkins, eds, 2003; King, 2000; Rochester, et. al., eds, 2011). Less is known about the regional development of health and welfare structures, particularly for women as providers and consumers of welfare. Existing studies emphasise the early twentieth century when welfare systems were more fluid and state structures more rudimentary (eg. King, 2005; Koven and Michel, eds., 1993; Lewis, 1992). Therefore, we need to further develop our understandings about the various healthcare providers, their responsibilities and relationships, in a variety of community settings if we are to understand how to adapt current healthcare to best meet the needs of individuals in all communities. This is particularly important in economically deprived communities with health outcomes below the national average.

We were interested in the healthcare available for people surviving just above the threshold of destitution during a period of rapid change in municipal provision with the 1929 Local Government Act, the formal end of the Poor Law, the 1948 introduction of the National Health Service (NHS) and its early years of provision when a large group of people had access to formal healthcare services for the first time. During these years and into the 1970s, the Queen's Nurses were one of many providers of healthcare for the poor. They were outside the NHS, yet from 1948, provided a core service for it, including training district nurses (until 1968). Previous studies about the Queen's Nurses have highlighted how district nursing has evolved over the years and nurses perceptions of these changes (Dougall, 2002), the professionalization of nursing, geographical contexts, treatments, myths and stereotypes (Sweet, with Dougall, 2007) and the challenges of district nursing in remote areas (Morrison, 2013). By focusing our study around health inequalities and healthcare, this study sought to extend previous findings by investigating the actual tasks nurses performed on their visits, what medical and social challenges their training prepared them for, and how patients responded to the nurses and the care they provided. Within this, this project highlights how inequalities were addressed, both formally and informally.

The time frame of c. 1930-1970 was chosen to enable understanding of the changes in provision that included vast changes in British healthcare systems. These years cover the end of the Poor Law, the introduction of the NHS, and the end of the Queen's Nurses providing the training for district nurses, as well as other organisational changes within the NHS. Due to the age of the nurses willing to take part in the study, we extended the timeframe to the end of the twentieth century in order to better understand the impact of the changes within the NHS on the work of a Queen's Nurse.

We started the project with two core research aims, which we hoped our interviews with Queen's Nurses would help address. The overarching research question was: What healthcare did the QNIS nurses provide for the poor and how did they shape health and welfare provision in Scottish communities? In addressing this broad question, this project aimed to:

(1.) Highlight the changing role of the QNIS nurses in caring for poor Scottish women and their children between c. 1930 - c. 1970 to increase our understanding of the healthcare they provided.



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(2.) Contextualise the QNIS health and welfare provision in poor communities within that of international debates about health inequalities. Here we will try to understand the Queen's Nurses leadership role in health and welfare innovation. Were they influential in developing policy surrounding health and welfare provision for the poor, or were they followers of either policy or other providers?

Hence, this project was designed to address a small, but important, part of a longer term about who provided healthcare for the poor before and after the NHS and the associated choices patients made.

Methodology:

We adopted a primarily oral history methodology in order to learn not just what people did (in our case, the Queen's Nurses), but what they now think they did and what they believe is historical fact (Portelli, in Perks and Thomson, eds., 2006, p. 36). In addition, oral history provides people the opportunity to offer their own interpretation of events (Perks and Thomson, eds., 2006) and the freedom to express ideas and thoughts which may not have been preserved in a written form (Boschma, Scaia, Bonifacio, and Roberts, in Lewenson and Herrmann, eds., 2007, p. 79; Thompson, 2000). Oral histories have been argued to be a particularly valid methodology for nursing history because knowledge of the past teaches nurses about who they are. Current nurses can learn from past nursing experiences to influence current day-to-day practice (Lewenson and Herrmann, 2008, p. 2). Nurses are in many ways hidden in history as few documentary sources survive relating to them or their experiences. In addition, we believe that oral history puts people at the centre of history – events, time and place – providing a much broader context than could be gleaned from documents alone. Nevertheless, we remained aware of the pitfalls surrounding oral history, particularly in relation to the unreliability of the memory of the participants (Marwick, 2001, p. 147). Although our questions focused on the lived experiences of the nurses, in order to avoid the constraints posed by memory, we used documents to contextualise and validate the facts posited by the participants. We did not, however, seek to challenge their lived experiences of events as these are individual.

Recruitment: Locating willing participants was time-consuming, but rewarding. We identified our interviewees from the 2013 Annual Gathering in Crieff; we met many by joining the Glasgow Queen's Nurses' coffee mornings at the Millennium Hotel, Glasgow, and through word of mouth. No nurses were pressured into providing an interview and while some declined, most were delighted to have the opportunity to talk about their work and enthusiastically did so. Ethical guidance was followed and clearance provided by GCU's ethics committee. Consent forms were utilised to preserve the integrity and in some cases the confidentiality of the interviewees.

The majority of the interviews were conducted by the postdoctoral research assistant, Dr Alex Flucker, but with the lead researcher conducting a few. All interviews were face-to-face. In all, we conducted 14 semi-structured interviews with Queen's Nurses who served poor Scottish communities, both urban and rural. While we initially planned to focus on Glasgow and Ayrshire, it quickly became evident that we should broaden our scope and extend our timeframe to 1990. This was not merely for practical reasons in order to secure interviewees, but also because while there were similarities in the duties and experiences of the nurses, the urban/rural differences were quickly apparent and we wished to explore these further. The questions developed during the course of the project included:



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Questions:

1. Where and when did you do your nurse training? Where and when did you do your QNIS training? How long was your QNIS training?
2. Were you a midwife/HV as well?
 - a. When and where did you do your midwifery training?
 - b. Triple-duty nurse?
3. Where did you get your first job as a Queen's nurse?
4. How did you get this job (and subsequent Queen's Nursing jobs?) Who was your employer? Were you interviewed? By whom? Why did you change jobs? Getting a district?
 - a. Advert; word-of-mouth; headhunted; other
 - b. Queen's Nurse Tutors? Superintendents? (what about after 1948).
5. What did it mean to get a district? (before that was it relief work in any district?)
6. Did you get a nurse's house? (who provided that?)
7. Who compromised the majority of your patients?
 - a. The poor?
 - b. The elderly?
 - c. Children?
 - d. The terminally ill?
 - e. Chronically ill.
 - f. Mothers.
 - g. Antental.
 - h. Men.
 - i. Any impact from gender/class or income/religion/immigrants?
8. What types of care did you provide for the poor?
 - a. Medical – Administering injections? Care of the dying? Fevers? Disease? Blood pressures? Vaccinations? Health advice?
 - b. Surgical – dressings? Postoperative care?
 - c. Midwifery – antenatal? Intrapartum? Postnatal?
 - d. Social – non-medical care? Was this routine?
 - e. Trauma?
 - f. Convalescence?
9. When did patients come to you for help?
 - a. Preventive?
 - b. Curative?
 - c. Palliative?
10. What was the referral system?
 - a. How did the poor access your help?
 - b. Only through G.P.'s? Through hospitals?
 - c. Could you suggest patients to take on?
 - d. How did this system change from the 1930s to 1970?
 - e. How did the poor access other healthcare facilities?
11. Who decided your work remit/duties and areas of responsibility?
 - a. How much leeway did you have to try new things/change practice? Was this encouraged/resisted?
 - b. How did your responsibilities to the patient change over time?
 - c. Overnight stays?



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- d. Home visits?
- e. Clinics?
12. Did you run clinics as well as making home visits?
 - a. What sort of clinics did you run?
 - b. Were they well-attended?
 - c. Who formed them and why? (patients? Govt. initiatives, nurses themselves, G.P.s, outside influences).
 - d. Where were they held? (Church halls etc?)
13. Do you feel that your training adequately prepared you for the nursing work you were expected to undertake? Were you confident in your abilities to deliver the care?
14. What challenges did you face in caring for the poor?
 - a. Environmental : –dealing with hygiene issues; space/ overcrowding; neighbours
 - b. Economic – how did the poor pay for the services? Did you provide medicaments? Dressings?
 - c. Social – family; neighbours; understanding of disease process/condition; prognosis.
 - d. Did the poor use their own home remedies etc? What was your view on this? Did the remedies conflict with (or complement) your care and advice?
 - e. Did you recommend non-prescription medicines ?(might be cheaper for the patients – prescription charges expensive for simple remedies).
 - f. Old wives' tales.
15. How were caseloads managed?
 - a. Did you decide when a patient needed further treatment out with your jurisdiction or competencies?
 - b. Did you decide when someone needed discharged or did they need to see the G.P.?
 - c. How did you report back to the G.P. about a patient's progress/lack of progress/prognosis?
 - d. What was the communication system? Did you and the GP/other healthcare workers meet/have meetings to discuss patients and their progress and needs?
 - e. Triage system – did certain problems or issues push people to the top of the list?
16. What was your working relationship with other professionals delivering healthcare in your area?
 - a. G.P.s?
 - b. Other nursing staff?
 - c. Chemists?
 - d. Hospitals?
 - e. Schools/school boards?
 - f. Medical charities.
 - g. Social workers?
 - h. Others?
 - i. Were you and your profession well-respected by other healthcare professionals?
17. What was your relationship with the women, children and families you cared for in general?
 - a. Were they appreciative of your care?
 - b. Did they respect your decisions and listen to your advice?
 - c. Did they seek your advice for other issues beyond what you were treating them for?
18. Who were you accountable to for your practice?
 - a. QNIS – Superintendants?
 - b. The register?



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- c. The General Nursing Council for Scotland?
 - d. G.P. Practice?
 - e. Local authority manager (from 1948?)
19. What impact did the NHS have on your work, duties and responsibilities?
20. In what ways did your responsibilities and practices change over time?

SUPPLEMENTARY QUESTIONS (added after the first few interviews)

21. Was it dangerous?
22. Did you ever feel intimidated?
23. Infant feeding and breastfeeding? Class differences? Support and encouragement? Advice given etc.?

Recognising that the interviewer is an active participant in the oral history research, these questions were designed to be indicative, rather than prescriptive. They provided more of a guide of discussion topics for the interviewer (a structural framework) rather than a prescriptive list of questions. The interviews were then transcribed verbatim, followed by a thematic analysis. The key themes identified included varieties in care provision, the importance of patient- practitioner relations and inter-practitioner relations, nursing duties and responsibilities. These were explored and further developed, with corresponding revisions and additions to the interview questions and topics, as well as relating them to existing historiography. The transcriptions and the oral interviews will be deposited in the RCN archives for longevity and for future research.

Results and discussion:

The two core project aims are interrelated, so while discussion is divided between the aims, many issues and outcomes span both.

Aim 1.) To highlight the changing role of the QNIS nurses in caring for poor Scottish women and their children between c. 1930 - c. 1970 to increase our understanding of the healthcare they provided. The associated research question: What healthcare did the Queen's Nurses provide for poor Scots between c. 1930-1970 (later 1990)? And, where did their provision fit within the broader Scottish context of health and welfare provision?

A core theme stemming from our interviews was the diverse nature of the Queen's Nurses healthcare provision. While one of the broader goals of the NHS was to address health inequalities, the Queen's Nurses had to deal with health inequalities on a daily basis. Hence, their tasks varied from traditional nursing services to helping patients gain access to additional health and welfare services and ensuring communication between patient and all practitioners remained clear and constant. In some deprived homes, the nurses were also active in locating clothing and other items for patients, particularly new mothers (including prams and bedding). Nevertheless, in carrying out their responsibilities, the nurses consistently provided non-judgemental and holistic care and respected their patients as individuals. Under that broad umbrella of care, the nurses provided everything from ante and postnatal care, to wound dressings and diabetic care. A secondary, but equally important part of the Queen's Nurse's duties comprised educating patients about health and healthcare. Some of this corresponded with government agendas, such as trying to improve infant feeding practices, but much of the health education remained informal.



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Such education took many forms and addressed a variety of issues. It included countering some old wives tales, or just gentle conversations with, or hints to, people about changing certain practices, particularly surrounding hygiene issues. Yet before a nurse could suggest behavioural change, the nurses had to establish a bond of trust with the patient(s). Indeed, the nurses noted that core to the success in changing people's behaviour was the mutual respect between patients and practitioners. They noted that while they often entered challenging living environments, they were trained not to comment on it.

['You needed to remember that you were the visitor in that house.']

Instead, by focusing on the patient and the family, they gained their respect and trust.

[People had a respect... you know, for the district nurse and they would look after you. They had absolutely nothing, nothing, down in Granton and Leith, but, but what they had, you could have.']

['They recognised the uniform as someone they could go to for help... who wouldn't let them down... there was a trust there.']

That trust, in turn, increased the Queen's Nurses ability to suggest improvements in personal health and hygiene practices and the chances of them being accepted. For example, several nurses noted that health education formed a key part of their responsibilities. They also found their Queen's training beneficial for this role.

['You know, we were a bit of everything. But we, when we were in training, it was dinned into us that we were also educators.']

The nurses highlighted the example of persuading patients not to take leg ulcer dressings off and use Germolene instead. She noted that many people in her district considered Germolene to be a successful remedy for ulcers. As a nurse, her previously established patient/practitioner trust provided her with the confidence to explain how Germolene could burn the fragile skin surrounding the ulcers. Another example of using the nurse/patient trust to improve unhealthy practices was convincing people not to let their dog (or indeed neighbour's dogs) lick the wound. A third case comprised persuading patients not to use traditional herbal remedies in addition to Warfarin. Here, the nurse suggested the patient(s) stop the double medication for a while to see whether blood results would be affected, instead of telling the patient that herbal remedies were interfering with the Warfarin. Hence, rather than highlighting the patient's mistake or ignorance, she suggested an experiment where the patient would be an active, equal participant. And, a final example comprised persuading patients not to share their medicine with family and friends, even when symptoms were similar.

In all these situations, the nurse provided the patient with good reasons for avoiding the unhealthy practices and presented it in a manner where she was empowering the patient with new knowledge, rather than criticising their ignorance or patronising them for following 'old wives tales'. Through this practice, patients responded positively to the advice. This patient/practitioner trust and the informal health education have been omitted from written records, yet it was clear in most of the oral testimony. Studies of Scottish health and welfare provision primarily rely on the written record and hence, tend to emphasise either state provision of health education under the NHS (eg Black, forthcoming 2014/15), or the broader development of district nursing (Sweet with Dougall, 2007; Dougall, 2002) or the challenges of location (Morrison, 2013). Hence, gaining an understanding of the daily tasks, both formal and informal, of frontline nurses regularly engaged in health promotion,



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greatly extends our understanding of the actual healthcare services provided for the poor and sheds insight into the processes for changing unhealthy behaviour. Indeed, it suggests that both formal and informal initiatives at health promotion can secure successful patient outcomes.

Aim 2.) Contextualise the QNIS health and welfare provision in poor communities within that of international debates about health inequalities. Here we sought to understand the Queen's Nurses leadership role in health and welfare innovation. Were they influential in developing policy surrounding health and welfare provision for the poor, or were they followers of either policy or other providers?

The interviews also generated divergent responses from nurses who worked in primarily urban communities and those who worked in rural areas. Nurses working in larger towns such as Glasgow noted how the GP remained in charge of patient care and any questions or suggestions had to go through the GP. While nurses usually had a good working relationship with the local GP(s), they made it clear that the GP directed all patient care. Off tape, one nurse/midwife noted how she was under the impression that the GP's did not always trust the midwife's judgement, even when the latter had more training in a particular area (notably midwifery).

Nurses who lived in group accommodation rather than in their own cottage, noted the importance of the nurse superintendent in directing the nursing care and in providing consultation about difficult cases. The Superintendent managed their case load and all cases were reported on a daily basis to the Nurse Superintendent. Moreover, she managed the core liaison between the Queen's Nurses and the GP practices.

Nurses employed in rural communities had greater autonomy in addressing patient care and had a lengthier record of negotiating and liaising with other care providers to meet patient needs.

[‘You were in close contact with the family doctors.’]

[‘We really had a good relationship with the GPs. They were very good, and of course because we were, we were on call at night...’]

While this included the GPs, initiatives were not always GP led. Moreover, rural GPs seemed to allow the nurses greater autonomy in both midwifery and nursing than did their urban counterparts.

However, despite the different practitioner relationships between urban and rural nursing, all nurses had to rely on their own initiative and ingenuity on a daily basis. Even under the NHS, not all materials were provided to address all the health and welfare needs of the patients. Poor women particularly struggled to provide even basic necessities for their families. This was particularly evident with new babies and many patients benefitted from the Queen's Nurses ingenuity.

[‘But the thing is, because of that, we were very innovative. So any boxes that came in, we'd make bed cradles... Out of cardboard boxes...Biscuit tins... Went to bakers' homes... Used to say ‘oh, save that box for me’, because the tins, we'd line the tins with, nice, usually linen tea towels... Make the swabs and the cotton wool, put them in, bake them in the oven for an hour... To sterilise them.’]

[‘We would try and alleviate things without them having to spend money.’]

Several nurses identified their Queen's training as important in developing their initiative and ability to innovate. Moreover, it formed part of the responsibilities of a district nurse.



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Lastly, highlighted within these findings and, indeed, all the interviews, was the context of care. Queen's Nurses were able to adapt to the environmental and social situations in which they found themselves. Such healthcare contexts also suggested multiple and varied needs in terms of health care provision. Hence, the finding that holds the greatest contemporary relevance was the need for healthcare systems to develop according to local needs. Within this, healthcare providers need the training, adaptability and flexibility to meet the needs of diverse populations.

Case studies/ quotes to illustrate outcomes

'You were just on call for everything and you would just offer everything and they would come over not to bother the doctor...they would just come to you... you were available to go whenever you were needed and you'd probably be out the whole night at a confinement and still had to carry on with your normal duties the next day.'

'You had to adapt and be able to adapt.'

'We would try and alleviate things without them having to spend money.'

'We really had a good relationship with the GPs. They were very good, and of course because we were, we were on call at night...'

'They recognised the uniform as someone they could go to for help... who wouldn't let them down... there was a trust there.'

'You needed to remember that you were the visitor in that house.' 'You know, we were a bit of everything. But we, when we were in training, it was dinned into us that we were also educators.'

'The conditions people were living in were a bit of a shock. You had to adapt and be able to adapt.'

'But the thing is, because of that, we were very innovative. So any boxes that came in, we'd make bed cradles... Out of cardboard boxes...Biscuit tins... Went to bakers' homes... Used to say 'oh, save that box for me', because the tins, we'd line the tins with, nice, usually linen tea towels... Make the swabs and the cotton wool, put them in, bake them in the oven for an hour... To sterilise them.'

'People had a respect... you know, for the district nurse and they would look after you. They had absolutely nothing, nothing, down in Granton and Leith, but, but what they had, you could have.'

'...well, I don't think they would expect us to make them better but they were so pleased when the nurse came. They thought everything's going to be taken care of. I'm sure, quite sure they didn't think things were going to get better.'...

'...general health advice would be something... you didn't want to impose it upon people but if they were asking you for advice we were quite happy to provide that...yes.'

'Some of them had their own wee remedies like a kaolin poultice or a bread and milk poultice...'

'They were very responsive to any advice that you gave them.'

'The conditions people were living in was a bit of a shock.'



Lessons learned & what we would do differently

The importance of the context of care quickly became central to our interviews. If we were to do this project differently, we would have utilised a smaller interview base and used other sources (archival, journalistic and possibly interviews with other local providers, particularly GPs and district midwives who were not also Queen's trained) to develop a greater understanding of the broader context of care in different communities and the care provided by different practitioners. This would have made easier the contextualising of the the varied roles of the Queen's Nurses within the different communities and aide the task of drawing out urban/rural comparisons.

Secondly, we probably underestimated the amount of time it takes to transcribe an interview. In future, we would either build in a budget to employ someone to transcribe on an hourly basis, limit the number of interviews, or extend the time frame of the project.

Conclusion

While our conclusions are summarised above, the primary conclusions are twofold. Firstly, healthcare needs to develop based on the needs and demands of the local community. Therefore, while 'healthcare for all' may be an overarching political goal, in order for this to be implemented, peculiarities of place need to be incorporated within this provision. Secondly, a greater understanding of the daily tasks of different care providers is necessary to learn more about the development of healthcare in urban and rural contexts. This includes not simply the extent and nature of the healthcare provided, but also additional tasks such as providing poor patients with basic necessities (such as for infants) as well as the degree, type and diversity of health education.

Dissemination Plan

Dissemination is ongoing.

- Our findings were presented to the Queen's Nurses through a poster and engagement at Crieff.
- A paper presented at a workshop, 'Caring for the Poor in 20th Century Britain', held at GCU in September 2014.
- The oral histories and their transcriptions will be deposited in the RCN archives.
- An article based on the September paper will be submitted to a historical journal later in 2014.

Future developments/ next steps:

The centrality of the context of care that arose from this project has led to the development of an additional project involving Queen's Nurses. We have submitted another grant to the QNIS and Wellcome Trust to conduct more oral histories with Queen's Nurses about their role in the care networks in their community and the development of such systems. That project will feed into a later project that addresses the questions of how do healthcare systems develop in poor communities; and, do these systems follow national or regional patterns? In order to address the latter question, this project will examine both Scottish and northern English communities (urban and rural).



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Personal Development:

This project has developed the oral interviewing skills in both the lead researcher and the postdoctoral researcher. It has also further developed the research skills of the postdoctoral researcher, particularly in the area of oral history methodology, all of which will help her in her quest for an academic career.