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PSYCHIATRIC PROVISION DRAWING ON LARGE INSTITUTIONS

ORGANISING AND MANAGING TO DEVELOP BETTER SERVICES

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Organising and Managing to Develop Better Services

I Developing Innovation from Within

II Key Issues and Useful Examples

These working notes were prepared by Chris Davidson, Ann Davis, David Downham, Joan Rush and David Towell, with support from the King Edward's Hospital Fund. Grateful thanks are due to staff in the Health and Social Services who shared their experience of tackling current problems in the psychiatric services with the above named. Comments, enquiries and suggestions arising from these notes are welcome, addressed to:

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1 DEVELOPING INNOVATION FROM WITHIN

Introduction

These working notes are the tentative first product of an initiative designed to explore how people in the health and welfare services are tackling the problems of developing comprehensive mental health services, in situations where these services are currently based on large institutions serving two or more Health Districts. We have focussed attention on the question of how the psychiatric services should be organised and managed so as to encourage high standards of care within the institution; foster the development of community-based services and integrate institutional and local provision. We identify here some of the key issues staff are having to face in confronting this question and try to provide a basis from which groups of staff can work towards relevant responses to the particular dilemmas of their own local situation.

Prescriptions for the future of the mental health services, especially the 'Better Services' White Paper and its recent reflection in DHSS 'Priorities' and NHS 'Strategic Plans' have aspired to new forms of provision involving a gradual transition away from dependence on the large hospitals as local psychiatric services are developed. Belatedly however, there has been growing awareness that realising these aspirations and ensuring high standards of care during the lengthy transition period, pose very substantial difficulties.

In part these difficulties are a consequence of financial deprivation. In a situation where continuing political struggle will be required to achieve priority for the 'Cinderella' services, we are keen that this deprivation should not be underestimated. The main resource to many large populations continues to be the 19th century institution whose poverty may be particularly apparent on the wards for long stay patients and the increasing numbers of the confused elderly. Outside, the development of community provision on any scale often remains a long term aspiration.

Other difficulties seem to exist in making the best use of present resources. Traditional attitudes may handicap innovation and prove a barrier to suitable collaboration between the different disciplines and agencies providing care. Management may appear hardly adapted to the complexity of the tasks involved in ensuring the development of better services.

The organisational arrangements for related services may themselves constitute a disincentive to desirable improvements in provision. Indeed over the past few years, changes affecting large hospitals, (including the disappearance of medical superintendents, the dissolution of HMC s, and the reorganisation of both Health and Social Services) seem to have left many without effective leadership and led some observers to conclude that Britain now has no unified mental health services. Moreover the improvements in planning and collaboration between Health and Local Authority services which were an intended consequence of these reorganisations seem rarely as yet to have been fully realised.

The King Edward's Hospital Fund is committed to the belief that in deciding how to tackle such difficulties, there is usually much to be learnt from the variety of experience already present in the health and related services. Moreover, responses to the Fund's earlier publication on 'Living in Hospital' and a range of other innovative approaches to improving patient care with which we are familiar, have fully demonstrated the capacity of staff working in these services to make informed changes in their own situation.

These efforts have also served to underline the influence of wider organisational arrangements in sustaining such innovations. Our experience suggests that within the opportunities created by the resources which can be made available, there is much that appropriate organisation and management can do to facilitate, foster and support the development of better services.

With the support of the King's Fund Centre therefore, we have prepared these notes as a contribution to what it is hoped may be a wider programme of action which seeks: -

(i) To discover how the problems of services drawing on large institutions are being tackled in different places, the practices which are emerging and their potential relevance elsewhere;

(ii) To provide some additional opportunities (for example, in the form of working conferences and exchange visits) for concerned people to share experiences and develop ideas as part of their efforts to make progress on these problems;

(iii) To help staff concerned with services drawing on particular large institutions to design and implement their own local strategies for developing these services.

Initial Explorations

During 1977, the writers of these notes worked as a small team in visiting a few Districts with large psychiatric institutions where considerable attention has already been devoted to work on organisation and management. In discussions with doctors, nurses, social workers, other paramedical staff, and those with management roles in the relevant health and social services agencies, we have tried to identify the key issues which are being faced and the alternative practices which are emerging. We have also drawn on our personal experiences of what is being attempted elsewhere.

Soon after we began these explorations, the Secretary of State for Social Services established a National Working Group to study the organisation and management problems of mental illness hospitals, with the aim of making recommendations by the end of 1978. We are sure that the composition of this working group and the resources available to it, will mean that a very comprehensive report will be forthcoming. In anticipation of this, we have given our main attention here to what we hope will prove a complementary endeavour: discovering how people in the field can themselves develop better ways of working in the light of such national guidance and other relevant experience. For past events strongly suggest that however excellent its recommendations, the National Working Group report in itself is likely to have limited impact unless it is possible to mobilise the active participation of local people in bringing about change.

It has not been our intention to prepare a 'blue print' or argue for the 'one best way' of dealing with current problems. Rather we assumed that there are likely to be valid differences in perspective among the different disciplines, levels of management, groupings of employees, and clients of psychiatric services, which will necessarily make effective organisation a matter of compromise. We assumed too that variations in circumstances, history, resources and stages in the development of local services, are likely to mean that different management arrangements will be appropriate in different situations.

Our explorations have suggested that there are often subtle relationships between the leadership offered by key staff, the extent of shared understanding about institutional functioning, and the management arrangements which have been adopted. For example, we have seen what on paper seem highly articulate formal structures which lack in practice the necessary wide commitment among staff to make the prescriptions work. Conversely, we have seen informal and even ill-defined arrangements where through long experience of staff working together, considerable effectiveness seems to have been achieved. We have also noted that it may easily require several years to fully develop multi-disciplinary team working, or mutually satisfactory liaison arrangements between hospital and community services.

Although wary of any simple answers to current problems, we have been convinced that there is much that can be achieved where participants in a particular situation are prepared to critically examine their existing practices and themselves initiate such changes as are seen to be necessary.

An Approach to Local Action

Efforts to develop innovation from within the psychiatric services are themselves likely to be handicapped by existing deficiencies in organisation and management. The central problem here seems to be that any approach to development must seek to overcome the current fragmentation in the psychiatric services consequent on the multiplicity of professional, administrative and hierarchical divisions which characterise the Reorganised Health and Social Services. This fragmentation can be particularly evident in the case of large hospitals serving two or more Districts.

The conflicts of interest that can easily arise among the different agencies involved in this complex system, for example over the rate of development of local psychiatric provision, add to this problem. Further handicaps arise where bureaucratic patterns of working have reduced the scope for individual autonomy among managers who might have been expected to take problem-solving initiatives. And for this and other reasons, it appears that some of the opportunities created by the new structures, for example, relating to joint planning and financing, are not always being well used.

It will be evident from these observations that we do not believe the difficulties being experienced in the services drawing on large institutions can be resolved wholly within these institutions, although the continuing isolation of some institutions perhaps suggests that there are people both inside and outside who wish such resolution was possible.

Rather, what is being achieved in some places we visited suggests the value of an approach which starts from the needs of the clients for these services and asks two sets of questions. First, what is the nature of the total service it is hoped to provide to meet the needs of a specified set of clients? Which staff, facilities and agencies would be required to develop this system of care? Second; what organisational, planning, financial and management arrangements are most likely to ensure the effective use of existing resources and facilitate the implementation of these new patterns of provision? In principle then, questions about organisation would follow consideration of the total services to be provided, not vice versa.

We have seen that these questions can be asked about different sets of clients and on different scales. The focus of attention might be the 'long stay' patients in a particular institution, the people of a specified District, or the population of the whole catchment area served by an existing set of facilities. In each case, having identified the resources and agencies which are, or should be, concerned with the provision of services to these clients, efforts can then be made to create organisational arrangements which superimpose some unifying boundary on these services. For example, considerable attention has been given in some places to creating service 'divisions' which bring representative staff from relevant parts of the large institution together with those from local facilities and community services which make up the total psychiatric service being provided to each District. Management arrangements for 'divisions' are then required to ensure that available resources are used to provide an effective service to this population and high standards of institutional care.

Similarly, when attention is directed to the development of services across the whole catchment area of a large hospital and the network of other agencies which should be involved in providing services there, it seems important that this process should: -

reflect a clear strategy;
seek collaboration and integration between the contributions of the different agencies;
involve the participation of the staff actually delivering these services; and
be based on informed assessment of needs and opportunities.

Thus even on this large scale where the problems often seem immense, we have seen from our visits that: -

where individuals have been prepared to take initiatives based on their own experiences of deficiencies in the existing services;

where people have come together in relevant groups to examine the nature of these deficiencies;

where groups at other levels in this complex system have sought to take complementary initiatives; and

where some people in key roles have worked to maintain the integration of these efforts;

then substantial progress appears to be possible.

Using these Notes

We have organised the more specific things we learnt from our visits in two main ways. First, we have sought to identify from the wealth of experience shared with us in our discussions, the key issues which people concerned with these services are commonly having to face. These issues then suggest clusters of questions which we hope those responsible for different parts of the total service and at different levels in the present structure, may find helpful to examine in their own efforts to overcome current problems.

Second, we have tried to prepare brief accounts of the kind of responses to some of the most important of these questions which we saw represented in the innovative practices already developing in different parts of the country. The examples we have chosen reflect our own interests, and there is no attempt to be comprehensive. Often innovations were in a state of flux so that at best these examples might form part of a jig-saw in which the full picture has yet to emerge. Clearly any useful ideas will need to be creatively adapted and adopted according to the stage of development and other relevant conditions in any different situations.

These notes are intentionally unfinished. While there is much more which could be written about what we have seen, it would be unrealistic on the basis of their small-scale explorations for us to do more than provide some elements in a framework for the more detailed work which needs to be undertaken locally. Nevertheless, we hope that what follows will prove to be of assistance to colleagues who are seeking to achieve improvements in the current organisation and management of psychiatric services drawing on large institutions. We expect there may be various ways in which suitable local forums can be established for staff to review their own situation, consider problems and alternative solutions, and experiment with new practices with the

support required to bring about change. We anticipate that where this is occurring, another valuable resource is likely to be the experience of staff in other situations, who may be facing similar difficulties. On a larger scale, we already know of one Region where staff at all levels are involved in a sustained attempt, through regular workshops and other means, to develop the management of the psychiatric services. And we anticipate that the National Working Group's report itself will lead to a centrally sponsored programme of application.

As one contribution to all this work, we shall be very interested to hear from colleagues who have either already tackled these difficulties in ways which might have wider relevance; or are keen to do so, and prepared to share their experience with others. Our hope then is that these working notes will prove to be only a preliminary statement in what becomes a much wider dialogue among all those concerned with the improvement of psychiatric care.

II KEY ISSUES AND USEFUL EXAMPLES

Introduction

We have organised these notes around four main sets of issues which appear to be of particular concern to staff working in the psychiatric services.

a Organising and Managing Services Drawing on the Large Hospital:

What organisational and management arrangements need to be developed to ensure: -

- high standards of care within the institution
- the creation of opportunities for improving local services
- the integration of the developing pattern of community based services with the remaining institutional provision

b Relating Services to the Community:

How can better patterns of services be built which draw on community resources and are responsive to client needs?

c Working Together as Professionals:

How can good working relationships be developed between the different professions involved in the psychiatric services in order to provide effective management and delivery of a comprehensive service?

d The Role of Higher Management:

In what ways can higher management in the Health and Social Services Authorities plan and co-ordinate their agencies' activities, so as to achieve optimum development of better services?

These notes are intended to assist individuals and groups of staff who are examining their own local situation.

For each set of issues we provide: -

- background notes which introduce the major topics.
- key questions which staff can ask and answer about their own situations.
- examples of responses to some of the questions raised which staff in various parts of the country are currently developing.

A ORGANISING AND MANAGING SERVICES DRAWING ON THE LARGE HOSPITAL

Key Topics

(i) 'Divisionalisation'

(ii) Building Divisional Management

(iii) Managing the Hospital

(i) 'Divisionalisation'

Background notes: -

Following Department of Health and Social Security policy statements and Health and Social Services reorganisation, staff in large psychiatric hospitals have been considering the division of their own institutions. The primary aim has been to link the services provided by the hospital to specific catchment areas. At the same time, staff have also had to consider the desirability or otherwise of retaining centrally particular resources and staff skills to provide specialist care for certain client groups, e.g. the confused elderly.

Many different stages have been reached in this 'divisionalisation' process. Some hospitals have not yet committed themselves to this policy. Others have made a start and are learning from their experiences. Others have gone a long way to complete divisionalisation. It has been argued that geographical divisionalisation is a basis on which comprehensive psychiatric services, drawing on the large hospital, can be developed. For any one hospital, the number of divisions are determined by a number of factors related to geographical and administrative boundaries and particular specialisms in patient care. The range of the service which is provided within each division can also vary considerably, depending on the facilities which are centrally retained.

Ideally, perhaps, the 'division' has been seen as bringing together within a common boundary, all the elements of the psychiatric service to a defined population (e.g. a Health District). While it is usually possible to identify fairly clearly the relevant part of the large hospital, the relationship between this and the community based elements of the service is often more difficult to specify exactly.

'Divisionalisation' does generate new possibilities for the development and planning of psychiatric services, both in the health field and in collaboration

with Social Services Departments. It raises problems which need regular monitoring and review. As differences in rates of local development, policies and demands for resources emerge between different divisions, crucial implications for overall management of the Service arises.

Questions:

(1) How is the large hospital organised in relation to its total catchment area?

(2) What criteria are used for determining the size and number of divisions within the hospital? E.g. population served; number of consultants; Districts served.

(3) Which aspects of the service are best provided 'centrally' rather than divided amongst divisions?

(4) What criteria are used for deciding these 'central' services?

(5) How are the centralised services best related to the work of -

(i) the divisions within the hospital;

(ii) the locally based psychiatric provision, e.g. District General Hospital Units; day hospitals?

Example

One hospital we visited served two Districts within one Area Health Authority and its coterminous county. Building on experience prior to reorganisation three divisions had been created. One serving the smaller District and two serving the larger. This split in the larger District permitted a closer balance between the three divisional teams and was in line with that District's strategy for two District General Hospitals.

Factors taken into account in dividing the catchment area and the hospital included the population size and spread, the number of acute and support beds and the number of consultants. These elements were related to each other to find the most practicable solution. Two of the divisional teams had two consultants each, while the third team had four, and further sub-divided its catchment area into two sectors each with two consultants. This last team had acute beds at a unit situated locally within the District served. The nursing structure reflected the divisional structure with one Senior Nursing Officer per division, except for the large one, which initially had two Senior Nursing Officers, one at the local acute unit and the other covering the long stay wards at the large hospital.

While the beds at the large hospital were allocated on a geographical basis, certain functions and their related departments continued to provide a central service to the hospital as a whole. e.g. the main re-settlement activity was organised this way, with the Occupational and Industrial Therapy Departments and the re-settlement social worker. The social worker's efforts here were focussed mainly in the local catchment District of the large hospital, although a service was provided to all three divisions. In other words, long stay patients were often not discharged back to the distant catchment area from whence they originally came, but to a town nearer the hospital. These arrangements were undoubtedly helped by the fact that only one Social Services Department was involved in the whole catchment area.

(ii) Building 'Divisional' Management

Background notes:

Whatever pattern of 'divisionalisation' is established within a hospital, its management will depend on contributions from a number of separately organised disciplines. In addition, links will be required with representatives from Health, Social Services and other relevant agencies within the locality served. It can be difficult to specify precisely the nature of the relationship between these various contributions to the local service. Within the hospital, representatives of the various disciplines will need to meet as a management team with corporate responsibility for the institution-based part of the service. Ideally this team and representatives of local agencies should also meet in a 'divisional management forum'. This body would seek to ensure the optimum integration and development of the total psychiatric service to the locality.

Such divisional management can often face considerable barriers to effective collaboration where distance and different District, Area (and sometimes Regional) boundaries separate the hospital from its catchment population. Staff in some situations express concern that these barriers result in marked differences between 'divisions' in the levels of service provision.

Where centrally retained sections of the hospital have been created on the basis of patient group (e.g. security; re-settlement; confused elderly), the relationship between these sections and the management of the divisions may also require careful attention.

Questions:

(1) What criteria are there for membership of the divisional management team?

(2) How can the most appropriate input to the management of the 'division' be obtained from relevant local Health, Social Services and other agencies in the locality served?

(3) How are support and other central services in the large hospital managed so as to facilitate the work of the 'divisions'?

(4) What kind of management and monitoring arrangements are required within 'divisions' to ensure the best use of resources in providing patient care?

(5) What information systems and administrative support are required to provide the conditions for effective 'divisional' management?

Example

The example cited in the previous section was of a two District Area, the host District served by one 'divisional' team and the receiving District by two. All these teams meet formally with agendas and minutes and the membership comprises medical, nursing, occupational therapy, psychology, social work and administrative staff. The team serving the host District comprises solely staff from the large hospital. One of the teams serving the other District has acute and psycho-geriatric units locally which rely on support beds in its division of the large hospital. The membership of this team is drawn from both the large hospital and the local District, with representatives from the latter in the majority. The third team has almost all its facilities at the large hospital and hardly any in the District served, so most of its members are based at the large hospital, but with the Senior Nursing Officer and an Administrator from the receiving District. The large hospital has a Hospital Management Team (H.M.T.) which, amongst other things, is responsible for the overall management of the hospital.

The team serving the host District's own catchment area has the most clearly definable organisational relationships. It is responsible to the Hospital Management Team for the service based on its part of the hospital and the Hospital Management Team is, in turn, accountable to the host District Management Team. The relationships of the other two teams are more complex. The first has the use of resources managed by each of the respective District Management Teams (i.e. part of the hospital as well as local units) and provides a service to part of the catchment of the 'receiving' District Management Team. The second team has resources based mainly

at the large hospital but serves the receiving District and seeks to integrate the hospital's facilities with the developing community services.

One point to bear in mind is that the team with nearly all its resources at the large hospital, yet which is serving a distant District, may feel in the weakest position of the three. Whatever organisational pattern is chosen, it must ensure the needs of this team are met - indeed, it should perhaps even discriminate in its favour. Other channels, such as planning teams, may or may not provide adequately strong links with District Management Teams to overcome this weakness.

(iii) Managing the Hospital

Background notes:

Our impression is that a major concern of managers of the psychiatric services is how to achieve a sound balance between the policies of 'divisional' teams and the on-going management of the hospital as an institution.

It appears that whilst divisional teams are increasingly concerned with building locally-based services, the reality often is that the large hospital continues to provide most of the skills and physical resources on which the service draws. At the same time, staff need to consider the patient population who may remain within the institution until the end of their lives.

In some situations where locally based developments have been given a relatively high priority and status, there is evidence that a feeling of uncertainty and demoralisation has grown amongst staff working within the large hospital. This has obvious implications for the quality of patient care which is being provided.

The task of managing the large hospital is complex, therefore, and needs to draw on the skills of a multi-disciplinary team who can co-ordinate the activities of individual managers, look at the consequences of 'divisional' policies for the hospital as a whole; and oversee the quality of on-going institutional care. Such a management team should be able to give a sense of direction to staff about current and future policy. It should be aware, also, of the changes which occur in the nature and balance of the services and respond to them. Our discussions also suggest that there is a

vital need for management teams to ensure that staff and their representatives are adequately involved in policy-making and that appropriate means are developed by the team for anticipating and resolving industrial relations issues which may arise.

Questions:

(1) What management arrangements are required for the large institution as a whole?

(2) What are the criteria for representation on hospital management teams? e.g. range of disciplines, 'divisional' representatives.

(3) How does the hospital management team relate to both the centralised and divisionalised services?

(4) How do the hospital management arrangements monitor standards of care within the institution?

(5) What are the likely implications for staff morale, recruitment, etc. in the large hospitals, of the developments in local services and how are these issues best dealt with?

(6) What information systems and administrative support are required to ensure effective decision making by the hospital management team?

(7) How can trade unions and professional associations be appropriately involved in shaping policy?

(8) What is the relationship between the Hospital Management Team and the host and other relevant District Management Teams?

Examples

All the places we visited had a multi-disciplinary management team for the institution as a whole. Such teams were usually corporately responsible to the host District Management Team for any necessary co-ordination in the work of the hospital, the management of common services, and the allocation of resources to different parts of the services based on the institution.

Within this common brief, teams operated in a variety of ways. In some places effective management teams had been constituted by beginning with tripartite structure of Sector Administrator, Divisional Nursing Officer, and Chairman of the Hospital Medical Staff Committee, and then extending this either by the addition of paramedical perspectives (e.g. the heads of Psychology, Occupational Therapy and Social Work in the hospital) or by inviting representation from divisional management teams, or indeed both, with other officers

invited to meetings as and when it was appropriate. In some places it has been found useful to have other heads of service departments as full members (e.g. the hospital engineer).

Arrangements enhancing the effectiveness of teams at this level appear to include a clear executive system which ensures that issues are actioned between meetings and (particularly for the larger team meeting less frequently) that urgent problems are given appropriate attention. The meeting itself appears likely to require skilled chairmanship to focus the main discussion on the most significant issues and ensure all the relevant perspectives are heard. The team also requires background support in the form of information papers and detailed studies of key problems. The institutional management team in a large hospital may be particularly important as the only management body for central aspects of what is in fact a supra-District service. There is a need then, not only for the host District but also District Management Teams in the other Districts served to establish appropriate relationships with hospital management and find the best ways in which the team's accountability upwards can be discharged.

In one relatively simple two-District Area the 'Psychiatric Management Team' was seen as accountable to both District Management Teams who through bilateral arrangements were establishing the broad policies and procedures within which this team operated. Equally here, the team was in a position to draw attention to problems which cross-cut District boundaries and required joint action by the District Management Teams concerned. In more complex situations, we have also seen the potential benefit to be derived from District Management Teams identifying one of their members to represent and give some continuing focus to their interests in psychiatric services.

One hospital we visited has set up as a sub-committee of the Hospital Management Team a 'Quality of Patient Care Committee' which collectively could assess standards, review short term and long term goals, and make recommendations.

Their terms of reference were to: -

(i) assess existing standards of total patient care provided by all agencies connected with the hospital;

(ii) identify sources of information within the hospital and establish a specific reference system of information provided nationally;

(iii) provide an on-going system to monitor and evaluate specific aspects of patient care;

(iv) elicit and consider suggestions from patients, visitors and personnel alike;

(v) make recommendations and give advice on attainable aims relating to patient care, both immediate and long term.

The committee consisted of a consultant, a senior nurse, an administrator, a senior psychologist and a social worker, and it was accepted by the hospital that this committee had access to all wards and services provided to the hospital. The committee decided on key areas for action, such as, the catering services, and activity levels in the long stay wards.

Observations were carried out by members of the committee, either on a routine visit basis or with systematic charts which measured aspects of the service. A number of problem areas were uncovered, and work was going forward to improve certain areas of patient care.

B RELATING SERVICES TO THE COMMUNITY

Key Topics

(i) Linking Hospital and Community

(ii) Community Participation

(i) Linking Hospital and Community

Background notes: -

A clinical team needs to be able to call on a range of resources and professional skills from both the hospital and the community if it is to provide a good service. Vital to meeting patient need is a detailed working knowledge of the local community and groups within it, who are concerned with psychiatric illness.

Community Nurses are playing an increasingly major role in this area. Our impression is that as the development of this service has differed from place to place, a wide variety of approaches have emerged. In some localities the community nurse is a key part of the rehabilitative programmes - playing a vital role in follow-up into the community. In others the community nurse is primarily involved in preventative work with other members of crisis teams. What was made clear to us was the value of the links which community nurses are building with primary care teams, health visitors and social workers. Indeed, the overall value placed on this service by other professionals was shown in the high level of morale which we noticed amongst community nurses.

Social Service Departments provide a wide range of services through their community-based, family orientated teams. The establishment of close working relationships between the specialist clinical team and the social services team can have mutual benefits. The clinical team can share their specialist knowledge and skills, whilst gaining fresh insights into family and community situations. Social Service Departments are also responsible for providing a social work service to the Health Service; psychiatric, residential and day care facilities; and domiciliary services. All of these are vitally important to creating community care networks for patients and their families. Because of the complexity of social service organisations and their wide ranging responsibilities, the social worker allocated to the clinical team needs to take particular responsibility for identifying the relevant personnel whom the clinical team may wish to contact.

Questions:

(1) What links have been established between the clinical team and relevant community-based services and groups?

(2) How does the service provided by the large psychiatric hospital relate at field level to the community-based social services provision in the following areas: -

(a) Rehabilitation;
(b) After-Care;
(c) Out-Patient and Day-Patient Services;
(d) Domiciliary Visits;
(e) Specialist Training Opportunities for Staff?

(3) How do community nursing staff from the hospital relate to community-based nursing staff, general practitioners and social services social workers?

(4) What is the particular role of community nurses in relation to their psychiatric team?

Examples

a. A rehabilitation team of senior social worker, a social worker, a nurse and an occupational therapist is based in a large hospital. It undertakes a thorough rehabilitative programme with self-selecting groups of patients. When these groups move on to a group home or lodging house accommodation the team continues to provide support through a counselling and visiting service. Through this service the team is able to meet regularly with both groups of ex-patients and landladies. The team view this part of their work as crucial in settling and maintaining the ex-patient in the community.

b. A large hospital, partly serving a rural area, provides a travelling day hospital service on a day-a-week basis to outlying parts of its catchment area. The specialist day hospital team provide support and consultation, not only for patients and their families but also for the community-based social workers, health visitors, etc. who are working in difficult family situations.

(ii) Community Participation

Background notes: -

Participation by the patient, his family and the community, in the development of psychiatric services can be a valuable source of strength. It can provide

a measure of how well the service is meeting need and it can also strengthen the attitudes of concern within the community which are basic to the development of community care. Traditionally, patient participation has tended to be part of a programme of treatment on some acute wards with a therapeutic community approach. As such, it has often been divorced from the activities of the majority of patients and staff in the hospital.

Where programmes have been designed to increase opportunities for participation by patients in long stay wards, we were told that positive change appeared to have been made on both dependency levels of patients and the work satisfaction of the staff involved.

Voluntary work provides an important channel for the community to actively participate in improving the quality of psychiatric provision. It has proved effective, both in the community (e.g. group homes and support schemes) and within the institution (e.g. befriending individuals, joining in social and ward activities). This resource appears to be used most effectively where a co-ordinator is appointed (often a hospital-based voluntary services organiser). Such a co-ordinator can match interest to need, develop the understanding of both staff, patient and volunteer and develop the potential of this service.

Community Health Councils: These bodies have an interest in the total service provided to the District they represent (including that part of any institution which serves the district but is located outside it) so their participation in developing psychiatric services is an avenue well worth exploring. Their interest in psychiatric provision can provide a source of comment and stimulus on the decisions being made and the standard of the service being provided by clinical teams.

Questions:

(1) What opportunities exist for patients and their families to participate in the management and provision of services? (e.g. patients' committees, relatives' groups).

(2) What contribution is made by voluntary organisations to both the hospital-based and community-based aspects of the service?

(3) How is voluntary work linked to other hospital activities?

(4) Does the Community Health Council(s) play a part in monitoring service provision?

(5) How is the work of the Community Health Council(s) linked to the management and development of the service?

Examples

The staff on one long stay ward of a large psychiatric hospital decided to try to minimise the institutional nature of the ward regime. One of the innovations was to create a residents' committee with the involvement of ward nurses, the ward doctor and a psychologist. Setting up and maintaining the work of the residents' committee needed a great deal of effort, enthusiasm and commitment from the staff, but, after a year's work, the committee was reported to be functioning well. The areas where the committee had made progress were notably in increasing opportunities for choice. The committee had worked out schemes to give residents a choice of menus, choice of 'lie-in' and going to bed. They were totally involved in the organisation of the ward work, helping in the kitchen and at meal times, and helping other residents. The committee made recommendations about such things as the need for a ward telephone, different furniture, and different arrangements of furniture, and these recommendations were listened to and acted upon by staff. The improved participation of residents had an impact on morale for staff and residents, and the psychologist who was monitoring the changes in the residents reported a marked improvement in social interest and social competence with a lessening irritability and retardation.

In a district whose psychiatric service was provided by a large hospital thirty miles away, the local MIND group started a Sunday bus service with several pick-up points for relatives and friends who wanted to visit patients. Volunteers were used to man the bus and the fare charged covered the cost of hire. The growing numbers of people using this service as the weeks went on, clearly demonstrated the transport difficulties, previously unrecognised, which were being shared by a number of local people. Staff on the wards were surprised to discover the change in what they had previously thought of as 'disinterested' relatives.

C WORKING TOGETHER AS PROFESSIONALS

Key Topics

(i) Professional Collaboration

(ii) Line and Multi-Disciplinary Management

(i) Professional Collaboration

Background notes: -

Our visits suggest that a multi-disciplinary approach to working can be of benefit at all levels of the service. This approach depends on the co-ordination of the skills and differing viewpoints of a range of staff, which may be very difficult to achieve. Our impression is that where a firm multi-disciplinary foundation has been established, it has been based on an understanding and acceptance by all concerned of the distinct contribution which each discipline can make to the service. This takes time, as newer disciplines, such as psychology, occupational therapy and social work become established and nursing and medical staff become familiar with their ways of working. Our discussions suggest that consultants, in particular, may face challenges in developing their leadership roles. It may be useful for staff to look at this topic at two levels - treatment programmes and management.

Treatment Programmes An individual treatment programme will draw on different disciplines at different stages. It is important therefore, that all staff explain, as well as demonstrate, the contributions which their own discipline can make to individual patient care. Each discipline member needs to be prepared to accept responsibility for their part of the treatment programme; and should consider themselves accountable in their work to both the clinical team and the discipline of which they are part.

Management Participation in the various levels of management may be for some staff a new experience and this needs to be recognised. The size of some discipline groups may mean that the time they are able to give to this activity is limited. Time and the development of shared and agreed policies appear vital to collaboration and considerable work is likely to be necessary in clarifying the nature of team responsibility.

Questions:

(1) How is understanding reached of the contribution of each discipline to the service provided?

(2) What roles and functions are most appropriate to staff from different disciplines; levels of experience and skills in the various forms of team work?

(3) What distinctive contributions can specialists in different disciplines make to the overall development of better services?

(4) What forms of organisation have emerged to integrate the contributions of staff of different disciplines to the process of patient care?

(5) Are there particular ways in which the contribution of small specialisms (e.g. Occupational Therapy and Psychology) in managing the services can be best arranged?

(6) What administrative contribution is required to support effective, multi-disciplinary service management?

Example

One hospital management team we attended provided a forum for fairly open discussion where matters within the managerial competence of individual officers were questioned by other members of the team and influence brought to bear. The team, as a whole, monitored the performance of individual managers, who might, for example be asked to account for budgetary variations. The team also played a critical role in examining the ways budgets were used. Budgetary control remained the responsibility of the individual manager, but the management team gave its members the opportunity to 'lean on each other' to ensure they were working towards the same overall ends.

It is difficult to strike the right balance between ensuring that professionals are relieved as far as possible of administrative duties, so as to be able to make the maximum use of their own professional skills while at the same time ensuring through the multi-disciplinary team that the work of each staff group is sensitive to the aims and contributions of the others. Multi-disciplinary team work is time consuming but seems indispensable if the different professions are to be effectively co-ordinated.

(ii) Line and Multi-Disciplinary Management

Background notes: -

The development of multi-disciplinary working has posed problems for some disciplines (e.g. nursing) where there is considerable emphasis on line management. Clear statements about the relationship of individual discipline policies and multi-disciplinary team policies are a helpful way of ensuring that staff participation is not unnecessarily hampered by uncertainty and conflict about their responsibilities. Senior line management should recognise that successful multi-disciplinary working depends on staff at all levels feeling confident about representing their own discipline.

Equally, multi-disciplinary teams need to recognise the dual accountability which all members hold. Accountability to the discipline for maintaining professional standards, quality of work and departmental policy. Accountability to the team in carrying out treatment programmes and shared managment tasks.

Questions:

(1) In realistically identifying responsibility and accountability for patient care, who is responsible to whom, for what?

(2) What implications has the multi-disciplinary approach for the responsibility accountability of individual managers?

(3) What should the relationship between team work and the particular responsibilities of each discipline be?

(4) What arrangements are most appropriate for relating 'line' management to 'team' management?

(5) In what ways can consultants best participate in management processes? How can competing demands on their time best be balanced?

(6) How should the cogwheel structure for managing medical work relate to other aspects of institutional and service management?

Example

The interpretation in practice of multi-disciplinary management takes place at a number of levels i.e. ward, 'divisional' and institutional, and in a variety of situations. Generally the multi-disciplinary approach appears to pose particular problems for medical staff. In situations where it is working effectively it appears to depend on a significant contribution from at least some consultants at all levels of management.

This has meant that the benefits from time devoted to managing have had to be balanced against the often heavy demands of clinical work. It has also meant coming to terms with leading a process of change which brings an increase in the contribution of other disciplines to patient care and so may challenge the traditional role of the consultant.

At the higher levels of management the relevant organisation of medicine as a discipline usually takes the form of 'cogwheel' divisions of psychiatry in each District, and a hospital staff committee which brings together all the senior doctors based at the institution. It appears that as multi-disciplinary management and planning teams are developed, 'cogwheel' divisions are assuming their main function as part of the District medical advisory machinery and as forums for the resolution of medical issues and the exchange and evaluation of clinical experience. Where this is the case, medical advice to the 'divisions' can be available from the 'cogwheel' psychiatric division in the District served. Whilst the hospital medical staff committee is likely to provide medical advice to the Hospital Management Team through its representative there.

D THE ROLE OF HIGHER MANAGEMENT

Key Topics

(i) The Health Service

(ii) Health and Social Services

(iii) Finance

(i) The Health Service

Background notes: -

The development of a new pattern of services is a complex and challenging task. Because of this, management at higher levels - District, Area and Regional have a vital part to play.

At District Level Some Districts are still very dependent on the large hospital for their psychiatric services, whether or not it is within their boundaries. Others have developed local services including D.G.H. Units and demands made upon the large hospital are small. There are many variations between these two situations but in all of them there may be a need to look at the relationship which exists between the District Management Team and the managers of the psychiatric services to their District.

Whilst host District Management Teams have a clear responsibility for overseeing the day-to-day running of the institution, the monitoring of the service received from the hospital by other Districts and the links between their planning and hospital development tends to be much less clear.

The experiences of staff we talked to were that where a District Management Team was actively involved, the related 'divisional' team gained strength and encouragement. This sometimes resulted in different rates of development between 'divisions' with a tendency for staff providing for outlying districts to feel isolated from local developments. However, we noted that where strong District Planning Teams were operating, a focus was provided for the joint activities necessary to build a comprehensive local service.

At Area and Regional Level Where large hospitals are serving several Districts, Areas and even Regions, there is a key part to be played by Area and Regional levels of the service. Broad policy needs to be indicated in order

that adequate liaison and overall direction is developed. In situations of local disagreement a higher tier arbitrator can also be at hand.

Questions:

(1) In what ways can the higher levels of management at District and Area level most appropriately seek to ensure that their overall responsibility for the nature and quality of services are met?

(2) To what extent will management arrangements vary according to the relative extent of provision of District services outside the large hospital?

(3) What special role does the host District Management Team have in relation to the large hospital?

(4) What is the role of the District Management Team in each District served in developing psychiatric services to their District and influencing the management of the relevant service 'division' of the large hospital?

(5) How should District Planning Teams take account of the contribution of the relevant 'division' of the large hospital in planning and developing services?

Example

We have seen examples of negotiations between Districts over the development of local services and the implications for the large hospital. If a District receiving a service from a large hospital has no local facilities, then the psychiatric staff will be based at the hospital. There is, therefore, a practical difficulty for the receiving District to staff community services or relatively small day hospitals and, in one instance we encountered, such staffing was provided from the large hospital itself.

The 'receiving' District provided and maintained the day hospital building, and provided ancilliary staff, while medical, nursing and paramedical staffing was the responsibility of the host District. It was acknowledged that this arrangement implied a loose accountability of the Divisional Nursing Officer, Psychiatry to the District Nursing Officer of the receiving District for nursing policy for the running of the day hospital. The host District recharged the receiving District for the cost of staffing, although there was some disagreement about the staffing level required and the charge to be levied. It was probably generally accepted that the arrangements were transitional until such time as it was practicable for the 'receiving' District to assume responsibility for providing its own services.

(ii) Health and Social Services

Background notes: -

1974 reorganisation ensured the matching of Area Health Authority and Local Authority Catchment Areas so that collaboration between Health and Local Authorities through Joint Consultative Committees became easier. Subsequently Joint Care Planning Teams have given stronger officer support to this process. The quality of such planning depends in part on the kind of liaison between Health and Social Services Departments which exists at District and 'divisional' levels. Clinical teams, 'divisional' teams, District Planning Teams and District Management Teams all need to ensure that they have a voice in monitoring new ventures and planning for the future.

Our observations suggest that a crucial factor in this process is the liaison which has been developed between health and social services at 'divisional' level. Given the right kind of representation here, comprehensive policies can be developed which take into account the range of community resources which can be drawn on. Such policies can be used as informed local input to the Joint Care Planning activities at Area Level. It is important that staff have a clear understanding of the channels through which they can effect policy. Where more than one Area Health Authority and several Local Authorities are the recipients of the service based at a large hospital the task of Health and Social Services collaboration becomes complex. In such situations a joint group which can look at an overall development strategy for this service may be needed.

Questions:

(1) What type of collaboration has been established by various levels of Health and Social Services to plan, manage and develop the psychiatric service?

(2) How is collaboration between Health and Social Services in planning and delivery of services in each District to be accomplished? How are such plans and services to be co-ordinated across districts? (i.e. links to 'division', H.M.T., D.M.T., and J.C.P.T.s).

(3) What are the respective roles of: -

   a. Area and District on the health side
   b. Directorate and field divisions of Social Services

   in relation to these issues of strategy, planning, management and delivery of service?

(4) How does the 'divisional' team comment on and influence joint planning and joint financed projects?

Example

One of the four geographical 'divisions' of a large hospital spans part of two distinct Local Authority catchment areas. The management team responsible for this 'division' includes three social services representatives: the hospital based social work team leader employed by one of the Local Authorities; a principal officer with health liaison responsibilities for his district (employed by the same Local Authority); and the area officer responsible for the community based team in the relevant part of the other Local Authority.

Each of these representatives makes a unique input into team meetings, drawing on their differing positions within the Local Authority structure. The health liaison officer who is responsible for co-ordinating social services with health provision at a district level, can view divisional developments in this context. He is also a member of several district planning teams concerned with services for specialist groups. The area officer has responsibilities for fieldwork, day, residential and domiciliary services within his area and can therefore play a key part in looking at service development. The hospital team leader can relate institutional concern to social services. When the need arises for the 'divisional' team to focus on a particular aspect of social services provision, all representatives are willing to link the team to the most appropriate representative of their department.

(iii) Finance

Background notes: -

The allocation of finance is a crucial influence in the running and development of services. A balance needs to be achieved between the allocations used to improve standards in the large hospital and those which develop local services and reduce dependence on the institution. Decisions about this need to draw on the planning process within the hospital, related Districts and higher tier strategy. The hospital management team, District Planning Teams and District Management Teams all have a part to play in this.

A variety of transfer arrangements have been established in situations where the development of local services has diminished demands made on the hospital. Typically such arrangements tend to follow developments rather than enabling them by guaranteeing allocations for a proposed service. An additional source of finance is that of joint financed monies designed specifically to promote 'community based schemes which result from health and social services collaboration. These monies open up extra possibilities for innovative and creative use of both health and social services skills.

Questions:

(1) How should the finance available to the hospital be determined and what are the implications of this for management and budgeting arrangements in the reorganised Health Service?

(2) What budgeting arrangements are required to facilitate the appropriate development (and rundown) of services across Districts?

(3) Can satisfactory budgeting arrangements be devised to provide a financial incentive for the development of local services?

(4) Are there budgetary responsibilities which are best delegated to teams rather than line managers?

(5) What avenues exist for 'divisional' and District levels of the service to influence the use of joint finance monies?

Example

In one Area we visited arrangements had been made to use financial allocations for encouraging the development of local services. Here it was an acknowledged principle that where clearly identifiable resources (e.g. community nurses) were transferred from the host District to work in the receiving District that the appropriate funding should be transferred with them. These districts were also receiving development monies which were allocated in proportion to the size of the revenue budget. While these monies were not tied to specific services, the host District acknowledged that the sum which effectively related to the running cost of the large hospital should not be spent without discussion with the 'receiving' District. It is evident that the 'receiving' District's development monies are proportionately far less in respect of psychiatry, as the running cost of the large hospital is far higher than the local facilities in the District. Yet, it is in the local District that funds are particularly needed in order to make up this deficiency. It is for this reason that the two District Management Teams felt that the host District's development monies should be used not only within the hospital, but to meet the broader needs of the developing service.

The Districts were helped by the planning system in deciding how the allocations should be used. The Health Care Planning Teams for the two Districts had formulated plans for local services as well as to meet the needs of the hospital. These plans had been incorporated in the respective District plans, and the Area plan had subsequently ensured the proposals were compatible.

We wonder whether the principle underlying transfer arrangements such as these could be extended. The agreements which exist show the acceptance that local services diminish the demand on the large hospital. This being so, it seems a logical extension to plan the creation of new services on the basis of transferring the funds which they will realise. If this principle were accepted it would allow a financial incentive for developing better services. The above example is of an Area which is 'gaining' under the Resources Allocation Working Party. 'Standstill' and 'losing' Areas have a much harder task in allocating additional resources to psychiatry.

APPENDIX - Short list of useful references

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