PRIMARY HEALTH CARE GROUP

Working paper for managers: 6

DECENTRALISING COMMUNITY HEALTH CARE IN ISLINGTON

Gillian Dalley

King's Fund Centre for
Health Services Development

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Introduction

The contribution of a development work project to promoting innovation in community health services management

Health services development work is concerned with bringing about innovation; it seeks to test out new ideas, learn lessons from them and disseminate results to other parts of the service. It may take the form of a specific project, with a single worker or small number of workers taking responsibility for the operational design, running and assessment of the project and with a steering group acting as support and management. In some instances, the development worker will act more as a consultant to managers or professional staff in the service, offering ideas, assisting in implementation and assessing results.

A development work project bridges the gap between the realm of theory and the world of practice. Government reports and academic studies often make recommendations about the need for change — but rarely move beyond the level of exhortation and requirement. Professional bodies take the lead in advocating developments in professional practice but do not have the authority to ensure they are taken up. Managers and front-line practitioners are usually preoccupied with running and delivering the service and do not have the time or resources to spend on mounting small-scale, experimental initiatives to test ideas that come from outside.

There are three essential components to a development work initiative: setting objectives for the work; designing and carrying out the work; assessing and disseminating the results. The key characteristic of development work is its experimental nature; such experiments must be documented and their results made known to justify their establishment in the first place.

It is an advantage for development work to be sponsored by an institution with a reputation for supporting innovation and experimentation — such as, in this case, the King's Fund. Funding from other bodies is more likely to be forthcoming if it has such sponsorship; it also helps to establish the initiative's credibility 'in the field'. The resources of the sponsor may be available to assist in the documentation and assessment stage. Finally, powerful backing may ensure widespread dissemination, in influential quarters, of the lessons to be learnt from the initiative.

The initiative described in this report was part of a larger project (three initiatives in all) to test out ideas which came from a number of sources. It was concerned with looking at how far small-scale approaches to the management and delivery of services could improve the quality of primary health care and overcome the widely documented failures in collaboration at local level that currently exist. The Acheson report on primary care in inner London [1], the Barclay report on social work [2], studies of decentralisation of services in local authorities [3] and of patchworking in social services [4] had all examined the potential benefits of 'going local'; the proposed development work

project was to explore the application of this approach in a health service setting.

The project was established at the end of 1985 by the King's Fund to explore the possibilities for improving primary health care in the inner city by developing small scale (patch) management and planning of services, in which providers of statutory and voluntary services and service users would be encouraged to work more closely together to make services more effective. It was funded by the (then) Department of Health and Social Security (DHSS) under a budget following the report of the London Planning Consortium on inner city primary health care (the Acheson report).

Time was spent at the beginning of the project on defining the key issues relating to decentralisation. Appendix A records an outline of the issues and options as they were perceived at the outset. It was firmly acknowledged that the justification for adopting a patch-based approach must be in terms of its being likely to improve the quality of health care delivered. Nevertheless, a consensus on what constitutes quality of care was not necessarily a straightforward matter; different perspectives on quality (managers', practitioners' and consumers' perspectives) might emerge. The reasons why a 'patch' approach should be proposed as a way forward might also be varied: some stress idealised notions of community and community-spirit underlying the approach; some are concerned with the devolution of decision-making to make it speedier and more accountable; some stress the ability it gives to sort out inter-agency and inter-professional problems at local level. There were also difficulties in agreeing how a patch or locality should be defined: was it a 'natural community', an administrative area or a planning and service delivery unit?

The project involved development work in three health authorities: the initiative described here took place in Islington health authority. Reports of the two other initiatives — in Riverside and Lewisham & North Southwark — have been written up separately [5,6,7].

The Islington initiative

Once initial consideration of the key issues had been completed, the task of establishing contact with a health authority which was likely to be interested in developing the 'patch' approach began. Visits were made to a number of London health authorities and several promising contacts developed.

In the case of Islington, initial interest was expressed by the director of quality assurance and the specialist in community medicine (SCM); this was further developed by the newly appointed general manager for the Community and Continuing Care Unit (CCC Unit) when he came into post in January 1986. They endorsed in principle the philosophy that was informing the King's Fund project — namely, the view that one way of overcoming the fragmentation of services at the point of delivery might be by managing them on a more local basis.

After discussion, an agreement (see Appendix B) was reached between the unit general manager (UGM) and the King's Fund that the project's development worker should be involved on a regular, agreed basis in the development of a locality-based approach to organising the unit's community health services. She would work with the UGM on exploring ways of organising sub-unit management structures which would facilitate the locality approach. It was anticipated that this would mean looking at: the demographic features of the district; current knowledge of population needs; existing management structures and staffing levels; and lessons that might be learned from the experience of other health or local authorities that had already adopted a locality approach.

The process of decentralisation

From the outset, emphasis was placed on thorough preparation for change. Staffing levels had become depleted over the previous year, especially at more senior levels with a number of senior administrators and nursing managers leaving. The impact of general management had created uncertainty and resistance: staff expected change but were uncertain as to what it might mean.

The steering group

The first step in the process of preparing for the new structure — whatever that was to be — was the setting up of a steering group to consider the possible ways of reorganising the management and delivery of services. The steering group was convened by the UGM and its membership consisted of the UGM, the newly appointed director of nursing services, the acting unit administrator, the consultant community paediatrician, the SCM, the unit research officer, the Camden and Islington family practitioner committee (FPC) administrator and the King's Fund development worker. Membership changed over the months (with the unit administrator, the SCM and the research officer leaving and the general practitioner (GP) member of the district management board joining) but a core of members remained. The group met on a

regular fortnightly basis (the first meeting was held in February 1986) and planned to work to a strict timetable which meant submitting proposals to the district health authority in July 1986.

Demographic factors

Early meetings of the group were concerned with examining information available on the demographic characteristics of the district, considering them against the framework of variables used by Irving and Jarman in their work on deprivation. The profile of Islington which emerged was one of heterogeneity (although the information was based on admittedly 'old' 1981 census data). Those categories of the population regarded as likely to be most disadvantaged (the elderly, the unemployed, single parents, large families and ethnic minority group members) were spread broadly through the population and across its territory. There were few considerations of particular groups singled out from the remainder of the population. This was to be an important factor when later it came to agreeing boundaries for breaking up the district into localities and deploying staff accordingly.

Management arrangements

Possible management arrangements were then considered by the steering group. This raised fundamental questions about the philosophy of management which was going to be introduced. It was agreed that the broad principle of **general** management (that is: delegation of decision-making; accountability of a single manager at each level; the primacy of general management over functional or professional/management) should be applied within the unit. This implied that managers below UGM should be general managers responsible for different sorts of professional staff.

A locality approach

A commitment was also made to the view that effective community health care could best be achieved by 'going local'. The major issue was then to determine how a locality-based approach could be linked into a devolved general management structure whilst at the same time taking into account the characteristics and needs of the local population. A remaining — and key — factor also had to be taken into account. This was the fact that the local authority, the London Borough of Islington, had already decentralised into 24 neighbourhoods, each with its own neighbourhood office and neighbourhood management. Stress was placed on the need to link in with these arrangements as far as was possible.

Consultation

The importance of keeping staff in the picture was recognised from the outset, although in the early stages while the steering group was only discussing possible options, there was little information to pass on. When the proposals were almost ready for submission to the health authority, the UGM mounted a series of presentations at each of the

health centres; all staff were invited to attend and comment on the proposals. The meetings were well attended although they provoked little discussion apart from some about boundaries. In particular, there was disagreement over the way boundaries had been drawn between two localities where three health centres, their staff and their catchment areas, had to be allocated.

During this period, too, consultations with other interested parties took place. The UGM and King's Fund development worker made presentations twice to the district management group and took advice from them on the managerial arrangements. The UGM met the director of the local authority social services department and a number of councillors; they welcomed the proposals expressing the hope that it would bring the services of the authorities closer together. GPs, too, were consulted. The UGM attended a meeting of the Islington GPs' forum and also spoke to a number of individual practices. No overt opposition was expressed although it was acknowledged that the populations that GPs served (their practice populations) differed from the localised populations which were proposed for the community health services. The community health council was also given an opportunity to comment on the proposals and it gave its support. While most outside interest expressed favourable views, a number were sceptical as to how far the unit would succeed in its objectives.

The proposals

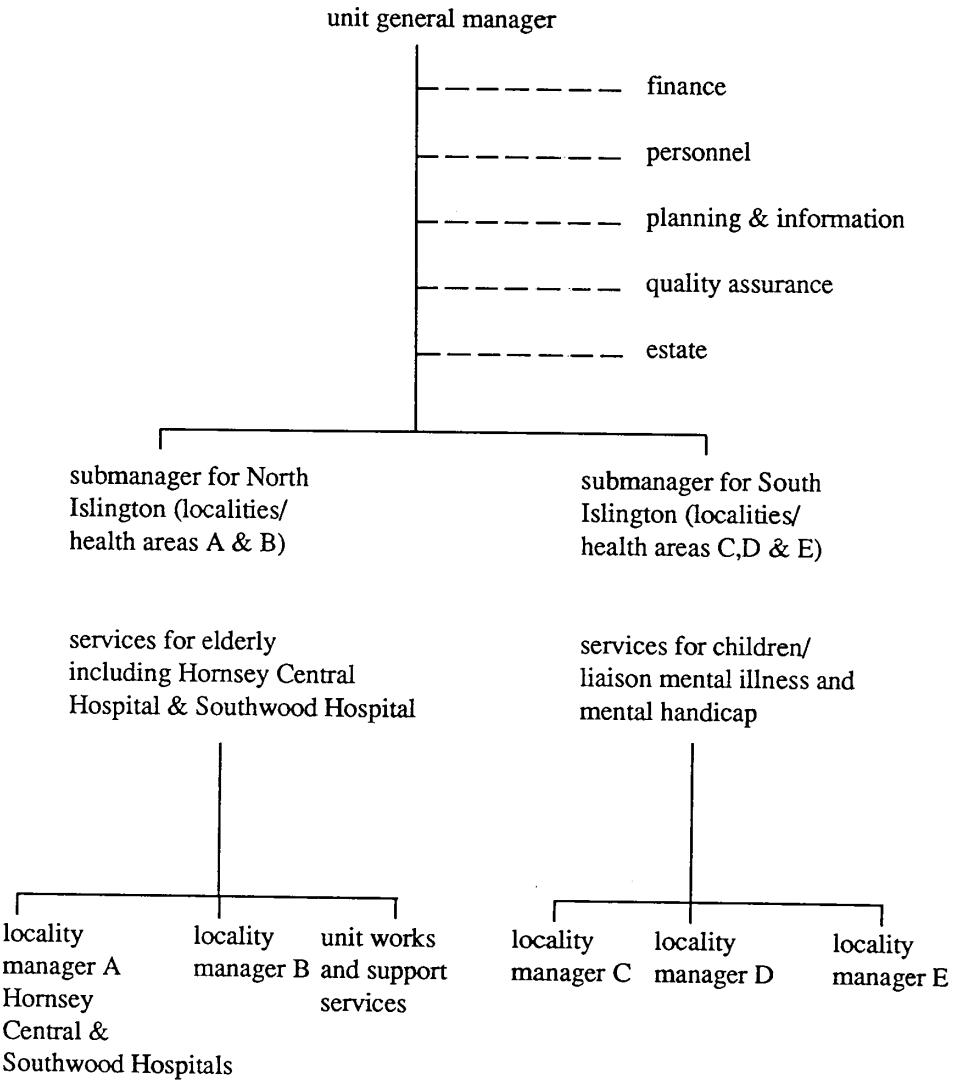
The proposals, which were put to the health authority in July 1986, incorporated general management into a decentralised service delivery system based on five localities covering the whole of the district. The details can be characterised as follows:

Geographical organisation: five localities with a population of between 26,000-33,000 people matching clusters of local authority neighbourhoods — without cutting across any local authority boundary; one health centre in each locality acting as administrative base.

Locality staff: to comprise health visitors, district nurses, school nurses, visitors for the elderly, administrative and clerical staff, clinical medical officers (paramedical staff to be deployed to localities at a later date).

Management structure: two assistant general managers (AGMs) to be responsible for three and two localities respectively (the south Islington AGM to be nurse adviser to the unit; the north Islington AGM to be responsible for the two small hospitals) [these posts were suggested by the district management board]; each locality to be managed by a locality manager (LM) — appointed as a general manager irrespective of professional background, responsible for all locality staff and charged with a duty to establish relationships with other agencies and services — both statutory and voluntary — within the locality.

Table of the structure of the unit.



NB.

i) All staff in health localities will be managerially accountable to locality managers (approx. 250 staff = each sub unit).

ii) The specialist functions (shown with a dotted line) will relate, as appropriate, to the submanagers & the locality managers.

The implementation

After the agreement of the health authority had been secured, implementation of the proposals could go ahead. There was some small adjustment of the boundary proposals in line with suggestions made during the consultation period. Appointments to the two AGM posts were made, to be taken up on 1 January 1987; locality managers were to be appointed as soon after that date as possible. The candidate appointed to the north Islington AGM post came from an administrative background, the current director of nursing services was appointed to the south Islington AGM/nurse adviser post.

The first few months of 1987 were taken up with establishing the AGM posts and appointing locality managers. These posts were general management posts, although their prime managerial responsibility initially would be for the community nurses in the unit. However it was hoped that candidates for the posts would come from a range of professional backgrounds and, in the event, they did. Professional backgrounds represented were:

- district nursing;
- health visiting;
- administration;
- chiropody;
- academic research.

Once all were in post the UGM saw the key tasks facing the unit as follows:

- 'launching' the localities;
- informing other agencies about their plans;
- finalising professional advice arrangements within the unit;
- deploying staff to the localities;
- considering the implementation of neighbourhood nursing (Cumberlege);
- developing sensitive information systems;
- devolving budgets;
- developing locality planning;
- improving the working of primary care teams;
- developing consumer involvement;
- raising staff morale and commitment.

Progress to date

Decentralisation has been continuing now for almost three years. Considerable progress has been made both in practical terms and in terms of building the morale of staff working in the unit (both factors seen as prerequisites for improving quality of service for the user). Some of the achievements can be listed thus:

- staff have been deployed to the localities;
- budgets have now been devolved to localities;
- professional advice arrangements have been agreed;

- relationships with other agencies are being established;
- neighbourhood nursing has been introduced (see next section);
- staff morale is being fostered (recruitment and retention have both improved);
- the localities have been publicly launched (with open days in each health centre).

Some reflections on this progress will be contained in later sections of this report. The next section, however, will consider the introduction of neighbourhood nursing.

From planning for decentralisation to neighbourhood nursing

Phasing out the steering group

By the summer of 1987 the steering group disbanded. A large part of its role in the early days had been to support the UGM in the absence of management support within the unit. Once the AGMs and the locality managers had been appointed, management support was adequate. The other major part of its role — planning and preparing for decentralisation — had also been completed. The operational tasks of getting the process moving were now management responsibilities.

Emphasis was thus placed on developing management thinking about setting objectives and making decentralisation work effectively. The King's Fund development worker continued her association with the unit and was involved in reviewing operational progress and mounting a number of management workshops to look at aims and objectives, improving communication and collaboration, and developing operational plans.

There remained, however, one significant planning and preparation exercise which would take decentralisation a logical step forward — namely, planning for the introduction of neighbourhood nursing. As the steering group was disbanded, the UGM decided to establish a working party to look at the nursing issues.

The neighbourhood nursing working party

There were two reasons for considering the neighbourhood approach. Up till this point, community nurses in Islington had been 'loosely' managed with coordinators rather than managers — (eight health visitor coordinators, one school nurse coordinator, one coordinator for visitors for the elderly and four district nurse coordinators) — placed between field staff and the assistant directors of nursing services. The UGM wanted a more clearly defined management structure with clearer lines of accountability. At the same time, he also wanted an approach which fitted into the philosophy of decentralisation - which concentrated on identifying and responding to the needs of local populations. The Cumberlege report [8] on community nursing had recently been published and this advocated the introduction of mixed discipline teams under the leadership of a single ('generic') manager and focusing on particular geographical neighbourhoods. This approach seemed to fit very well with the philosophy of decentralisation which the CCC unit had adopted.

A working party was established, composed of the UGM, the two AGMs, the GP member of the district management group, co–opted representatives from health visiting and district nursing, the FPC administrator and the King's Fund development worker. As with the steering group before, meetings were held fortnightly. Key issues which were dealt with included:

- philosophy;
- generic nurse management (the single nursing team leader);
- principles for primary care team working;
- neighbourhood boundaries;
- deployment of staff within neighbourhoods;
- preparing for multi-disciplinary team working.

Progress towards neighbourhood nursing

The working party met for a period of four months; it was a time of intensive work. As the work progressed, worries and some resistance from staff began to emerge.

The importance of *consultation* had been recognised since the first days of the steering group; it became even more important once the arrangements for community nursing began to be considered. Field staff realised that the plans which were being made would affect them directly, so their interest and concern was much greater than when broader unit-wide matters (that is, decentralisation of the unit) had been under discussion.

Discussion papers were circulated and the UGM and the AGM/Nurse Adviser addressed many well-attended and lively meetings of community nurses. Most worries came from health visitors in the unit; their main concern was about the introduction of the single (generic) nurse manager. They were concerned about the possibility of being managed directly by someone who did not have a health visiting qualification. They were particularly concerned as to how this would affect the management of child abuse cases. Other nurses expressed similar views about generic management and mixed team working, but never so strongly as the health visitors.

Health visitors in the district called on a representative from the Health Visitors Association to take up their worries. The UGM met with her on many occasions to discuss the plans. A representative from the Royal College of Nursing also met the UGM to discuss district nursing concerns. It was generally agreed that further action should be taken.

The King's Fund development worker and a colleague from the Fund agreed to mount workshops for staff designed to air the issues, explore their worries and to suggest to them that the problems could be resolved.

The workshops

Two two-day workshops were organised. They were carefully structured to:

- allow participants to air their grievances;
- compare fears across disciplines;
- explore the meaning of the new philosophy;
- meet management directly to express their views.

The workshops revealed the ignorance of different groups of staff about, each other. It

showed how, once brought together, staff from different disciplines could establish friendly relations. Role play sessions — exploring what working in a mixed team would mean — showed that common working would be possible. Managers joined the workshops for each final session. They had to listen to some frank talking but the sessions ended positively with good relationships established and a willingness to cooperate with each other in the introduction of the new approach.[9]

Planning for neighbourhood nursing

The workshops marked a turning point in *planning* for the future; they did not solve all the problems but they brought about a change in attitudes. The low point had been reached and progress after that improved.

Locality managers and their staff became closely involved in working out plans for each of their localities (each locality was to be divided into two neighbourhoods) in terms of the allocation of staff and their deployment. Numbers of staff had to be measured against population size and demographic characteristics of localities and neighbourhoods. Some staff would be obliged to move from existing bases and give up existing caseloads although disruption was not enormous. As mentioned earlier, Islington was notable for the relatively even spread of its mixed population — there were no marked pockets of affluence or deprivation which would have required heavy weighting of staff and caseloads accordingly.

The first half of 1988 was spent in preparation: the training and personnel departments were involved in the exercise; the localities were publicly launched with open days at the health centres; nursing staff were deployed according to plan. A new AGM/nurse adviser came into post during this period, a professional development nursing post was introduced and the neighbourhood nurse managers took up their posts on 1 October 1988 (nine were appointed; two teams were located in each of four localities, with a single team in the smallest, fifth, locality). Neighbourhood nursing was becoming a reality.

The King's Fund development worker continued her association with the unit although gradually disengaging. During this time she had continued her involvement with the UGM, AGMs and locality managers in thinking about aims and objectives and operational plans. Her earlier role of supporting the UGM through the steering group in the absence of other managerial support had diminished. The training department became involved in assessing training and development needs. It was clear that further developmental needs should be met from resources available within the unit and district.

Monitoring decentralisation

The aims of decentralisation were ambitious both in terms of its philosophy and the size of the structural change involved. The problem of how to assess the impact of such major changes, however, was great. Many factors had to be taken into account in evaluating the effectiveness of change:

- whether there were alternative options available;
- existing structures;
- existing personnel;
- low morale after a long period of uncertainty;
- problems of recruitment and retention;
- the readiness of unit staff to accept decisions from newcomers;
- effectiveness of consultation procedures in 'selling' the plans to the unit;
- the timeliness and the time-tabling of the plans;
- the attitudes of interests outside the unit.

All these factors interacted and had an influence on outcome quite apart from the intrinsic appropriateness (or not) of the original decision to decentralise. Ideally, a full evaluation ought to be able to assess the impact of each of these factors as well as forming some judgement about the central enterprise.

In practice, however, such an evaluation would have been impossible; too many variables existed. Plans for decentralisation did not exist as a fixed blueprint to be introduced into a vacuum untouched and unaffected by past structures and attitudes. Plans were proposed, discussed and modified before implementation; as implementation proceeded they were modified further in the light of experience gained. Many different interests were represented in the process — managers at different levels, different groups of staff, different groups of patients or clients. 'Success' or 'failure' could be assessed differently according to the interests involved. The ultimate measure of success — in terms of an improvement in health outcomes (that is, a measurable change in the health status of the population of Islington) — would be difficult to identify for a very long time; and because so many factors are involved in the community setting, it would be difficult to attribute any such improvement to the impact of decentralisation *per se*. Any evaluation that was conducted, then, would have to be a more modest exercise.

The evaluation: aims and scope

After some discussion, the UGM and the King's Fund development worker decided that it would be possible to map out a monitoring and review process which, if adhered to, could provide useful information for a longer term assessment of the whole decentralisation process. It was necessary to break down the review process into its constituent components and stages as follows:

a) the planning
- were the right objectives set
- were the right procedures employed
- were the right participants involved
- what were the expectations of and reservations about the proposals

b) the implementation
- was it effective (did it do what it set out to do)
- was it acceptable (to those whom the changes affected)
- was it speedy
- was it clear and unmuddled

c) the outcomes
- did it consolidate and further the general management principle
- did it achieve delegated decision-making
- did it facilitate inter-professional and inter-agency collaboration
- did it increase consumer involvement and satisfaction
- did it increase awareness of local needs
- did it create localised information systems
- did it create cross-locality review procedures
- was it efficient in economic terms
- did it increase staff commitment and raise morale.

These three stages were essentially short-to-mid term stages in the process. They said nothing about the long-term outcome of changes in health status; they were mostly to do with organisational matters.

It was agreed that the evaluation should be done through a process of interviews and documentary analysis. First, those who had been in any way involved in the decision-making process would be interviewed for their views, followed by interviews with a range of staff from different levels who had been affected by the changes but not directly involved in the decision-making. By interviewing all interested parties, it was hoped to build up a composite picture in which successful and less successful factors could be recorded, explored and understood. This pluralistic technique has been developed in other evaluative studies [10] as a means of coping with the differing perspectives which inevitably emerge in a complex public service health care system. Secondly, reports and minutes of meetings which had been produced during the period of change would be examined and assessed against original objectives.

As anticipated, contrasting views tended to emerge at different organisational levels:

District: At district level, senior managers — who were not closely involved but who nevertheless wielded influence — hoped that the plans would make the community health services more accountable and more effective. A number of them believed that community based services failed to demonstrate their effectiveness in the past; they expressed support for the plans but reserved judgement on their long-term impact. They had little to say about the process of drawing up the plans, the consultation procedures or their implementation. Theirs was a perspective removed from the practicalities of daily reality but concerned, especially, with effectiveness and value for money.

Unit: Managers at unit level were, of course, directly involved in the decision-making process. They were satisfied on the whole with progress to date but well aware of the constraints under which they had to operate — shortage of resources, the demands of competing interests (especially expressions of resistance from staff within the unit), and the need to satisfy managers and health authority members at levels above them. Their own personal interests coincided with the aims of decentralisation — they had a vested interest in its success. They felt that the consultation procedures had been sufficient and tended to feel that any opposition was unreasonable.

Sub-unit: But at lower levels in the unit, differences of opinion emerged. Staff expressed sceptical views about the value of the decentralisation exercise and the degree to which they had been consulted and kept informed. They tended to feel their opinions were not taken into account, that their futures were in jeopardy and that philosophical claims underpinning the plans were mostly rhetoric. There were, however, some individuals at this level who were less sceptical; they tended to be those who planned to apply for posts in the new structure. They had much to gain from being committed to the new approach; they hoped to become stakeholders.

By looking back over the numerous working papers, minutes and reports which had emerged over past months, it was possible to assess the practical aspects of the planning and implementation process. Aims and objectives were specified; timetables drawn up; discussions reported. The process was well documented and from the point of view of some of the assessment criteria (mentioned above), it had been successful: the plans were clear; the objectives were sound; the timetable had been kept to; consultation had been undertaken; a generally managed structure was now firmly in place. In terms of **process**, then, much had been achieved. In terms, however, of **progress**, it was still premature to make an assessment. [This first effort at evaluation took place in the autumn of 1987.]

The management of change

Many of the aims established at the outset were achieved with little difficulty: objectives were set and agreed; structures were put in place in a timely and orderly way; appointments to new posts were made successfully. But there were problems. The planned changes were not wholly well-received by unit staff. The introduction and management of change was undoubtedly the greatest challenge facing senior managers in the unit. The changes came in two phases — first, the introduction of locality management with its accompanying philosophy of decentralisation of management and service delivery in order to identify and serve local needs. Second, the introduction of neighbourhood nursing, itself an extension of the decentralising principle. Broadly speaking, locality management was greeted with a degree of scepticism but no great overt resistance. Neighbourhood nursing on the other hand, was welcomed in theory but resisted in practice.

The advent of the proposals was linked with wider developments in the health service — notably, the introduction of general management. There had been widespread hostility throughout the service in preceding years; attitudes within the unit to the idea of locality

extension of the principle to lower levels of the system rather than being linked to a philosophy of its own. In addition, staff had grown used to what they saw as constant organisational changes which they felt had brought very little benefit. They had to be convinced that locality management would bring improvements for either themselves or their clients. They tended to think it was yet another example of 'change for change's sake'.

In the case of neighbourhood nursing, the community nurses saw from the outset that the new approach might have direct and tangible benefits for their clients. They approved of the philosophy, but at the same time they also felt their own positions threatened. Some feared that working in a common, mixed team would mean an encroachment onto their own professional territory or a loss of autonomy in their own clinical roles. Health visitors said they did not want to become district nurses and district nurses did not want to have to take on health visitors' duties. Likewise members of both disciplinary groups were hostile to the idea of being directly managed by a nurse of a different discipline from their own (the generic nurse manager).

Meeting the challenge

The challenge then for senior managers was first to motivate staff towards accepting the philosophy of 'going local' and persuading them of its benefits, so that they would participate fully in the process, and second to persuade nursing staff that the positive advantages of neighbourhood nursing for clients outweighed any potential disadvantages for them as individual professionals.

A number of strategies were devised to help meet the challenge of motivating staff and building their commitment. This took a number of forms:

- training and development programmes including the nursing workshops which were the first of a number of activities provided for managers and staff in the unit;
- communication was improved with regular briefings and the publication of a regular monthly newsletter, *Locality Letter*;
- visits to other districts also decentralising their services were arranged to share ideas and experiences;
- the appointment of positively motivated nurse managers and of the professional development officer encouraged nursing staff and made them feel valued.

The beneficial effects were marked. Over the past 18 months (up to the time of this report being written), recruitment and retention of staff throughout the unit have improved radically. Requests coming from other districts for visits, advice and information have increased substantially. All these developments are clear indicators of success and evidence that the morale and commitment of staff in the unit have improved [11,12].

Over the two year period 1987-89, the role of the locality managers has gradually changed. In the initial stages they were directly responsible for the community nursing staff. The position of the coordinators in the nursing structure was ambiguous and locality managers had to take on direct managerial responsibility for field staff. This tended to limit scope for developing other aspects of their work — notably, developing

links with outside agencies, a crucial part of putting the philosophy of going local into practice. Once the neighbourhood nurse managers came into post however, locality managers were able to shift their attention towards building these links, while the nurse managers were able to spend time on nursing developments.

The task of building links in an environment which has traditionally been relatively hostile is not easy. One of the reasons for decentralising was to try to overcome historical fragmentation and divisions between agencies and professionals in the field.

Locality managers and their staff have begun to make links. They have developed contacts with local authority neighbourhood offices especially with social services staff; there has been some sharing of accommodation. Voluntary organisations now know about what the local community health services can offer; again, there has been some sharing of accommodation for meetings. A directory of services and resources in Islington for clients and other professionals has been compiled; clients and local professionals (from statutory and voluntary services) were invited to the locality launches.

The biggest challenge has been to build links with local GPs. The GP forum expressed no overt hostility when the decentralisation plans were first presented to them by the UGM. However, the publication of the Cumberlege report on community nursing provoked a great deal of critical comment from GPs at a national level. They saw the concept of the neighbourhood team as a direct threat to the primary care team centred on the GP practice. These attitudes have affected local GPs. However, GPs react individually; some have been more critical than others. A number have been prepared to establish contacts with the localities and explore ways of collaborating — even in terms of thinking about establishing common catchment areas with nursing neighbourhoods.

Devolving budgets down to localities was one of the original aims. This has now taken place. Locality managers in conjunction with their nurse managers are able to make decisions about the local allocations of resources. If savings are made under one budget heading they can be put to other uses in the locality; this has allowed for much more sensitive and appropriate spending of resources at local level. The environment in the health centres has been improved markedly as a result. The unit's information system is now coming into service and a locality planner has been appointed. Localities are now beginning to have access to skills and information which will allow them to make the sort of sensitive and informed decisions which were envisaged in the original proposals.

'Going local' — some reflections

Decentralisation in Islington began in 1986. In the following three years, the CCC unit has seen major changes: progress has been sometimes steady, at other times patchy. The interim review of progress (described above) showed that the process of drawing up and implementing the proposals for decentralisation had worked well. The ideas were sound and the planning was efficient. Gaining the commitment of staff however was a more complex process. Careful nurturing was necessary over a long period to rebuild confidence and to begin to focus on the future. Tangible, practical benefits are only just beginning to emerge because they were dependant on other parts of the plans being put into operation first (appointing and training staff, developing information systems and devolving budgets).

Practical improvements at ground level could not have been achieved without restructuring at higher levels — in terms of redefining the management role, changing the focus of the services and remoulding the unit's underlying sense of mission. But all this required time. Perhaps the main challenge facing senior management was to take things forward at several levels in as coordinated a way as possible in spite of all the constraints operating to inhibit them.

It was important to balance speed against thorough preparation. If managers pressed ahead with change, they ran the risk of doing things too quickly — pressurising staff and turning them against new developments. If, on the other hand, they delayed and spent too much time on preparation, they were in danger of allowing uncertainty to develop. In an atmosphere of uncertainty, staff morale would have dropped and resistance to future change become more entrenched.

After three years, positive change has been achieved in structure, staff commitment and organisation; there has been a genuine commitment to the aims of decentralisation throughout the unit. The next, and most important, stage will be to transform those changes into tangible benefits for the consumer.

References

1. Acheson, E.D. (Chairman) *Primary health care in Inner London.* Report of a study group. Department of Health and Social Security, 1981.

2. Barclay, P.M. (Chairman) *Social workers: their role and tasks.* Report of a working party set up in 1980. National Institute for Social Work, 1982.

3. Hambleton, R. & Hoggett, P. (editors) *Decentralisation and democracy: localising public services.* University of Bristol, 1987. (Occasional paper no. 28)

4. Hadley, R. & McGrath, M. *When social services are local: the Normanton experience.* George Allen and Unwin, 1984.

5. Dunford, H. & Hughes, J. *Pimlico patch committee.* An experiment in locality planning. King's Fund Centre for Health Services Development, 1988.

6. Harwood, J. *Locality management: preparing for change in Riverside.* King's Fund Centre for Health Services Development, 1989.

7. Morgan, D. *Locality management: from proposals to change in Lewisham and North Southwark.* King's Fund Centre for Health Services Development, 1989. (Working papers for managers no. 5)

8. Cumberlege, J. (Chairman) *Neighbourhood nursing: a focus for care.* Report of the Community Nursing Review. HMSO, 1986.

9. Dalley, G. and Brown, P. *Introducing neighbourhood nursing: the management of change.* King's Fund Centre for Health Services Development, 1988. (Working paper for managers no. 3)

10. Smith, G. & Cantley, C. *Assessing health care: a study in organisational evaluation.* Open University Press,

11. Brown, P. Challenges for community nursing in a decentralised community service. *Senior Nurse* vol 9, no 3, March 1989.

12. Brown, P. Whither health visiting? Managing health visitors in a decentralised service. *Health Visitor* vol 62, no 10, October 1989.

Appendix A

Patch: some issues and options

We can identify certain specific aims within the general objective of *'improving the quality of primary health care'* along the following lines:

— the matching of need to resources;

— greater effectiveness of services;

— greater efficiency;

— greater accountability;

— greater equity;

— a shift from a purely medical model or conception of health to a social one.

Issues arising:

Needs and resources: the immediate problem is *how* to measure need (subjectively/ objectively; level of demand; practitioner's assessment; planner's assessment; patient's assessment) and *how* to maximise resources.

Greater effectiveness: greater effectiveness for whom - the service deliverer or the recipient?

Strategies to improve effectiveness frequently cited are:

collaboration/cooperation between professionals and between agencies 'team work'. This is a service-provider-focussed approach, which may or may not enhance effectiveness for the patient;

integration of services to avoid duplication or omission - where does choice become duplication? Patients may wish to retain choice, and avoid monolithic organisation of services;

appropriateness of service — no point in providing highly efficient, integrated service if no-one uses it (either through lack of need — perceived or un-perceived — or inaccessibility);

accessibility — taking into account all types of accessibility spatial, cultural, language, time....

Greater efficiency: effectiveness of services for the patient may not enhance efficiency from the provider's perspective (for example, centralisation — often in the name of efficiency — is seen as working against effectiveness/ appropriateness for the recipient). Economic concepts of cost-benefit, cost-effectiveness not necessarily appropriate from patient's or practitioner's perspective.

Greater accountability: accountability of whom, to whom? professionals to the public, top-level management to the periphery, periphery to the centre, public representatives to the 'mass' public.

— by what mechanisms — advisory or decision-making rights? Greater equity: extension of the needs/resources issue. What is the yardstick against which 'justice' is measured? How to make decisions between positive priority-giving to one 'unjustly' served interest as against another; and where to withdraw resources from, if the cake to be cut is finite.

From medical to social: where to start? How to challenge 'medical imperialism' and the organisational structures which go along with it.

Why patch?

The concept of patch has been mooted as one way of attempting to achieve the objectives outlined above (in spite of some of the problems mentioned).

Arguments in favour of patch tend to be a mixture of the philosophical and pragmatic:

— smallness of scale makes some of the issues more concrete and therefore tangible;

— idealised notions of community: community as an organic entity with needs, skills, 'spirit', the sum of the individuals within it; set against the monolith of the unfriendly, authoritarian, professional and bureaucratised state;

— the patch as the 'front line', the interface between professional and patient, between one agency and another, between one professional and another, where the playing out of tensions generated by structural, ideological, professional differences is situated (the implication being, that by seeing them happen, they can be resolved — through 'goodwill', 'common sense', low-level or small-scale organisational change, eg. telephone accessibility, meetings, shared accommodation);

— smallness and discreteness of the patch allows for needs to be more easily identifiable and quantifiable; and more easy for changes in need to be able to be monitored. Resources can therefore be more easily and more quickly directed to their satisfaction;

— devolved decision-making (planning, budgetary) should allow for equitable resource decisions to be made within the patch;

— localised information gathering and analysing can demonstrate quickly and efficiently the indicators upon which decision-making (above) processes can be based;

— the patch as 'laboratory' in which all interacting factors determining health and ill-health (medical, social, environmental) can be monitored;

— the patient population is likely to have a sense of its own existence as a local area (be it seen as 'neighbourhood', 'community' or whatever) and have its own investment in it — wanting things to be done, discerning and defining needs, tasks, etc. — and wanting to participate in the planning and accomplishing of them;

— patch shortens structural distance between patient and services — allows for early referral, preventive strategies, and can foster smooth linkage between secondary and primary sectors (eg. discharge procedures).

How patch?

a) Problems of determining what a patch should be:

— might be a specified geographical area, encompassing a specified population (chosen for particular characteristics — numbers of elderly, children, ethnic groups or environmental factors, such as dockland, industrial estates, etc.);

— geographical area perceived as a community or neighbourhood by its inhabitants — may bear little relationship to administrative boundaries (below);

— geographical area encompassing all relevant professionals'/ agencies' boundaries (ie. emphasis on co-terminosity). Patch becomes that smallest area where these boundaries coincide (danger that it may not be very small). Administratively defined, may not bear much relation to public's conception of 'neighbourhood-ness'.

— quasi-geographical area, focussed on particular professionals within it — notably GPs. Their list is the patch.

b) Perspectives on patch:

— patch as a planner's tool; smallest-scale information gathering exercises. Their way of identifying and seeing the 'real' world?

— patch as means of fostering good inter-professional working relationships;

— patch as means of community exercising control over the local state, and its profesisonals;

— patch as conjunction of public, professionals and bureaucracy;

— patch as the blurring of specialised professional rites — 'we are all genericists now'; the neighbourhood is the specialism;

— patch as devolving (or throwing) care on the shoulders of informal care networks, and reducing the role of professionals;

— patch as policing. Information gathering, surveillance — medical/social boundaries become blurred. What sort of information is stored, and where and who has access to it? Information sharing between professionals and their agencies builds into intrusive picture of whole population.

Options:

Criteria for choice (some of which are mutually exclusive):

— existing intentions to 'go patch' at unit management level;

— well-established, well-used health centre network with specific services based there on patch basis;

— functioning (to whatever degree) primary care 'teams' — involving HV and DN attachments;

— well-developed group practices running own clinics, with own attachments;

— existing evidence of consumer interest and involvement in health matters;

— good relationship between FPC and DHA, both favourable to patch concept;

— local authority which has 'gone local';

— well-established de-institutionalisation policies (which can link in with patch initiatives);

— key people in district prepared to work on, or cooperate with a patch initiative (be they planners, managers, practitioners);

— degrees of possible autonomy (planning, budgetary, management);

— well-developed information gathering and monitoring systems at local level.

What sort of patch:

— strictly geographical, based on dividing up or zoning of community health service;

— strictly geographical, focussing on 'natural' communities (defined in lay terms);

— strictly geographical, based on defining catchment areas for health centres;

— strictly geographical, matching local authority patch boundaries;

— broadly geographical, focussing on GP practices and their lists.

The patch process:

Implement by

— sequential process, first one, then next, and so on pragmatically — what is most practicable, convenient;

— sequential as above, but selection on grounds of priority (means of positive discrimination in resource allocation);

— particular service, focussing on one at a time, eg. child health, services for the elderly.

What size of patch:

— possibilities seem to vary from 10,000 - 40,000 pop.

Appendix B

DHSS-funded initiatives in decentralisation

The DHSS, in response to recommendations in the Acheson Report, 1981, is funding a number of initiatives aimed at improving primary health care in Inner London. One of the initiatives that it has decided to fund, through the London Programme of King's Fund, is a project concerned with assessing the relevance and value of the process of *decentralisation* as applied to the management and planning of DHA community services. Three demonstration projects in three London DHAs will be set up during the course of the next three years.

If Islington DHA were to decide to decentralise its services, it is proposed that consideration be given to the possibility of collaborating in this initiative.

The proposed role of the King's Fund development worker in Islington

The King's Fund development worker would spend the equivalent of three days per week in Islington, based with the health authority, and the remaining two days per week at the King's Fund Centre for the duration of the period.

Timing	Role
Stage One A.S.A.P. 3-5 months	a) Working with the unit management group and appropriate departments within the health authority, helping them to think through their decentralisation planning and organisation — its implications for management, staff and patients. b) Assessing feasibility of constructing measures by which the process of decentralisation in relation to service outcomes might be evaluated. c) Establishing contact within Islington Health Authority and with external agencies in the district. d) Selecting a local area on which to focus for second stage of work, by looking at a number of factors, for example: — distribution of existing facilities (health centres, GP practices, community-defined neighbourhoods, concentration of 'coterminous' workers, LA neighbourhood offices);

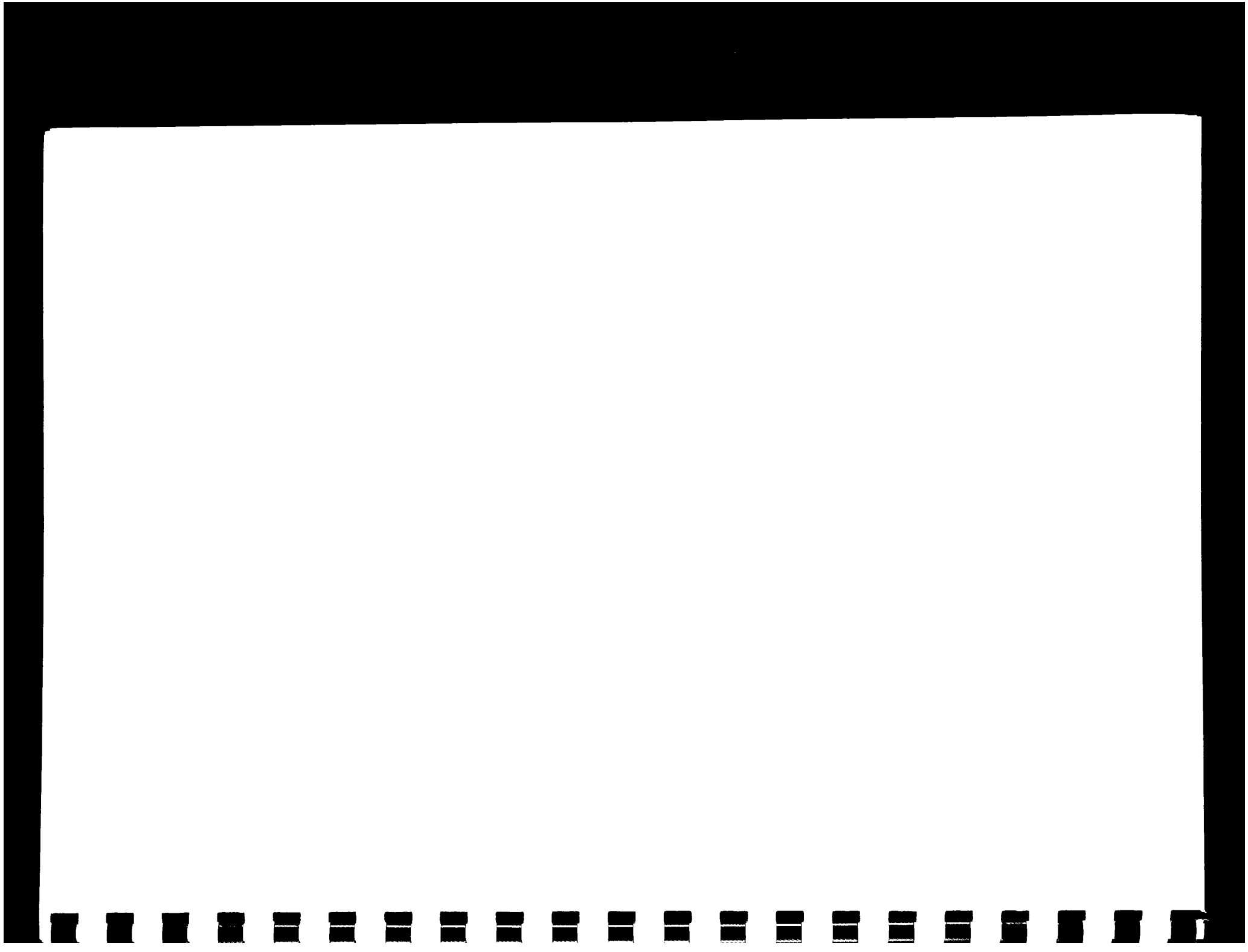
Timing	Role
	— levels of deprivation as shown by recognised indicators; — responsiveness of key local professionals and/or community groups.
Stage Two Mid-1986 approx. 18 months	Focussing on one local area, a 'patch' (as selected above), and contributing to the implementation of the decentralisation process by assessing the developing needs within the patch for maangerial action where necessary, for example in relation to: — dissemination of information about the process of change; — understanding of the implications, both managerial and professional, of the change for staff at all levels; — devising of solutions to practical problems (eg. accommodation, telephone access, lack of information about services and staff available within the patch, building day-to-day contacts between patch staff); — facilitation of inter-agency (LA, voluntary organisations, community groups) and inter-professional collaboration and communication; — gathering and analysis of local data, in relation to needs and services; — participation in and response of local people to the patch process; — monitoring the outcomes of the decentralisation process in relation to the measures established in stage one; — three-fold feedback of information re all above factors (up-down within the DHA, and across localities).

Timing	Role
Stage Three End of 1987/early 1988- mid 1988	Assessment of progress to that point and evaluation of that progress in relation to: — own work in the local area; — progress of the DHA towards decentralisation; — relevance of own work as a demonstration of the issues (both positive and problematic) for the rest of the district (and beyond).

Appendix C

Glossary of abbreviations

AGM	assistant general manager
CCC unit	community and continuing care unit
FPC	family practitioner committee
GP	general practitioner
LM	locality manager
UGM	unit general manager
SCM	Specialist in community medicine



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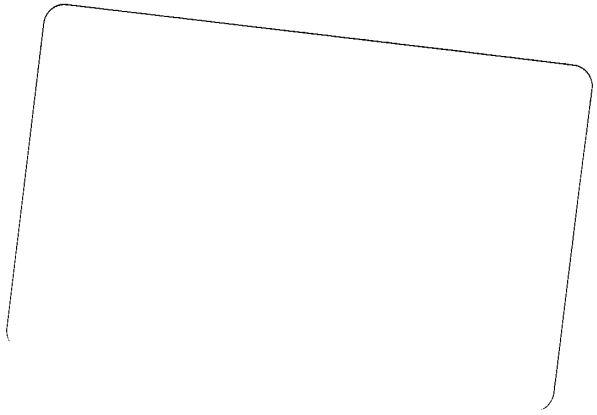

Islington HA
community health ~~care~~ services
locality care services

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