DECENTRALISING COMMUNITY HEALTH SERVICES

Report of a workshop held on 25 June 1987 at the King's Fund Centre

Primary Health Care Group
King's Fund Centre for Health Services Development
November 1987

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to ecourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary health care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

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Preface

On 25 June 1987 a national workshop was held at the King's Fund Centre to chart the progress being made on decentralising community health services. Following the management restructuring inspired by the Griffiths Report, some districts already had decentralised structures in place and even more were making plans to introduce locality management and/or neighbourhood nursing teams. The time therefore seemed right to offer managers an opportunity to exchange information, compare experiences, and discuss the issues and problems that were emerging as implementation proceeded.

The workshop was organised by members of the Primary Health Care Group at the King's Fund Centre who have a special interest in the development of decentralised community health services. They have established, with funding from DHSS, demonstration projects on locality management and planning in three central London health authorities and are documenting and evaluating their progress. The wider aims of this work are to help managers engaged in decentralising services think critically about the developments they are introducing and to offer information and advice to managers in other districts who are contemplating decentralisation.

Over 100 managers from 50 health authorities took part in the 25 June workshop*, most of whom were in the process of planning or introducing either locality management or neighbourhood nursing teams in their units. The workshop brought together a substantial body of experience on decentralisation and this report gives a full account of the day's discussions.

The structure of the report follows the workshop programme** and is divided into three main sections. Following the chairman's introduction, the first section includes presentations from two general managers who have implemented decentralised structures, in which they look back over the process and review the issues they had to deal with. In the second section, three locality managers explore the nature of their new posts and the challenges they are facing. The third section, 'themes in decentralisation', includes reports of the five afternoon discussion groups which debated some of the key questions raised by decentralisation. The presentation by Dr. Geoffrey Rivett, which gives an overview of decentralisation and its relationship to current central government policies, concluded the workshop.

The workshop was organised and the report produced by Gillian Dalley, Jane Hughes and Christine King. Summaries of the discussion groups were prepared by Pearl Brown, Pamela Constantinides and Liz Winn. Special thanks are also due to the workshop contributors for reading and commenting on earlier drafts of the report.

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* See APPENDIX I

** See APPENDIX II.

Chairman's introduction

Peter Griffiths, District General Manager of **Lewisham & North Southwark Health Authority in London**, welcomed participants to the first national workshop on decentralising community health services. He proposed that the day should proceed with a minimum of formality, to encourage participants to share their experiences and ideas.

The number of people interested in attending the workshop showed that decentralisation was an idea that had come of age. This was also apparent from the results of a questionnaire sent out to all health authorities in the autumn of 1987: 87% of the 159 districts which responded said they were actively engaged in or had plans for decentralising community and/or priority care services.

Reshaping community health, primary care and out-of-hospital services presents the NHS with one of the biggest organisational and management development tasks it has ever had to face. Decentralisation is important because it offers a structure for developing coherent, integrated and locally-responsive services. The idea of decentralisation has received additional impetus from Julia Cumberlege and the report of the community nursing review, which focused attention on the need to 'go local' and make services more responsive to their users. The work of Sir Roy Griffiths and the recommendations of his inquiry into the future of community care are also likely to have an important influence on the shape of health services in the community.

The chairman outlined four practical aims for the day. This was to be a workshop in the best sense of the word and it would provide opportunities for participants to:

- learn how to cope better with problems they faced by exchanging information and sharing experience;
- hear about how implementation of decentralisation was progressing in a wide selection of districts;
- identify and analyse common issues that are emerging from the process of implementation;
- meet informally colleagues from different parts of the country who are trying to achieve similar ends.

1. Issues in decentralising community health services.

The first two speakers described the process of decentralising community health services in two contrasting health authorities: rural West Dorset and inner-city Wandsworth. The paths taken were rather different, but in charting their progress **Paul Harker**, Unit General Manager, Community Health Services, **West Dorset Health Authority**, and **Deborah Hennessy**, Manager, Community Health Services/Nurse Adviser, **Wandsworth Health Authority**, highlighted similar achievements and obstacles. Both presentations illustrated the challenge of devising an appropriate management structure for decentralised community health services and the particular problems of integrating paramedical services into a locality management model. The importance for successful implementation of full consultation with staff, other agencies and the public was another common theme. Both speakers also emphasised greater participation by local people in decisions about their health care as an aim of decentralisation, but recognised that there was a long way to go before this would be fully realised.

Progress in West Dorset

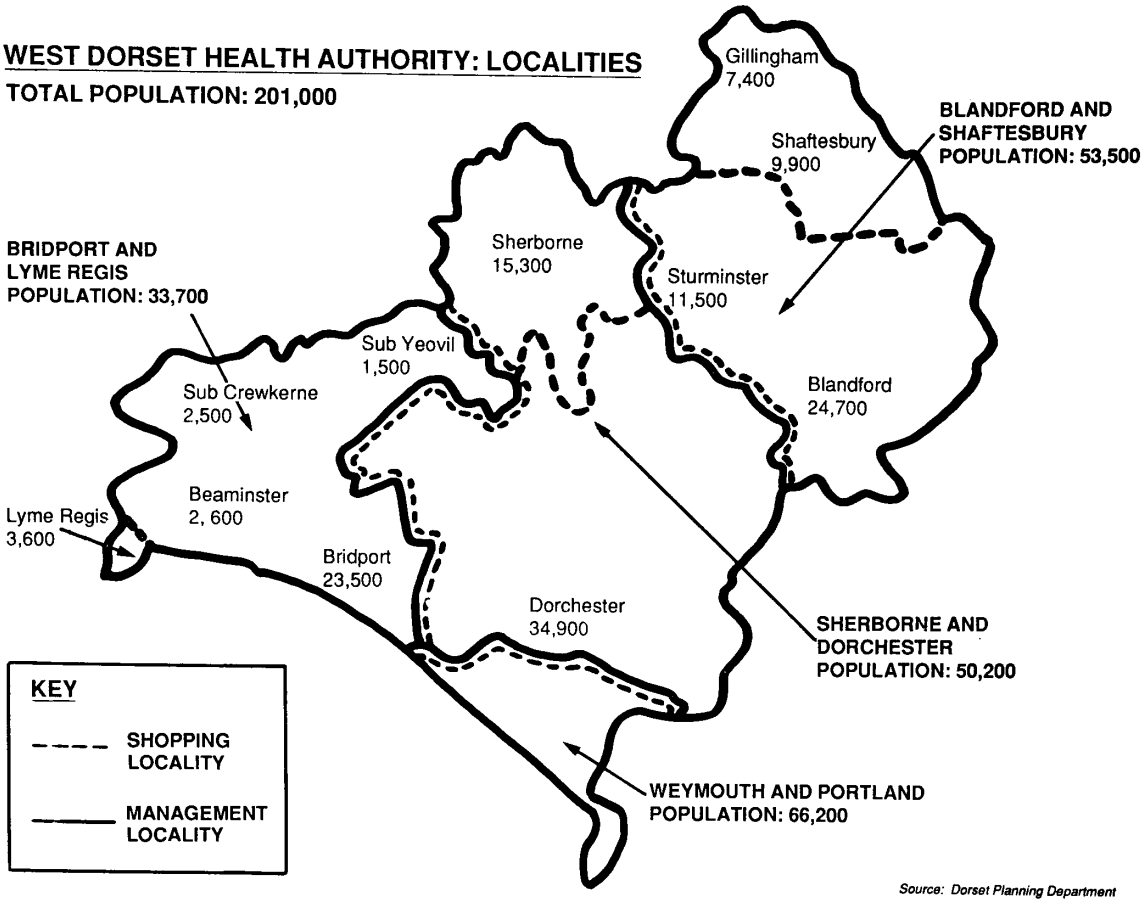
The community unit in West Dorset includes community health services, five community hospitals and services for mentally handicapped people. Prior to the introduction of general management in September 1985, the work of the unit had been organised in traditional ways and services had been criticised for being too centralised. In West Dorset there is strong identification with localities and during the period of consultation about the new unit structure opinion was heavily in favour of 'going local'. Therefore some eighteen months ago, a system of locality management was introduced for community services, with generic locality managers.

The district

West Dorset is a large district, covering 660 hectares, with a total population of about 200,000 people. It is made up of a series of market towns, the largest of which is Weymouth with a population of 60,000 (including Portland). Dorchester, the county town, has a population of 30,000. The county council has identified 13 natural 'shopping neighbourhoods' in the district. These are places to which people go to do their shopping and vary greatly in size.

The localities

The district has been divided into four localities, three of which include community hospitals. There is also a small fifth 'locality' for the services which remain centralised — health promotion, child development and guidance, and the unit headquarters.



Source: Dorset Planning Department
1985 Estimates

Two main criteria were used to decide the size and boundaries of the localities. First, they had to be large enough for the locality manager posts to carry sufficient clout managerially, and to achieve the aim of maximum devolution of operational planning and budgetary control. Three of the locality managers are on scale 18 and one on scale 14 (without responsibility for a community hospital). Second, the boundaries of the localities should be the same as those of local authority services. Complete coterminosity has not been achieved — one area was too large to manage as a single locality, so it has been divided into two localities, which together match the social services area. Each health locality incorporates several 'shopping neighbourhoods', as shown on the map.

Locality management

All the locality managers were internal appointments (although one post was advertised externally); three managers have administrative backgrounds and one was previously a nursing officer in one of the community hospitals. Within each locality, there is also a community nurse manager who is responsible for community nursing staff; a senior nurse managing services for mentally handicapped people; and, where there is a community hospital, a matron manager responsible for all services within the hospital. These posts are all managerially accountable to the locality manager.

Professional advice

Nursing advice in the unit is built into two non-managerial posts — the Director of Community Nursing Services and the Unit Nurse Adviser for Community Mental Handicap Nursing. The latter post is combined with the role of nurse tutor in mental handicap, which is an interesting development. There is now no line management relationship between nurses in the localities and these two unit posts, although all nurses are professionally accountable to the DNS/Unit Nurse Adviser. The role of the DNS (Community) covers quality assessment of nursing care, including private nursing homes. She also gives specialist advice on child abuse and is working with a full-time community nursing tutor to develop locally-based training for staff.

For paramedics arrangements are different: district heads of paramedical services still manage staff working in the localities. However, there are plans in each locality to develop heads of paramedical services who will take some management responsibilities.

Issues and achievements

In the process of decentralising community health services in West Dorset the issues that have received most attention and those which appear to be the most successful aspects of decentralisation are

- **local sensitivity** — services are more in tune with the feelings of fieldstaff and local communities. One example of this is the relationship with GPs which has been improved by the locality arrangements. Making services more responsive will require continuing management attention.
- **communication and decisionmaking** — the locality approach improves communication and fosters team spirit. Since locality management was introduced in West Dorset some difficult decisions have been taken to make financial savings. The successful results are due to active participation by staff.
- **public relations** — there are now much better links with local media. A senior person on the spot to talk to the press is particularly valuable.
- **spotting and making use of opportunities** — the community hospitals are now better used by the health authority and other agencies, including social services and the Alzheimer's Disease Society.
- **local team spirit** — there has been a deliberate attempt to build multidisciplinary working, whilst retaining professional identity and pride. The need to break down professional barriers is recognised and has proved easier to achieve within localities.
- **local leadership** — locality managers can be identified as champions of the local cause even though they may have to deal with the delicate balance between local opinion, their own opinion and directions from the centre. The UGM does not lose control: he can ensure that there is equity in a highly responsive system. At the moment there is a remarkable spirit of striving for equity across localities at the same time as each locality manager is 'carrying the flag' for local identity.

Difficulties and disappointments

Some problems have arisen in the introduction of locality management in West Dorset, but these are not seen as major barriers to the continuing development of the locality approach. The disappointments and issues which need to be given more attention in the future are

- **paramedical services** — the umbilical cord between paramedics and district heads needs to be cut so that paramedical services can develop their own local identity. This should not reduce the status or priority given to these services. Locality arrangements have given fieldstaff the opportunity to question what they are doing; ask how well services meet local needs; and to see the possibilities for change. The district-led model for services with small numbers of staff may well limit rather than encourage change. Local heads of service should be given higher status than people previously at that level. One post may need to include district advisory functions. There are problems with pay because no one has heard of locality chiropodists, for example, and there is no agreed rate for the job.
- **developing community nursing services** — community nursing has not developed satisfactorily under locality management because of resource shortage and the need to define management roles more clearly in the new structure. The potential for establishing specialist clinical community nursing posts is currently being explored, particularly in the care of elderly and physically handicapped people, children at risk and health promotion. This is in line with Project 2000 and may offer greater career incentives to fieldstaff. Community nursing services may develop more rapidly if there are several specialist nurses in the locality rather than a single community nurse manager in post. Specialist nurses would ideally be paid on the lower levels of the senior nurse grade, but would not be identified as managers or senior officers. Changes may need to be backed with money within the constraints of the national Whitley negotiations. However, in making any changes it will be important not to lose the leadership given by nurse managers.
- **services for particular care groups** — the geographical approach has not assisted the care group aspect of community services and this needs renewed attention. The needs of elderly and physically handicapped people are not being identified sufficiently thoroughly. It has also been a disappointment that social services for people with mental handicaps are not being decentralised in the same way as health services and locality managers are increasingly having to deal with central social services managers.
- **involving consumers and communities** — this is in the very early stages. Managers are currently exploring community development approaches to health promotion; advocacy; and participation in the development of hospital services. An interesting initiative is a patients' committee at a local hospital, which seems productive and could be a model for community services, too.
- **developing information systems** — locality managers currently have little information that is useful for management purposes and this requires attention. The unit has only a

limited research capacity which makes it difficult to identify the needs of groups such as physically handicapped people.

- **arrangements for monitoring quality of care** — quality control is best done at the 'coal face' but monitoring quality is only just beginning to feature as an aspect of locality management. In the community hospitals clinical activity monitoring groups which include nurses, doctors and managers have been established. The quality of community care needs attention by nurses working locally backed up by specialist input from the unit.

Conclusion

In West Dorset, locality management has been introduced without any major difficulties. Professional groups have generally supported the new approach, although there have been some reactions with fear of loss of status. The benefits of decentralisation are already beginning to be seen. Some aspects of the new system still require management attention to get them right and to ensure that locality management results in improved services to the community.

Progress in Wandsworth

Wandsworth is an inner city health authority in south west London. It covers a much smaller area than West Dorset, but has a population of about 186,000. There are four units of management: acute, mentally ill, regional specialties and continuing care. The Continuing Care Unit is divided into three groups: elderly people (at present this only includes those in hospital care); people with disabilities; and community services. Each of these has a service manager who is accountable to the Unit General Manager. The community services manager is also nurse adviser for the unit.

An aim of the unit is to develop strong community health services that are well coordinated with services provided by other agencies. To achieve this aim managers felt that some reorganisation was necessary and explored the possibility of decentralisation.

Before decentralisation

Community services in Wandsworth used to be organised in quite traditional ways. There was a district child health service, with clinical medical officers (CMOs), audiologists and speech therapists based centrally and health visitors based in eight clinics with four nurse managers. District nurses were based in four centres with their four nurse managers, plus an evening/night service manager. Chiropodists and dentists were based in six centres. The one community dietician, eight Asian link workers, the health promotion team and the community mental handicap team were all centrally based. Physiotherapists were based in hospitals. Only 25% of Wandsworth's 68 general practices had attached nurses. Because of these organisational arrangements there was considerable opportunity for

fragmentation, discord, gaps in service delivery, apathy and shaky morale, especially amongst nursing staff.

Philosophy of decentralisation

The first step was for managers to work out a philosophy and decide what they really wanted to achieve. At this stage the Cumberlege Report and the Green Paper on primary health care were published, which helped to crystallise thoughts and provided a framework for decentralisation.

The philosophy considers people, professionals, teamwork and management.

- **People** in Wandsworth are from a wide variety of ethnic and social class backgrounds. Their needs are very diverse and require a range of different service responses. Information from the 1981 Census was collated to give crude but useful indicators of the different levels of health need in the district. It is a management responsibility to ensure that services are acceptable to local people and to encourage them to become involved with health care.
- **Professionals** should be encouraged to be innovative and experimental, to explore new ways of delivering care. High standards of professional care is the aim. Managers should allow well-considered risks to be taken, with an awareness of the accompanying accountability.
- **Teamwork** between professionals and in consultation with users of services is essential if high quality and cost effective services are to be provided. Coordination of health authority services with those provided by GPs and the local authority is a high priority.
- **Management** styles needed to change. An efficiently managed service is the aim, with decisionmaking devolved to as low a level as possible.

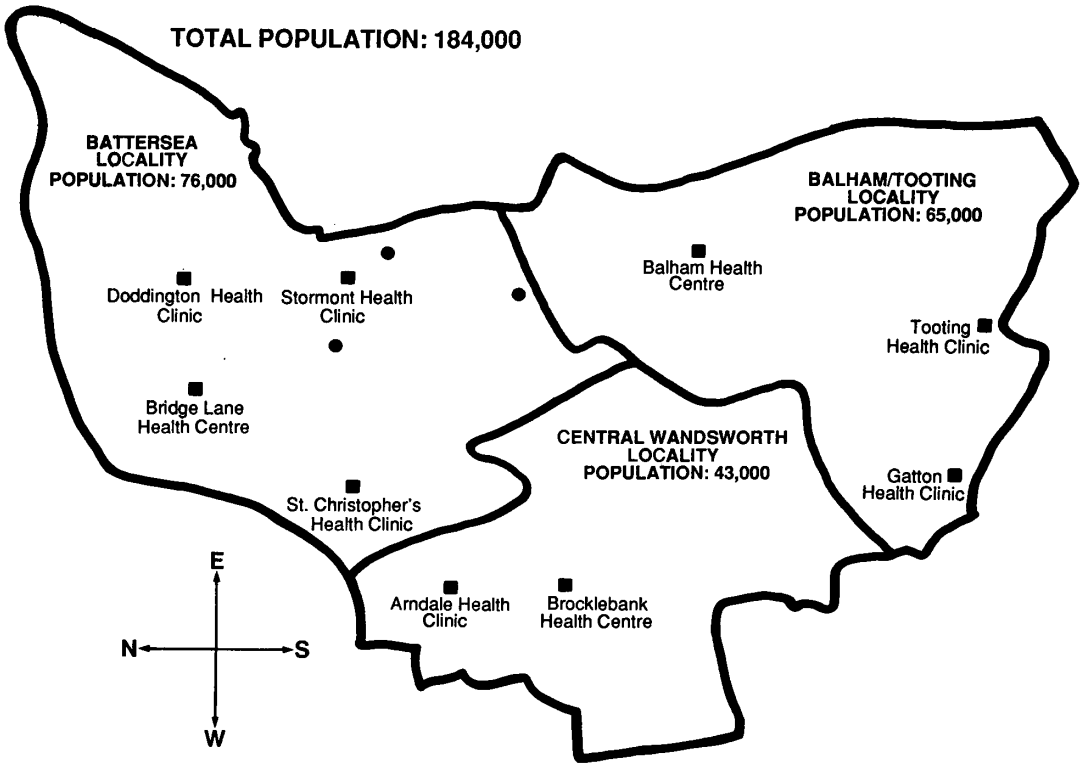
By September 1986 this rather idealistic philosophy had been agreed, and the new and developing structure for community health services is based on these ideas.

Devising a new structure

Some time ago, community clinics in Wandsworth had been organised so that mothers had to walk only a mile to reach their nearest clinic. The nine clinics are therefore well placed to serve as bases for health care teams. Three clinics are in health centres, and the size of the population served by each clinic varies according to local health needs from 15,000 to 30,000 people: populations are smaller where needs are greater.

The neighbourhood served by each clinic and the working patterns of staff more or less matched electoral ward boundaries and the areas of social services patch teams. The clinic 'neighbourhoods' were therefore easily identified and manageable units on which to build a structure for community health services.

WANDSWORTH HEALTH AUTHORITY: LOCALITIES



It was decided that these nine neighbourhoods should be grouped into three localities of about 60,000 population, each managed by a generic locality manager, who would be responsible for staff, manpower budget, building and works, and accountable to the community services manager. Neighbourhood health care teams, each headed by a neighbourhood nurse manager, would be developed in each locality.

Implementation

The next stage was to work out a programme for implementing the new structure, with clear objectives, targets and timetables.

The three locality managers were in post by the end of 1986. One has a background in health visiting; one in district nursing; and one in administration. Their objectives reflect the unit's philosophy and are about identifying health needs; providing services to meet those needs; professional development and management of financial and building resources. Wandsworth has financial restraints: it is a RAWP'ed district and must make imposed savings. There are also difficulties with old building stock in the community: one of the nine clinics recently had to close prior to demolition.

Planning neighbourhood health care teams

Before setting up neighbourhood health care teams throughout the district, it was considered essential to evaluate the idea in one locality. Six months' planning was undertaken before a pilot scheme was started in April 1987 in a locality of 60,000 population with three neighbourhoods. In October 1987 aspects of the pilot scheme will be reviewed.

The six months' planning included extensive consultation to raise awareness among staff and the public. As part of this process, demographic and health information on the neighbourhoods has been collated and presented at meetings of health service staff, other statutory organisations and voluntary groups. It shows that the five electoral wards covered by the three pilot neighbourhoods are among the most deprived in the district. This is one of the reasons why work started in this locality.

A Community Health Council representative was seconded to help in the consultation for six months prior to starting the pilot. She provided a constant reminder that community health services were for people living in the community and not just about professionals and management. This helped to bring some difficulties out into the open and, although there were sticky patches in the consultation process, these helped to clarify managers' thinking and sharpen some decisions. Efforts were made to meet all local community organisations and their representatives were invited to attend consultation meetings. Open days were held in the locality at which people were asked about local services and told about the proposals. A small survey of users of clinics was carried out. Considerable time was also given to explaining the plans to GPs and other professionals working in the locality.

Neighbourhood nurse managers

In each of the three pilot neighbourhoods there is one neighbourhood nurse manager (NNM) who manages a team of health visitors, district nurses, school nurses and family planning nurses, as well as administrative and clerical staff in the health centre or clinic. The NNM's responsibilities include encouraging team development and establishing links with local authority services and community groups. This is a very big job and, although NNMs are supported by the centre administrator in each neighbourhood, they may require further assistance in the future.

The first three NNMs volunteered to take on this role. They and all other nurse managers were trained during the six months' planning and consultation period which started by everyone attending one of the many public presentations given by the Community Nursing Review Team. There was also much discussion and a day release course to prepare for change and develop leadership and management skills. The process ended with a weekend away on a management training and team building exercise. Arrangements for training have continued with the appointment of a Professional Development Officer — a "luxurious necessity" — with responsibility for developing a quality assurance programme for nursing in the unit, which includes performance review and continuing education.

The six months' pilot scheme will give district nurses and health visitors time to try the new system and comment on it. One issue is that some district nurses and health visitors are now no longer managed by a nurse of the same discipline and this required sensitive negotiations with staff. In 1986 there was a serious shortage of nurses but movement into neighbourhoods has improved recruitment.

Posts have been filled and staff are enthusiastic about the change. The Community Manager is keen to have clinical specialists in each neighbourhood who will provide professional advice on child abuse, terminal and continence care. In the meantime, professional support is provided by a named district nurse in neighbourhoods where the manager does not have district nurse training, and vice versa for health visiting, and this seems to be working well.

GPs and CMOs

In the consultation period GPs asked many questions about the changes that were proposed. Discussion about the proposals was helped by maps showing how nurses would operate. As a result of these discussions one or two GPs have said they will zone their practice catchment areas to match neighbourhood boundaries.

GPs in the pilot neighbourhoods have been very cooperative and two new attachments have been made since April 1987. Attached nurses are based in the neighbourhood where the GP has his or her main surgery. Where GPs have patients in more than one neighbourhood, the patients get services from the attached nurse or the neighbourhood team that covers their home. The neighbourhood team serves the people in the neighbourhood, therefore a GP practice may have to relate to more than one neighbourhood team. In a small, densely populated area there is no way around having two systems working together. It is accepted and seems to be working satisfactorily.

Clinical medical officers are still managed centrally. There has been considerable consultation with CMOs and they are moving slowly towards working on a neighbourhood basis. There are definitely no plans to make CMOs accountable to neighbourhood nurse managers, but NNMs are responsible for coordinating all services in a neighbourhood — linking people up, making introductions and encouraging better referral systems.

Paramedical staff

While structures for management and delivery of community nursing services have been resolved satisfactorily, there is some way to go with paramedical services. An attempt was made to allocate paramedical staff to neighbourhoods but it is very difficult when there are so few staff. They are now centrally controlled again, although positively encouraged to work in specific neighbourhoods.

The future

The three pilot neighbourhoods have regular professional team meetings, users meetings and regular liaison with local community groups. The possibility of developing health care associations is being explored. The CHC has agreed to help with this in one locality on a trial basis. Involvement of local people is a long, hard process and responsibility lies with the neighbourhood nurse managers. To help them a voluntary coordinator post may be necessary.

A start has been made on decentralising community health services, but there is still some way to go. The planning and consultation process was a particularly important factor in Wandsworth's successful implementation of the new structure. It has generated a feeling of involvement and cooperation, helped team development and contributed to better recruitment and morale. An added bonus is that all community services, including midwifery, community psychiatry and community mental handicap, are moving towards working together in neighbourhood health care teams.

2. What is locality management?

Three locality managers, all of whom had direct experience of working out the practicalities of decentralisation, spoke about their own work. They talked about the difficulties — and the benefits — of moving into posts that were entirely new, and that were based on a philosophy which was, for the most part, as yet untried. One of the chief challenges was how to create an identity both for the patch (locality or neighbourhood) for which they were responsible and for their own newly-created posts; another was the broad issue of how to turn the community services they managed into efficient and responsive local services which their consumers would value. Although each manager's post and the units in which they worked differed in scope and characteristics, many of the issues with which the managers were dealing were remarkably similar.

Stuart Chidgey, locality manager from **North Devon Health Authority**, and originally from an administrative background, opened the session. He began by describing his locality and its wider environment. North Devon Health Authority is small in population terms (142,000 people) but large in geographical size (930 square miles). It has a small revenue budget and is made up of two units: the acute/district general hospital unit and the community unit, which is divided into four localities. Stuart Chidgey manages the Barnstaple/ Fremington locality which has a population of 50,000, a staff of 90 and a budget of £750,000. He is responsible for all the community services within the locality (district nurses, school nurses, health visitors, community psychiatric nurses, community mental handicap nurses, administrators) and, in addition, manages a number of district services (a child opportunity centre, a mental illness day resource centre, and a mental illness rehabilitation centre). Paramedics are managed by their functional head of department, who is accountable to the unit general manager. The paramedical heads of department are responsible to locality managers for delivery of services in the localities. Each of the four locality managers is a coordinator of a particular care-group review team and this is an effective way of tying in care-group concerns with the locality structure.

Each locality manager is supported by an advisory structure — the local advisory team — consisting of a GP representative (nominated by the Local Medical Committee), a consultant (nominated by the Medical Executive Committee), a nurse (a health visitor nominated by the locality manager in Barnstaple's case), a 'local interest' representative (the local coordinator of voluntary services, again in Barnstaple's case) and a social services representative (to give an inter-agency perspective).

Stuart Chidgey listed some of the main concerns which he had been addressing over the past twelve months:

- defining the relationship between the community and hospital services;
- establishing the advisory structure and clarifying its role;
- developing ideas on how to involve consumers, and how best the organisation could be shaped to suit consumers' needs;
- working out the relationship between care-groups and locality planning;

— trying to define the locality manager's role in relation to a number of issues: planning, budgeting, staff which the locality manager does not manage but which work to the locality (paramedics), other agencies;

While he strongly supported the concept of locality management, Stuart Chidgey could already identify a number of potential problems — the most important of which related to the ability of the locality (and its staff) to withstand conforming pressures from the centre. How far would a locality be able to retain a degree of autonomy which was necessary for it to be able to develop its own style and foster arrangements appropriate to its own needs? The ability to respond to local needs was, after all, the particular attraction of locality management. He was also concerned about what the impact of future central government policy on locality management would be: the Griffiths inquiry on community care had yet to report, and future primary health care and personal social services policy was not yet clarified. Mostly, however, he wanted to press ahead with immediate concerns such as forging good relationships with other professionals, for instance GPs; establishing satisfactory networks of professional advice; and investigating the nature of the locality and its health care needs.

The presentation from North Devon was followed by **Teresa Gardner**, neighbourhood nurse manager from **Central Birmingham Health Authority**. Although she is not responsible for as wide a range of staff as the other locality managers, as neighbourhood nurse manager, Teresa Gardner has many of the same perspectives in terms of fostering inter-professional teamworking and adopting a neighbourhood approach to health care. Unlike many locality managers who may come from any professional background, in the case of a *nurse* manager, a nursing qualification is essential. Before taking up her present post in February 1987, Teresa Gardner was a nursing officer responsible for a total of 64 health visitors, school nurses and family planning nurses. Now she is a neighbourhood manager, she has responsibility for the whole range of community nursing staff (apart from the family planning nurses) in the neighbourhood, a total of 43 staff, but with a smaller geographical area, the ward of Sparkbrook, to cover. The decision to introduce neighbourhood nursing fitted the unit's overall aim of making the community health services more accessible to the consumer. As part of this, the neighbourhood nurse manager offers a first and comprehensive point of contact to members of the public.

Teresa Gardner saw her role as having four central components: *planning, motivating, coordination* and *control.* As leader of a team of mixed nursing professionals, she had access to a wide variety of knowledge and information about local health needs which the different staff groups had previously held separately. She was able to draw this information together and combine it with 'hard' data available from OPCS and local authority statistics, which could then be used for *planning* purposes. Differing patterns of service provision and delivery could then be matched with differing patterns of demand. Previously, the existence of several managers had led to different sets of priorities being developed within the same area. As sole manager she was able to consider requirements from a number of staff and other perspectives and make decisions which were more coherent and less conflicting.

Great emphasis in neighbourhood nursing was placed on the 'team approach' and this had helped her to *motivate* staff. They were positively encouraged to spend time together and to share information.

In this way they were able to identify problems and to come up with solutions. This had a beneficial effect on staff and morale, and in particular had encouraged non-nurses — chiropodists, speech and occupational therapists — to think in terms of a neighbourhood approach and so contribute to the overall aims.

As manager in charge of several different nursing groups, she was given the opportunity (and responsibility) for *coordinating* the nursing input into community health services. She therefore had to be conscious of the range of skills needed, and the appropriate staff mix to suit that need; she was also responsible for identifying overlaps in provision — as well as gaps — and for taking action where necessary. Her coordinating role extended to the health authority link with the local authority, especially with social services. Previously, coordination and consultation between the two agencies had been difficult because too many people were involved. With a single neighbourhood manager it had become a lot easier. Even in very practical terms, the task of coordination and decisionmaking had become much easier.

Because Teresa Gardner was the single focal point of management, she felt she was able to establish closer and better relationships with the staff at the two health centres she was responsible for, and had a deeper knowledge of the work they were doing and the problems (especially in relation to such things as child abuse) that they were facing. She therefore had much greater *control*: she was better placed to supervise the work and to know what was happening.

In the future Teresa Gardner hoped to work much more closely with the community in assessing need; there were plans to set up neighbourhood forums. She felt that neighbourhood nurse managers would enable more effective planning to take place, and she expected to take a leading part in implementing these plans. Neighbourhood nurse management, she stressed, was an opportunity for solving problems which had long confronted the community health services.

Peter Higgins, localities manager from **Exeter Health Authority**, whose background was in nurse management, concluded the session. He started on a note of caution, by emphasising the need to be realistic about just what powers locality managers had in practice. There was a danger, he felt, of falling into the trap of believing locality management would be able to achieve anything and everything.

He described the way Exeter Health Authority was organised. There are two units: acute/district general hospital and community (which includes GP hospitals, decentralised consultant beds, homes for elderly confused people, mental handicap centres, domiciliary services, health centres and so on). The district is divided into twelve localities, with six localities managers appointed to be responsible for pairs or clusters of localities. His own localities, Exmouth/Budleigh Salterton, have a total population of 43,000, 220 staff and 130 beds. He is responsible for a budget of £2.25 million.

Peter Higgins saw the role of the localities manager as being responsible for staff, the identification of needs and the allocation of resources, based on local information. Each locality was different and likely to have its own particular needs. Localities managers in Exeter are encouraged to develop

locality identity and to establish local self-sufficiency wherever possible. Knowing users' views and getting them involved are of central importance; localities managers are expected to get out and about and listen to individuals' views about the services. The localities manager also had a significant role to play in making use of the locality planning teams.

He was concerned to develop a common philosophy based on principles of normalisation amongst staff within the localities along with high standards of care. Health promotion, too, was an important objective and he gave a number of examples of initiatives in that field. Emphasis at all times was to be placed on *local* involvement (both of staff and public) and local integration of services, especially of those for mentally ill and mentally and physically handicapped people.

All these aims, he said, were good but there were problems: shortage of resources in relation to demand; personnel difficulties; inter-professional barriers. The locality manager was caught between the community and senior management and often the pressures from both directions were great. However, he felt that locality management could work as long as two things were safeguarded: first, there had to be a commitment by the health authority to decentralising community-based, flexible models of care. Decentralisation must not be 'just another' structural exercise. Second, managers had to listen to local views. There must be a forum to tap local knowledge, and in Exeter these took the form of the locality planning teams, which were multidisciplinary groups of health, social services, education, housing, church and police representatives along with consumers (mostly from voluntary organisations), local councillors and CHC representatives.

There was never a 'right time' to appoint locality managers. They should be seen as catalysts for change (essential in a district which planned to close all its large institutions by 1990) and they should be given support and freedom to act independently in the best interests of the locality wherever possible. The measure of success for locality management, Peter Higgins concluded, was a positive answer to the question 'has going local done anything for the patient'.

3. Themes in decentralisation

In the afternoon participants joined one of five discussion groups to explore in more depth some of the themes of decentralisation. The themes were:

- implementing a decentralised structure;
- meeting the information needs of decentralised community health services;
- building in consumers' views;
- neighbourhood nursing teams and decentralised structures;
- promoting professional collaboration.

Discussion in each group was led by two people with relevant experience. The main points they made and the contributions of the participants are summarised in the following reports.

Implementing a decentralised structure

In this group, the discussion leaders described the implementation of two different models of implementation in Solihull, West Midlands and Islington, inner London.

Jacqueline Brooks, Community Unit General Manager, **Solihull Health Authority**, discussed decentralisation based on groups of GP practices. Solihull has six localities of approximately 30,000 population. Currently all the locality managers are nurses, but this may change in the future. In the process of implementation, time had been invested in talking to all general practitioners and explaining the details to them. It was hoped to continue this dialogue. The message was reinforced by the development of a community news sheet devoted to locality issues. Having clearly defined objectives and confidence in the reasons for 'going local' helped tremendously in the consultation period.

During the implementation period Solihull had carried out a survey of staff on styles of leadership in the community services. They discovered from this that some staff had little idea of district objectives and policies on care groups. These findings led to useful discussions and helped to firm up the thinking behind the reasons for decentralisation.

The initial consultation paper on decentralisation had met with some opposition from certain paramedical services but this had been resolved and from 1 September 1987 they will also be decentralised, and allocated to localities. The difficulties of 'splitting' small services was raised as an important issue in the discussion.

It was decided by the unit general manager that investment in training was paramount for the success of the implementation and particular attention had been paid to helping the locality managers develop from their former nurse management role. In addition it was felt that they should develop a locality identity and so in the first six months in post the locality managers were asked to make contact with groups within the locality, gather a profile of the locality, and organise a locality lunch.

Geoffrey Shepherd, Community and Continuing Care Unit General Manager, **Islington Health Authority**, described a different model and approach to implementing decentralisation. A steering group was set up comprising the unit general manager, director of nursing services, Family Practitioner Committee (FPC) administrator, a GP, a specialist in community medicine and staff from the district directorates of planning and information, quality assurance and personnel. The group identified the following conditions for successful implementation of decentralisation plans:

- a commitment to the philosophy of decentralisation;
- clear aims and objectives;
- linking general management to the new structure;
- an awareness of local circumstances;
- enthusiasm.

Enthusiasm and commitment are probably the most important factors in carrying through such large-scale change. The group set itself a tight timescale and the unit general manager believed there were many advantages in keeping to it — so that staff worries and feelings of uncertainty were kept in check.

The local authority in Islington had already decentralised services and their boundaries influenced those drawn up by the health authority. Five localities of approximately 30,000 population were agreed by the health authority and eventually each will probably have two neighbourhood nursing teams. Unlike Solihull, Islington has chosen to appoint locality managers from any discipline. As a result the locality managers have backgrounds in health visiting, district nursing, chiropody, administration and research. Possibly because of this mix the level of concern expressed by the paramedical staff has not been as high as in places where only nurses have been appointed.
In the consultation process, the unit general manager presented the case for decentralisation to all staff in each health centre and base. Information about the population in each locality was also discussed. Having the FPC administrator on the steering group had helped greatly with involving the GPs and initial negotiations with them were made through the administrator. There are roughly 20 GPs per locality to work with 40 health authority staff. An important point to get over to GPs was that the locality manager was the 'key' person to liaise with locally, being the 'local agent' of the health authority. Most GPs expressed appreciation of having just one person to relate to. Islington is an inner city area with few primary health care teams and GPs have generally been less anxious about decentralisation than elsewhere.

In the discussion that followed the presentations four main points were raised.

- There was anxiety about splitting up small services like speech therapy in decentralisation. Each speech therapist is likely to have a specialist skill required by a relatively small number of patients in the district and ways need to be found to allow for this specialisation to continue, at the same time as making a link with a locality.
- In contrast with Islington's close partnership with the FPC, one participant, himself a unit general manager and a GP, reported particular difficulties in getting information from the FPC.
- One of the major aims of decentralisation is to give local peole more say in their services but difficulties may arise in sorting out 'needs' and 'wants'. Most participants recognised this difficulty. In Exeter a district-wide evaluation team helps by advising on local matters, such as identifying needs.
- On the question of evaluation of decentralisation, there was no evidence yet that it had influenced health outcomes, but all participants thought that management of the service had improved. This in itself was an achievement and was likely to lead to a more satisfactory and responsive service in the longer term.

Meeting the information needs of decentralised community health services

Discussion was led by **Agis Tsouros** from the Department of Community Medicine, **Bloomsbury Health Authority** in central London, and by **Roy Carr-Hill** from the **Centre for Health Economics, York University**.

Agis Tsouros saw the move towards decentralisation as an enabling process in order to secure greater equity in the provision of services. The 'patch' or 'locality' could be used as a focussing point for the collection of the sort of information which would be useful for the development of services. The principles embodied in WHO's 'Health for All by the Year 2000' could be useful in establishing local priorities, but priorities had to be linked to some understanding of need and the problem remained as to how local need could be identified.

It was important to be aware of what was available already on a local basis. Mortality and morbidity data are available; likewise census data — but that becomes out of date relatively quickly. In trying to come to some assessment of what information was necessary, Agis Tsouros set out the following key requirements:

— a health profile which would set out the social, physical and environmental characteristics of the local population;
— an assessment of health needs;

— an assessment of local wishes;
— a service profile, which would include not only activity data, but some sort of assessment of quality (measured in terms of access, adequacy, etc.).

A number of sources can be used besides the standard sources; for example, data from GPs, from local authority social services and housing departments, from voluntary groups. Both quantitative and qualitative data can be used. Local residents as well as professionals can be involved in the assessment of data; where forms of community participation — such as patch committees — exist, these too can be involved. Local health surveys — 'mini Black reports' — are useful sources of information. Agis Tsouros concluded by stressing the need to monitor and update information regularly. The identification of health needs could not be a 'one-off' activity.

Roy Carr-Hill looked at some of the problems involved in collecting patch-level information. The information that was needed in planning primary care at the local level was:

— information relating to need;
— information relating to the utilisation of resources;
— information on the outcome of the use of health care resources.

The first practical/technical problem is whether to focus on electoral, ward or enumeration district. If the ward was used, certain problems arose immediately because there was often variation within wards in measures of 'deprivation' — such as unemployment, overcrowding, the lack of amenities and so on. He gave examples from his own study in Barnsley in which information was gathered from GP age/sex registers for local use. There were other well-known problems.

- How can need be measured with any accuracy? For example, studies have shown that increased awareness brings increased reporting of ill health (the General Household Survey shows a 50% increase over 10 years in reported ill health in middle-aged groups) which may not reflect actual need.
- The use of morbidity rates as indicators of needs is problematic: e.g. different client characteristics are involved; access rather than need may determine use of services, etc.

One alternative, according to Roy Carr-Hill, was to try to draw up a socio-economically determined profile of likely need, based on known links between deprivation and ill health. But the problem of out-of-date census data remained, and it was recognised that some of the commonly used substitutes for poverty/deprivation (such as unemployment) may be inadequate. He argued that the currently most acceptable proxy for poverty/deprivation was the number of people on supplementary benefit, and pointed out that information is available locally. This is a better measure than ten year old data from the census.

He concluded with a timely comment about whether or not health service providers will be successful in getting their message across even if they manage to develop an appropriate service. Recent research he had conducted indicated a widespread public ignorance of existing services and service providers.

Discussion centred round the issue of how to identify need accurately, the relationship between demand and need, the impact of financial constraints and the practical problems involved in gathering information. There was some dispute between those who suggested that the identification and satisfaction of need might be achieved through a 'market' approach to health care (through consumer surveys and the offer of 'options' to test what people were prepared to 'buy'), and those who believed that equitable provision of health care depended on a more scientific distinction being made between need and demand. The participants who supported the demand-led view gave the example of the GP as providing a service in response to demand, and pointed out that the DHSS was seeking to improve GP services by the provision of microcomputers by which GPs could analyse demands made on their services and so improve their efficiency. It was suggested that community nurses as well ought to be more analytical about the numbers and types of demand made on them: how, and on what, health professionals actually spent their time was a valid source of data.

Those who disagreed with this view argued that such an approach was inequitable; catering for expressed demand meant listening to the loudest and most articulate voices. Disadvantaged groups would inevitably lose out. This was one of the fundamental problems facing the health service. And even if attempts were made to identify the needs and unexpressed wishes of disadvantaged groups, there was always a danger of raising expectations which could not be fully satisfied in the current climate of economic restraint. One participant, however, pointed out that in his own experience there were many changes and improvements which consumers themselves have asked for which proved not to be too costly or impossible to carry out, and he encouraged the group not to be too timid in testing consumer views.

Nevertheless, the impact of financial constraints was a real problem which community units were having to face all the time; they found it difficult to meet increased need/demand (however it was identified). And the implication of acquiring better information systems — and hence more accurate information — always meant the possibility of increased outlay of resources to meet newly identified need. Greater efficiency achieved through better information was one hope which some participants expressed — as long as the other dimensions of a good quality service were not lost in the push towards efficiency. Equitable allocation of resources was of paramount importance and some concern was expressed that a decentralised service might lead to imbalances across a district. If one locality manager, for example, was more effective than others, he/she might achieve more for his/her locality at the expense of other localities.

Some of the practical problems associated with information-gathering which were mentioned related to relationships between agencies and between staff. Many of the difficulties centred on the FPC/DHA link. Variable experiences of the readiness to exchange information were described. Age/sex registers could be a useful tool for both family practitioner and community health services, but it all depended on good relationships being forged to allow common use to develop. One suggestion was that GPs might be amenable to sharing information if they were offered advantages in return, such as attachment of staff. But another participant commented that in inner city areas the relationships between GPs and their FPCs were poor, let alone between GPs and the community health services.

And even if individual GPs or practices were prepared to become involved in reciprocal, mutually advantageous relationships of this sort, it would mean that those good practices improved while the poor practices lagged further and further behind — which was hardly an equitable outcome for the patients involved.

Whilst all agreed that accurate and appropriate information and information systems were of central importance, there was no conclusive agreement as to how best this could be achieved. The problems were recognised by all participants; the solutions proposed were more contentious.

Building in consumers' views

The discussion leaders for the smallest group at the workshop were **Helen Dunford**, Development Worker, Locality Planning Project in **Riverside Health Authority**, inner London, and **Tony Day**, Planning Coordinator, **Exeter Health Authority**.

Helen Dunford described the aims, progress and problems of her work in Pimlico. The project is supported by the King's Fund and funded by the DHSS, and is based in Riverside Health Authority. Managers there are committed to examining the feasibility of planning services on a small scale and so the project is not simply an exercise in administrative reorganisation. It has clear aims: to involve more field staff in planning processes; to respond to the needs of community groups; and to develop inter-professional collaboration.

Pimlico was selected as a pilot area and a 'patch committee' was established, which draws a third of its representatives from each of three groups — the statutory sector (including a GP, housing officer, district nurse, health visitor, community psychiatric nurse and social worker), the voluntary sector (well known, very local agencies) and local residents. The initial tasks for the patch committee were:

- to identify a neighbourhood;
- to find ways of involving the local community in planning;
- to build up a comprehensive picture of all resources in the area;
- to identify health needs;
- to find ways of tailoring resources to meet need;
- to build communication networks between grassroots levels and the rest of the organisation.

Progress so far has shown that it was surprisingly easy to get professionals and local people involved in the committee; to achieve consensus on the boundaries of the neighbourhood they would relate to; and to discuss the needs of local people. The development worker provided a map and information

about the local population and services. The committee felt that the worker's initial focus on an existing social services patch was artificial and extended the boundaries to include what was locally recognised as 'the neighbourhood'. This has a population of 12,500.

The patch committee has attracted some representatives from the community, including three 'regulars' from local council housing estates and a priest. Concern about the representativeness of the group led to an attempt to link in with other community activities, e.g. the Pimlico Festival, to create a wider network for public consultation. One of the initial worries often voiced about opening up the planning process to users and potential users of services is that expectations will be raised and the floodgates of demand will crash open. In practice in Pimlico requests have been mainly for more information, since people tend to be concerned about better access to existing services.

Three 'priority' groups have been identified by the patch committee: elderly people; homeless families; and ethnic minority groups. Initially the focus has been on services for elderly people. Members of the committee have a wealth of information and direct experience of how well services are meeting needs. After only four meetings the patch committee has identified some important gaps in services but has not yet made any positive suggestions about better use of resources. The project has unearthed communication problems within the NHS, for example between community health services and community mental health services, to which managers have been alerted.

The patch committee is an experiment that is still evolving. It has achieved most of its initial aims relatively quickly, i.e. within six months. One difficulty in these relatively early stages of the project has been in relation to the recruitment of representatives. Only three local people attend regularly and one GP attends but his colleagues are uninterested and suspicious about the initiative. Another challenge for a project at the 'grassroots' is that people are unused to being asked what they think about the health service and so their response tends to be to ask for more of existing services.

Exeter Health Authority is one of the pioneering districts in decentralisation and consumer involvement, and Tony Day, who was until recently Secretary of Exeter Community Health Council, described the locality planning system and how it operates. He stressed that the method was only one potential way of involving consumers in planning health services.

In 1981 Exeter Health Authority decided that 'planning-by-norm' was inappropriate and outdated. They established sixteen patches on the basis of 'shopping localities' and held lunchtime meetings out of health authority premises to which all groups of NHS staff were invited. From these initial meetings locality planning teams were set up which now meet quarterly, at lunchtimes, and usually away from health authority property. Representatives include district nurses; midwives; health visitors; members of community mental health teams and community mental handicap teams; GPs; community pharmacists; social services, education (e.g. deputy head of comprehensive) and housing staff (sometimes); police; clergy; locality managers.

The aims of a locality planning team are to

- improve collaboration and cooperation between staff leading to a better use of resources. This has been the chief success of the system.
- make bids against the district annual programme on the basis of needs in the community. Bids have not been requested of teams but a few have emerged.
- allow virement within localities to facilitate a more equitable distribution of resources. So far this has occurred on a small scale.

The involvement of consumers only became an issue towards the end of the first planning phase. The CHC was very supportive of the development of locality planning teams and was asked by the health authority about ways of developing a consumer voice. Initially, the handful of representatives came from the parish councils and from voluntary organisations and these remain the principal sources. Experience of consumer involvement has resulted in every locality planning team increasing the number of consumer representatives. Most teams' consumer representatives run into double figures. Planning teams elect their own chairmen and more than half of the team chairmen are from the lay representative group.

The locality planning system is one way of involving consumers in the provision of health services. To succeed as a planning method it needs support from the top of the organisational structure together with the ability to achieve change at the local level.

The locality planning teams have made a number of decisions which reflect the partnership between the voluntary, statutory and community sectors. For example, some voluntary groups provide a nightsitting service; one hotel has set aside a regular time for pregnant women to use their swimming pool; social services home help organisers and health authority district nurses have reviewed their caseloads to identify clients they have in common who could be visited by one worker rather than both, thus freeing resources by preventing duplication. However, it was pointed out during the discussion that the 'winners' in this sort of partnership were statutory service providers, though obviously with spin-offs for users. Indeed, Tony Day agreed that the locality system was moving into a new phase whereby consumers on the teams were beginning to ask for additional services from the health authority. In general, community representatives tend to make 'responsible' demands — within the budgetary and planning constraints of the locality planning teams. Responses to demands are subject to negotiation; health authority staff have to be imaginative and flexible to come up with a positive and satisfactory response.

The discussion that followed tackled some of the common issues addressed in the two presentations: how to get consumer representation and how planning teams which included users work. Participants also discussed the feasibility of transferring the models from Exeter and Pimlico to other settings. In particular, the largely rural setting of Exeter and the concomitant social and administrative structures (e.g. parish councils, well-defined neighbourhoods) were seen by some as the main reasons for the success of the locality planning system. Other participants felt that some of the principles and experiences of both projects could be reworked in different settings.

Both speakers touched on the problems of getting users fully involved, and expressed some concern about the representativeness of those who did regularly take part in health planning forums. Those who became involved tended to be older people; young people rarely take part in discussions that may influence the health services they receive. Members of Exeter's locality planning teams tended to be middle aged and middle class — although this is not too far removed from the composition of the population. Some participants, however, were worried that too much attention to representativeness could be a distraction and could prevent consultation and participation ever getting off the ground.

It was recognised that contact with consumers requires effort on the part of the statutory services. Users who are dissatisfied and disillusioned are not likely to be receptive to a flysheet asking for comments or involvement. More informal, personal contact needs to be made, particularly with existing groups in the community.

Where users have become involved in the consultation process, the experience of both speakers was that initially their expectations were low and they tended to demand surprisingly little from the health service. For example, many requests were for more information about existing services, such as location of clinics, telephone numbers, how to make appointments.

Some of the problems raised by users have been outside the traditional domain of the health authority but nevertheless have a crucial bearing on health and health status. Some participants felt that this was a major problem and that health authorities should avoid 'overlap' work, say with transport services. Others felt that health workers could adopt a facilitator role so that instead of solving the problem, they were able to support and direct people towards help from other agencies.

Both examples presented to the group were based on principles of localness. It was felt that this facilitated responsiveness and fostered identity amongst both those working in the locality and those receiving services. Throughout the discussion the issue of 'top level' commitment was raised. It was felt to be essential that genuine support — not lip service — was given by the health authority; and not just to the *concept* of consumer involvement, but to all that it means in practice.

Neighbourhood nursing teams and decentralised structures

Twenty-four health authorities were represented in the discussion, which was started by participants describing briefly their authorities' current concerns in relation to community nursing and the introduction of neighbourhood nursing in particular. Their concerns centred mostly on professional accountability/ advice and generic nurse management; the relationship between locality management and neighbourhood nursing management; how primary health care teams fitted in; the place of specialisms; working successfully with GPs; the specific problems of relating neighbourhood nursing to inner cities or rural areas; and the prospects for each nursing profession in the future. Some

authorities had made progress towards the introduction of neighbourhood nursing, whilst some participants said they were attending the group in order to take further what were only initial ideas within their units.

The first discussant, **Peter Roberts**, Director of Nursing Services, **Nottingham Health Authority**, described the context in which neighbourhood nursing had been introduced into his authority. Nottingham Health Authority is a large (600,000 population) urban authority, with many of the problems characteristic of the inner city. He identified the advent of general management as providing the opportunity to raise staff morale, to move away from crisis management, to develop forward planning, and to encourage moves towards the establishment of coterminosity with the local authority. Managers were aware of policy development at the national level — Cumberlege, Körner and the Green Paper — and recognised the need to build on the best of the ideas being put forward.

It was decided to alter existing structures and bring the health authority in line with the local authority, so achieving coterminosity. Nottingham has been divided into four sectors, each with a sector manager who is generic and with clinical nurse managers accountable to them. Sector size ranges from 120,000 to 170,000 population. The first task was to open up channels of communication and dialogue between all levels of the organisation and to bring management and staff together. This was done by the unit management group (UMG) visiting the four sectors to meet staff and maintaining a monthly visit to each sector. In addition, health authority members accompanied the UMG to raise issues and problems which could be discussed with staff and managers together.

Teambuilding was a crucial element; likewise the aim to personalise services. A number of issues or problems had to be tackled — how to build up the low morale that existed, how to solve problems of accommodation and how to determine what should be the headquarters function in a decentralised service. Underlying all of this was the need to develop the general management function, based on principles of goodwill, equity and team spirit. Peter Roberts felt that progress had been made in achieving many of the aims of the exercise. Morale had been improved, posts had been filled and the professional groups involved had been carried along. It had been a slow, piecemeal process, but it had been successful.

The secret of their success lay in the effort which had been put into talking about the issues. They had spoken to GPs, the Local Medical Committee, the Community Health Council; the midwives and the community psychiatric nurses supported the developments once they had a chance to discuss them. Staff morale had been raised directly as a result of these improvements in communication; general management has demonstrated that it respects professionals and their roles and so has not alienated them. Peter Roberts concluded by saying that although he felt progress was being made, it was also important to recognise that everyone's needs (staff and public) could not all be met — certainly not in the short term. They had to beware of being over-optimistic in what the changes could produce.

June Clark, Director of Nursing Services in **West Lambeth Health Authority**, inner London, described how neighbourhood nursing was being introduced in the district, and compared West Lambeth's approach with her earlier exprience in Lewisham and North Southwark and West Berkshire.

To 'implement Cumberlege within three months' was the first target given to her on appointment. Implementation within three months was unrealistic but a commitment was given to develop a strategy within that period. This time scale was not compatible with the process which other districts have struggled with, of drawing lines on maps in search of 'perfect' boundaries; the only strategy possible was to develop a central focus for each neighbourhood, establish the team, and give them the task of working out their boundaries and ways of working. She felt it was important to proceed by evolution not revolution, using structures and relationships which were already in position. She felt that although this strategy was not a matter of choice, it was likely to be more successful.

West Lambeth Health Authority will be divided into three localities (50,000-60,000 population), each of which will contain two neighbourhoods. The locality manager, who could be of any discipline, will manage all community services in the locality. The neighbourhood manager, who will be a qualified community nurse, will manage an integrated team of about 30 nurses, plus their support staff and premises — i.e. a qualified nurse with a general management fuction. Concern had been expressed by some nursing staff about being managed by someone of a 'different' discipline (i.e. health visitors managed by district nurses and vice versa) but this had been overcome by pointing out the 'worse' alternative which was being promoted — that the neighbourhood managers need not be nurses. The nurses will be grouped into clinical teams — some in primary health care teams, some in functional health visiting or district nursing teams, using the groupings which are there already.

June Clark summed up her presentation by highlighting the following issues:

- the distinction between localities, neighbourhoods and clinical teams;
- specialist expertise, advice, support and quality within generic management;
- what is meant by professional accountability and managerial accountability: accountability for what, to whom?

One member of the discussion group was firmly of the view that neighbourhood nursing was a non-starter. She felt that it was quite wrong to introduce generic management and the 'generic' team into community nursing. Health visiting and district nursing were 'diametrically opposite' in their tasks and approaches and it was a mistake to try and link the two. Other participants felt strongly that this was not so, and that moves should be made to get the two groups closer together in the interests of clients' needs. As long as clinical support was given it was possible for the two groups to work within the same team. The important task was to get a parallel advisory structure in place alongside the general management structure. Managers should be responsible for the standard of the service whilst professional support was necessary for maintaining professional standards. It was important that general managers and those responsible for clinical support were in close and frequent contact to work through problems as they arose.

However, some felt that it was not always easy to distinguish between what was a 'professional practice' issue and what was an 'organisational practice' issue; and that difficulty became more apparent the closer to field level the issue arose. The need for adequate clinical (and managerial) support at field level on a day-to-day basis was stressed. It was important not just to rely on putting in

a unit adviser post at the top. Others saw 'standard of care' as being the main issue — how to implement and maintain policies — and that this applied to managers and practitioners alike.

One participant said she was district adviser on child abuse with 'the power to discipline' but that she was not a manager. Many felt that this was an untenable position — it blurred the real problem of how to distinguish between professional advice and management. She replied that she did not see it as a problem; she worked closely with and through the relevant managers. It was generally agreed that the issue of management and professional accountability was the major issue, but that this was a problem facing general management throughout the service, not just in relation to the introduction of neighbourhood nursing.

This central issue was linked into discussion about the role of specialisation, which was seen as another problem. With the development of neighbourhood-based generic teams, it was felt that specialist posts would get lost and that specialist services would not be available when required. Was it possible to spread small-scale limited services (as specialist services were) evenly across a number of neighbourhoods? One suggestion made was that clear and firm codes of practice (especially in the case of child abuse) be established which have to be adhered to and which would force the development of appropriate strategies to cope with this problem.

While a lot of support was expressed for the concept of neighbourhood nursing and there was a feeling that many of the key problems could be resolved, it was felt that unless staff morale was built up, it would be impossible to secure from staff the effort and compromise that new ways of working would require. Day-to-day support was necessary, along with good communication and a willingness to listen. Team building was an essential prerequisite in any programme of preparation that was devised. Teams and their members should be taken seriously by management; their direct experience of the field and knowledge of the way their clients felt was a valuable asset. There were many good ideas coming up from below and these should be taken on board.

Above all it was necessary to convince staff and clients that change was not being introduced merely 'for change's sake'. It had to be shown that the introduction of neighbourhood nursing would be of positive benefit to everyone concerned.

Promoting professional collaboration

This discussion group was led by two managers from London, **Sue Shaw**, Administrator, **Camden & Islington Family Practitioner Committee**, and **Christopher Payne**, GP and Director of Community Services, **Lewisham & North Southwark Health Authority**, and focussed on health authority managers' strategies and tactics for linking with and influencing GPs. All participants were convinced of the importance of working closely with GPs and all had experienced some difficulties in establishing effective links.

The group recognised that certain characteristics of general practice and GPs needed to be taken into account when strategies were being devised.

- Independent contractor status and fear of being 'managed'.
- Each GP in a district may have a different point of view, and there is no one body or organisation that can be said to fully 'represent' all GPs or present 'the GP view'.
- FPCs now have a planning role and are an important source of information and advice point, but on specific issues managers will also need to deal with individual practices and GPs.

The group agreed that there were two distinct levels at which health authority managers — UGMs and locality managers in particular — had to operate to influence general practice in their districts or localities. They had to establish relationships directly with individual GPs and practices, on a day-to-day basis, using informal channels. These relationships are built up opportunistically, around the specific interests, plans or problems of a practice. Most of the participants were working in this way to gradually establish rapport with GPs. Managers also have to work through the formal structures for service planning and policy development, and they need to get sympathetic GP representation on and involvement with management groups and committees. Participants were generally less enthusiastic and less optimistic about working at this level, but recognised its strategic importance.

Working with individual GPs

An important point for managers meeting GPs was that GPs, like many other professionals, may not fully understand health authority structures and management arrangements. Managers should be prepared to explain how the system works, where they fit in and what their objectives are.

Several participants had found that some GPs were not keen to work with the health authority — they were suspicious and reluctant to 'talk freely' making it difficult to identify mutual interests. It was agreed that managers needed to have something to offer GPs — a bargaining counter to get them interested in cooperating. Participants were able to give a range of examples of bargaining counters they had used successfully.

- Child development sessions in GP surgeries. In some districts (Portsmouth, Manchester) CMOs were doing sessions in surgeries for GPs who did not want to provide this service themselves. In other districts (Riverside) community paediatricians were doing child development sessions with GPs and offering them training.
- In a similar way community psychiatrists were doing joint sessions with GPs in Rochdale. Other districts were establishing links between community psychiatric nurses and GPs and one example was given of a clinical psychologist working in general practice.
- Direct access for GPs to services such as physiotherapy (Blackpool) and speech therapy were also cited as attractive resources.

- A scheme for shared diabetic care, with input from district nurses and chiropodists, had been developed in another district.
- Practice nurses were the subject of negotiations in some districts. Employed staff are a flexible additional resource for GPs but they may be reluctant to use them. Managers can help GPs think more creatively about the use of employed staff and offer training and professional support.

These were the kind of initiatives that enabled managers and GPs to work together positively and the feeling of the group was that this sowed the seeds for future joint working.

From experience in Rochdale, a persuasive case was made for using GPs to influence their colleagues. Managers had identified 'product champions' among local GPs: those who were prepared to take on board new ideas and 'sell' them to others. These opinion leaders had been coopted on to locality advisory groups with the specific aim of influencing their colleagues.

Working through formal structures

The Local Medical Committee is the statutory body that represents GPs' interests in a district. Participants differed in their views about how useful it was to try to work with and influence LMCs and FPCs. Some felt that to influence policy, managers must form alliances with FPC and local authority staff. It may be most productive to use informal meetings to discuss issues of common concern. Information needs to be shared; tactics and timetables discussed. There is little point in a manager pushing alone for something that is politically or practically impossible for others to agree with.

What should FPCs be able to offer health authority managers? By now FPCs should have clear strategies and plans for developing primary medical care. Managers should ask FPCs about their policies, for example, on:

- general practice premises — is there a regular programme of practice visiting; have suitable premises been identified for development; are FPC staff helping GPs bring about improvements?
- use of ancillary staff;
- accommodation for attached staff in new developments;
- information sharing — one FPC and DHA are sharing an information officer to compile information for common use.

Some saw the LMC as tactically important because it makes recommendations to those appointing representatives to the DHA, to the district management board, to unit management boards (sometimes) and to various other committees. Managers can influence the LMC directly, by getting invited to meetings or by working through others who attend. They can also influence the nominations for committees made by the LMC, who are not necessarily LMC members.

Other forums exists which bring GPs together and participants gave examples of how these had been used successfully to build relationships with groups of GPs.

- Some districts (e.g. Islington) have GP forums or working groups which have been established to discuss district policies and problems. These can provide a wider base than the LMC for communicating with local GPs as a group.
- In Bolton, a 'health centre users group' was a useful forum for managers to work with GPs in a large health centre.
- Managers in another district found a similar opportunity to work with GPs using a community hospital. Relationships were already good because both parties had the hospital in common and the GPs saw the value of working with managers.
- In Essex the local Royal College of GPs group meets regularly with district general managers and this forum has hammered out a policy on the use of practice nurses. A nurse practitioner post is currently being discussed and the training will be financed by a health authority.
- Postgraduate training centres are another source of information and education for GPs with which managers could establish links.

In conclusion, the discussion group identified many mechanisms by which community unit managers and locality managers can gain the cooperation and involvement of GPs. All managers should review how effectively they are currently using the various formal channels for collaboration in their districts and should not overlook the fact that they hold 'bargaining counters' which they can use to help build more informal relationships with individual GPs, practices and wider GP networks.

Concluding comments

To conclude the workshop **Geoffrey Rivett**, Senior Principal Medical Officer, **Department of Health and Social Security**, commented on the developments that had been discussed during the day and their relationship to national policy directions.

Health service systems require a structure appropriate to the task they have to fulfil. In the latter part of the 19th Century the idea of a district hospital developed, a hospital which provided people in a particular area with essential institutional care for the more common of the serious ailments. Then in the 1930s and 1940s it became clear that some rarer conditions required complex technology and specialised skills and the idea of the regions was born. This concept became associated with university medicine, and with the advent of the NHS the health service regions were created. The development of the idea of the neighbourhood is more recent. In the last few years we have seen the emergence of what might, in time, come to be regarded as a new operational tier, which is particularly important for the elderly, for people with mental and physical handicap, the mentally ill and for the organisation of primary health care. It provides a pattern which fits well with the traditional way in which general practitioners and community nurses work.

Neighbourhood organisation is a way of providing care on a multidisciplinary basis. It is not a concept which should be identified with any single group of staff, for it is about the best way to work together to care for people. Neither should it be considered purely structurally, for it is essentially about the way things are done. As a new concept, it has yet to be subjected to evaluation. It is developing in different ways in various parts of the country and this variation is a good thing. The essence of neighbourhood systems is that they reflect local requirements, and the needs in an area like Wandsworth are not exactly the same as those of Norfolk.

It is DHSS policy to allow districts the right, within limits, to determine how best to develop and deliver services in their own locality, to come to their own conclusions and make their own plans. Districts are of course accountable to regions for getting things right, and if there are significant protests about new decisions they are taking, they should take notice of what is being said and assess the validity of objections. This is especially necessary at local level, where sensitivity to local requirements is of the essence. At this early stage, it is too much to hope that all authorities will get it right first time, and there is nothing wrong in changing an approach as a result of consultation.

A second thread of departmental policy is that community care should continue to be developed. Most people would prefer to be cared for at home, whether their illness is acute or more long term. While neighbourhood services may assist in our policy of moving people wherever possible into the community, it is also the case that a well organised neighbourhood service can facilitate discharge of patients from acute hospital services which are under considerable stress in some parts of the country.

A third point all of us should watch is the quality of our communication. None of us seems very good at this but both district health authorities and family practitioner committees have a stake in the health service at locality level. At times FPCs complain that planners in their districts ignore them; and districts complain about the difficulty of getting information they need out of the family practitioner committee. Ultimately if the two authorities disagree the person to suffer is the patient. Authorities have a responsibility to work with each other, and learn the constraints under which the other operates.

Finally, it is essential for devolved community services to see one of their major responsibilities as the suppport and staffing of primary health care teams. For many years it has been DHSS policy to base health care in the community on properly staffed and housed primary health care teams, and while there are sometimes difficulties in the inner cities, these must not be used as an excuse to divide health services into separate and isolated components. The concept of the neighbourhood service is probably robust enough to be applicable to urban as well as rural areas. Inevitably many people when sick go first to their general practitioner, and primary health care teams will remain a 'given' and a key component of our systems.

The developments we face are exciting and challenging, and we should face them in a spirit of cooperation. On that basis I believe Miles Hardie was right, and that the neighbourhood is one of the most important concepts in the health service to emerge in recent years.

Appendix 1

Decentralising community health services: a workshop for managers

held at the King's Fund Centre on Thursday 25 June 1987

Chair: Mr P Griffiths, District General Manager, Lewisham & North Southwark HA

List of participants

	Mrs W Allard	Sector Coordinator, Worcester & District HA
	Mrs Ashworth	North Manchester HA
	Mrs K Aspinall	Primary Care Area Manager, North Manchester HA
	Mrs J Atkinson	Community Administrator, Lewisham & North Southwark HA
	Ms M Ayton	Health Visitors Association
	Mrs A Baker	Assistant Director of Nursing Services, Riverside HA
	Mrs S Barker	Director of Nursing and Patient Services Children's Programme, South Birmingham HA
*	Ms J Brooks	Unit General Manager, Solihull HA
	Mr R W Brown	Assistant Unit General Manager, Herefordshire HA
	Mr T J Buckler	Localities Manager, Exeter HA
*	Dr R Carr-Hill	Centre for Health Economics, University of York
	Mr C Chapman	Locality Manager, Haringey HA
*	Mr S Chidgey	Locality Manager, North Devon HA
*	Dr J Clark	Director of Nursing Services, West Lambeth HA
	Mr C L Clews	Assistant Unit General Manager, North Staffordshire HA
	Mr J R Collins	Unit Administrator, Greenwich HA
	Dr P Constantinides	Fellow, Evaluation & Planning Centre, School of Hygiene & Tropical Medicine
	Dr J Cornwell	Locality Manager, Islington HA
	Mrs N Coupland	Director of Nursing Services, North Lincolnshire HA
	Mrs E Cubbin	Director of Patient Services, Basingstoke & North Hampshire HA
	Mrs P Dalton	Director of Nursing Services (Sub-Unit Manager), Bolton HA
*	Mr T Day	Planning Coordinator, Exeter HA
	Miss M Dinwoodie	Unit General Manager, Harrow HA
*	Ms H Dunford	Decentralisation Project Worker, Riverside HA
	Mr D Durham	Unit General Manager, Paddington & North Kensington HA
	Mrs C Durkin	Assistant Director of Nursing Services, Bolton HA
	Mrs S Fry	Assistant Unit General Manager, Central Birmingham HA
	Mrs B Gallen	Director of Community Nursing Services, South Bedfordshire HA
*	Ms T Gardner	Neighbourhood Nurse Manager, Central Birmingham HA
	Mr N Gerrard	Unit General Manager, Oldham HA
	Mr J Girling	Unit General Manager, Rochdale HA
	Mr B Gooch	Unit General Manager, Wakefield HA
	Mrs J Gordon	Clinical Support Manager, Basingstoke & North Hampshire HA
	Dr G Griffiths	DHSS
	Mrs L Hadfield	Unit General Manager, Riverside HA

* denotes speaker

	Ms L Haggard	Unit General Manager, South Derbyshire HA
	Mrs S Hardcastle	Divisional Manager Community Services, Hartlepool HA
	Ms J Hargadon	Unit General Manager, Croydon HA
*	Dr P Harker	Unit General Manager, West Dorset HA
	Ms J Harris	Manager of Nursing, South Derbyshire HA
	Mr J Henly	Unit General Manager, Portsmouth & South East Hampshire HA
*	Dr D Hennessy	Manager Community Health Services/Nurse Adviser, Wandsworth HA
*	Mr P Higgins	Localities Manager, Exeter HA
	Mr A C E Holbourn	Unit General Manager, Merton & Sutton HA
	Mr A M Horne	Locality Manager, Portsmouth & South East Hampshire HA
	Miss D M Horridge	Nursing Officer Primary Care, DHSS
	Mrs S Hughes	Manager Community Psychiatric Nurses, North Manchester HA
	Mr R Jones	Senior Administrative Assistant, Bolton HA
	Dr K Kelleher	Unit General Manager/Specialist in Community Medicine, Sandwell HA
	Mrs A H Kemp	Locality General Manager, North Staffordshire HA
	Mr N I Khan	Service Development Officer, Winchester HA
	Miss J E King	Manager-Care Services, Leeds Western HA
	Ms M Lynch	Paddington & North Kensington HA
	Mrs J McEwan	Clinical Manager, Blackpool, Wyre & Fylde HA
	Dr J D MacPherson	Localities Manager, Exeter HA
	Mr A Makin	Macclesfield HA
	Mrs E Malia	Assistant Unit General Manager, Central Birmingham HA
	Miss C Martin	Unit General Manager, Kidderminster HA
	Mrs M Merricks	Manager, Community Services for Adults, Cambridge HA
	Mrs M Mitchell	Locality Manager, Haringey HA
	Ms K Money	District Planning Administrator, Paddington & North Kensington HA
	Mrs M Murphy	Assistant Director of Nursing Services, West Essex HA
	Mr T Noble	Child Care Group Manager, Southampton HA
	Mrs A Norman	Locality General Manager, North Staffordshire HA
	Mrs P O'Connor	Director of Nursing Services, Greenwich HA
	Mr K Page	Unit General Manager, Hounslow & Spelthorne HA
	Mr F Pajak	Member, Bolton HA
	Dr V Parker	Unit General Manager, North Lincolnshire HA
	Mrs B Paterson	Locality Manager, Haringey HA
*	Dr C Payne	GP and Director of Community Services, Lewisham & North Southwark HA
	Dr E Pelc	Unit General Manager, Brent HA
	Dr N Phillips	Unit General Manager, Worcester & District HA
	Mr I B Prosser	Unit General Manager, Coventry HA
	Ms C Raine	Unit General Manager, Central Birmingham HA
	Mr K Richards	Priority Care Services Coordinator, Riverside HA
*	Dr G Rivett	Senior Principal Medical Officer, DHSS
*	Mr P Roberts	Director of Nursing Services, Nottingham HA
	Miss J W Rogers	Locality Manager, Portsmouth & South East Hampshire HA
	Miss D R E Rose	Community Services Manager, Crewe HA
	Ms M Senior	Director of Nursing Services, Central Manchester HA
*	Mrs S Shaw	Administrator, Camden & Islington FPC
*	Mr G Shepherd	Unit General Manager, Islington HA
	Miss D Simpson	Community Unit Nurse Manager, Oldham HA

* denotes speaker

	Mrs K Smith	Unit Nursing Officer, Worcester & District HA
	Mrs M Smith	Deputy Administrator, South Birmingham HA
	Mrs E Spiller	Community Services Manager, West Berkshire HA
	Mrs P Steel	Standards Adviser, North Manchester HA
	Dr W Styles	GP, Royal College of General Practitioners
	Mr P Thorner	Locality Manager, West Dorset HA
	Ms P Thorpe	Divisional Planning Officer, Bloomsbury HA
	Miss D Tonge	Unit General Manager, Oxford HA
*	Dr A Tsouros	Department of Community Medicine, Bloomsbury HA
	Mr P Wallace	Unit General Manager, Bolton HA
	Mr J Watkinson	Unit General Manager, Pontefract HA
	Ms P Wedge	Service Development Officer, Lewisham & North Southwark HA

King's Fund

Ms P Brown	Development Worker
Ms G Dalley	Development Worker
Ms J Hughes	Programme Coordinator
Ms C King	London Programme Secretary
Ms L Marks	Project Coordinator
Ms L Winn	Project Officer

* denotes speaker

Appendix II

Decentralising community health services: a workshop for managers

to be held on 25 June 1987 at the King's Fund Centre

Programme

Chair: *Peter Griffiths*, District General Manager, Lewisham & North Southwark HA

9.45 Registration and Coffee

10.15 Chairman's introduction

10.25 **Issues and problems in decentralising community health services**
Paul Harker, Unit General Manager Community Services, West Dorset HA

11.00 **Neighbourhood health care — the users, professionals and managers**
Deborah Hennessy, Manager Community Health Services/Nurse Adviser, Wandsworth HA

11.35 **What is locality management?**
Stuart Chidgey, Locality Manager, North Devon HA
Teresa Gardner, Neighbourhood Nurse Manager, Central Birmingham HA
Peter Higgins, Localities Manager, Exeter HA

12.05 Questions and discussion

12.30 Lunch

1.45 **Discussion groups**

A Implementing a decentralised structure
Geoffrey Shepherd, Unit General Manager, Islington HA
Jacqueline Brooks, Unit General Manager, Solihull HA

B Meeting the information needs of decentralised community health services
Roy Carr-Hill, Centre for Health Economics, York University
Agis Tsouros, Department of Community Medicine, Bloomsbury HA

C Building in consumers' views
Tony Day, Planning Coordinator, Exeter HA
Helen Dunford, Decentralisation Project Worker, Riverside HA

D Neighbourhood nursing teams and decentralised structures
June Clark, Director of Nursing Services, West Lambeth HA
Peter Roberts, Director of Nursing Services, Nottingham HA

E Promoting professional collaboration in a decentralised structure
Christopher Payne, GP and Director of Community Services, Lewisham & North Southwark HA
Sue Shaw, Administrator, Camden & Islington HA

3.15 Tea

3.30 Plenary

4.00 **Patchwork: practicalities and policies**
Geoffrey Rivett, Senior Principal Medical Officer, DHSS

4.15 Chairman's summary