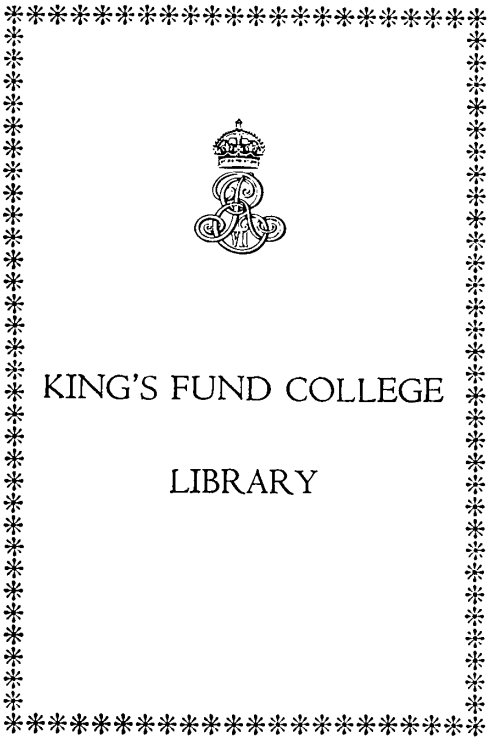
ENHANCING THE QUALITY OF COMMUNITY NURSING

Edited by Jane Hughes

The Primary Health Care Group is 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 encourage 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 care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes reports and papers.

Editor

Jane Hughes specialis as a masters degree in medical sociolo tor of the King's Fund London Prog alth care and disseminating the results. y health services and on medical a



ENHANCING THE QUALITY OF COMMUNITY NURSING

Edited by Jane Hughes

Primary Health Care Group,
King's Fund Centre,
126 Albert Street
London NW1 7NF.
Telephone 071– 267 6111.

First published in July 1990.

ISBN 0 903060 74 4

Published by the King's Fund Centre
126 Albert Street, London, NW1 7NF.

Contents

Preface

It's impossible to pick up a nursing journal today or sit through a health care conference without coming across a score of references to 'quality'. It seems to embrace every conceivable topic, from pot plants in the waiting room to choosing the best wound dressing. Yet, to the hard-pressed community nurse, midwife or health visitor, the idea of acheiving high quality in so many diverse areas may have little credibility. High ideals are all very well, but what about the reality?

Such scepticism is understandable, but it should be resisted: the issue of quality in health care is too important to ignore. Despite the tornado of change now sweeping through health and social services, one concern will remain constant – how to achieve the highest possible standards within a restricted budget. Nursing services are under closer scrutiny than ever before, and nurses are being asked to demonstrate precisely how the enormous public funds they consume actually benefit patients and clients. This is a difficult task for community nurses, since it concerns the complex relationship between the input to services (human and financial resources) and the outcome (how the nurse's intervention affects the patient).

Faced with such difficult questions, and overwhelmed by the magnitude of the changes, it is tempting for nurses to bury their heads in the sand and simply get on with their work. Tempting – but dangerous! Failing to take up the challenge could have disastrous consequences for both patients and nurses. Community nurses see every day what their clients need, and are well placed not only to meet those needs, but to make them known to service planners and budget-holders. If they forgo their role as patients' advocates, it is the patients who will suffer. Meanwhile, only a dynamic and proactive approach will help ensure that nurses retain control of their own work and their own future.

The changes planned in health and social care over the next decade seem daunting, but they provide many windows of opportunity for resourceful and inventive nurses. One example is the drawing up of contracts or agreements between purchasers and providers of services. Fear that these contracts will focus only on finance can be countered by nursing action to ensure that considerations of quality are equally prominent. Nurses themselves must take responsibility for specifying the standards of care they can achieve within the allocated budget, which also gives them weapons to fight for budget increases. They must also show they can deliver care to the standards they have specified. Whatever structures are introduced, and whoever employs them, nurses will best safeguard their patients' well-being, and their own, by exploiting such opportunities.

Comfort also comes from the pages of this publication. It illustrates some of the huge range of initiatives community nurses are already undertaking to enhance the quality of their care. Quality assurance will never be a uniform activity, and these examples of good practice show the creativity and diversity involved – there are many pathways to the quality destination. Significantly, though, many initiatives have the same starting point: identifying the clients' needs, both as individuals and as populations. This lays the essential foundation on which to build services and practices which really respond to those needs.

This is a complex challenge, perhaps the toughest one to emerge from these papers. Other challenges include encouraging the participation of service users in planning and providing

services, which has barely started. Focusing on the outcome as well as the process of care is another area for development. There is also a clear need to record and share experience – good and bad – to avoid reinventing the wheel. Finally, the ability to understand and control the processes of change of any kind is the key to lasting success in all this activity.

The work contained here is not condensed into specific recommendations, but provides many interesting ideas and food for thought. Reassuringly, those good ideas are often suprisingly simple. They also provide valuable ammunition in the struggle to demonstrate nursing's importance. Now, perhaps more than ever before, nurses must develop their ability to explain, even justify, their work to others, especially to those who believe that the skills and knowledge of a qualified nurse can easily be substituted by a health care assistant. So much community nursing work, with its focus on prevention and psychosocial support, is hidden and diffuse, but it must be brought to light, described, articulated and evaluated – chiefly by nurses themselves. Only thus can we empower community nurses to help themselves and raise their morale, and thereby provide the best possible service to clients. That's what quality is really about.

Jane Salvage
Director, Nursing Developments
King's Fund Centre for Health Services Development

Introduction

In early 1989 the King's Fund Primary Health Care Group held a series of three conferences to discuss quality in community nursing. Work on assessing the quality of nursing care is advancing rapidly and one of the aims of the conferences was to chart the progress being made by community nurses. It was impressive. The wide variety of initiatives that were discussed during the three days was a tribute to community nurses' imagination, energy and dedication to raising standards of care for patients and clients.

This book contains a selection of the papers that were presented to plenary sessions and to small groups in workshops. The papers are grouped in five sections which examine quality issues from different perspectives. This is a convenient way of organising the wealth of material from the conferences, but by no means the only way. Readers will see the obvious connections between sections, recognise parallels between papers, and appreciate that different approaches lead eventually to the same practical questions of assessing and enhancing quality of care. The book is not intended to be read from cover to cover – readers should use it imaginatively, selecting the topics and examples most relevant to them.

Each section begins with a 'keynote paper' that gives an overview of the issues. Themes from the keynote paper are illustrated or elaborated by shorter reports describing local initiatives to improve quality in community nursing. The accounts are necessarily brief but they offer lessons that are likely to be of value to others. For those who want to know more, each report concludes with the name of a person who can provide further information. There are also references to published papers and details of useful resources, such as policy documents and job descriptions.

Many people contributed to the success of the three conferences and to the production of this book. Special thanks are due to the conference participants, especially those who presented papers and led workshops: Lis Adams, Elspeth Alexander, Alex Barr, Mary Burd, Evadne Cameron, David Costin, Gillian Dalley, Jane Dauncey, Linda Evitt, Elaine Fullard, Ruth Graham-Pole, Hazel Harrison, Jenny Hunt, Keith Hurst, Helen Kendall, Diane King, Wendy King, Ann Langauini, Tom Langlands, Rosalynd Lowe, Brian Lowey, Diane Moss, Pat O'Neil, Jo Pask, Pam Pembroke, Sheila Rogers, Jean Rowe, Hilary Rowlands, Kate Scragg, Christine Simmons, Liz Skinner, Judith Stag, Alan Stopforth, Jane Tandy, Pat Taylor, Pat Tomlinson, Jenny Triptree. The conferences were chaired by Jane Salvage, June Clark and Ainna Fawcett Henesey who enlivened the debates and kept the proceedings running smoothly. Ami David organised the conferences and gathered the material for this book, which was edited by Jane Hughes.

Section 1

Management structures: frameworks for quality

Management structures: frameworks for quality

This section looks at recent developments in the management of community nursing services and raises questions about how organisational structures can contribute to service quality. The introduction of general management to community units paved the way for reviews of service organisation and delivery. In many districts these reviews led to services being restructured, often with the emphasis on decentralisation, including localising management and giving staff responsibility for a defined population. The Cumberlege report suggested a logical extension of these developments into nursing and some districts have now established a network of multidisciplinary neighbourhood nursing teams, each with a single, generic nurse manager.

In the keynote paper Gillian Dalley analyses the changes and suggests some indicators that could be used to judge whether quality is being enhanced by the new unit structures and nursing teams. Where new structures are in place, they have given impetus to managers and staff formulating an explicit philosophy of care and setting goals and standards. Although it may be too soon to assess outcomes for patients and clients, there seems to be encouraging progress towards resolving some of the longstanding problems of providing high quality community health care. Dalley warns, however, that districts must be allowed to consolidate and build on these developments before having yet more change imposed upon them. The proposals in the 1989 white papers on the NHS and community care have caused particular anxiety because of the upheaval they herald for the NHS generally and the possibilities they create for dispersing community health services.

Three of the short reports in this section are case studies from districts that have recently made changes to the organisation and management of community nursing services. They illustrate and reinforce many of the points made in the keynote paper. All three show that:

- management structures need to be carefully adapted to fit the particular circumstances and requirements of the district;
- securing good access to professional advice for general managers is an essential element to consider;
- effort put into managing change effectively is likely to be repaid;
- new structures in themselves do not necessarily improve service delivery;
- equally important is the subsequent process of developing new ways of working.

West Lambeth Health Authority in central London has decentralised community health services and appointed general managers who are responsible for all the staff in their neighbourhood. Although the neighbourhood managers have nursing backgrounds, they need nursing advice from all the community nursing disciplines. Clinical nurse specialists have been appointed: to provide advice; to help build neighbourhood nursing teams; and to develop the clinical aspects of community nursing.

In Croydon, a large urban district, neighbourhood nursing teams have been introduced on the lines described in the Cumberlege report. The neighbourhood nurse managers have initiated many new activities and have identified specific benefits brought by the new structure.

In the more rural setting of West Suffolk, localities are based on the catchment areas of primary health care teams and the philosophy of the Cumberlege report has been adapted accordingly. The aims of the nursing teams, however, are very similar to those of their urban counterparts and service developments are following parallel lines.

The final report in this section describes a study which raises questions about the need for management restructuring on a grand scale. Reorganisations generate a great deal of activity but the impact on patient care may be difficult to demonstrate. If the aim is to change the way services are delivered and improve their quality, then where is effort best directed? Research by Sheila Rogers shows that a change agent outside the management structure, working with field staff, can help them audit and improve their performance, releasing more time for patient care.

The impact of new community management structures: an overview
Gillian Dalley

This paper describes the context in which community nursing takes place, its organisation and the structures for locality management and neighbourhood nursing that are being developed in some districts. It also addresses the question of how an organisational framework might influence service quality.

Aspects of quality

Donabedian, an authority on quality, emphasised that quality was about both the technical and interpersonal aspects of care.[1] This dual approach is particularly important in nursing. He drew on systems theory for his analysis of quality and looked at structure, process and outcomes. Maxwell has argued that the quality of a service can be analysed by considering six dimensions: access to care; relevance of the care that is offered; effectiveness; equity; social acceptability; and efficiency and economy.[2] There are problems with this approach, because the dimensions may compete with each other, especially at times of resource constraint. Also, the dimensions of quality may be given different priorities by the patients and clients who use the service, the professionals who deliver it and the managers who are accountable for it. Managers' chief concerns are often value for money and effectiveness and they may sometimes need to be reminded that other dimensions, particularly the interpersonal aspects of care, are equally important. Assessing quality can therefore be a complex business.

Difficulties and developments

In the last decade community health services have faced a number of difficulties. They have typically been described as fragmented and the goal of providing integrated or seamless care has been hard to achieve. Numerous groups of professional staff, working from various agencies which have different ways of doing things, have made coordination of services difficult. Differences between professionals have also created problems which are all too familiar, and even within professions there can be conflicting points of view.

Looking at community services overall, they have suffered from the lack of planning in primary care. There have been few attempts to plan services across agencies, across units in the health authority, or even across disciplines within a profession. Finally, community health services have always been in the shadow of acute hospital services with their greater prestige and public visibility. The important job done by community health staff tends to be overlooked.

In the mid-1970s, government policy was to give priority to services in the community and to develop community care. Increasing emphasis was placed on community health services, but it was recognised that they were not organised to cope with the demands likely to be placed on them. Patients first drew attention to the need to organise services on a more local basis: 'the closer decisions are taken to the local community and those who work directly with patients, the more likely it is that patients' needs will be their prime objective'.[3]

The Acheson report on primary health care in inner London went further.[4] It recommended the establishment of 'units of management for the community services' to give them 'a single and authoritative voice'. In Scotland similar ideas were being discussed and a unit structure for community health services was also recommended.[5] The intention behind all these proposals was to give community health services the focus they had never had before.

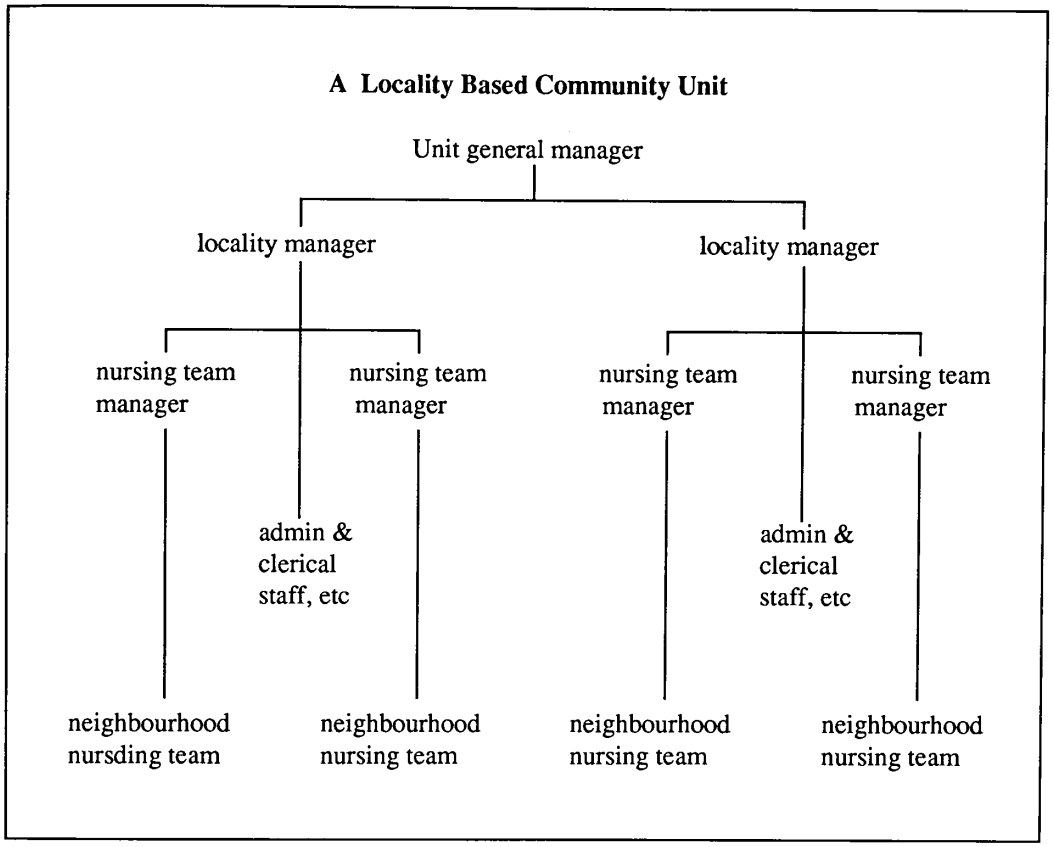
Despite the optimistic tone of these reports and the promise of the reorganisations which followed them, community health services have had to operate in a demanding and uncertain environment and are likely to continue to have to do so. There is increasing pressure to keep people out of hospital and to care for them in the community, sometimes without adequate resources. Hospitals' early discharge policies mean that many patients cared for in the community now have higher levels of dependency. There is also the question of how districts balance their priorities, for example deciding which units should be allocated resources to develop services. The acute sector usually wins and it is still difficult for community health services to find the authoritative voice that Acheson recommended. Over and above all this is the continuing uncertainty about where community health services will fit in the government's plans for the NHS. Despite more than ten years of consensus that community health services should be strengthened, there is still uncertainty and confusion about the direction that they should take.

Decentralisation to localities

After general management was introduced to the NHS, the King's Fund conducted a survey to find out what the new general managers in community units were planning. It showed that in 1986 140 health authorities were planning to decentralise services in one way or another, to take decision-making to a more local level. In a second survey in 1988, 77 of these 140 authorities were planning to introduce, or already had in place, neighbourhood nursing. It is clear that these two structural developments – decentralisation and neighbourhood nursing – often proceed hand-in-hand.

Decentralisation can mean many things. The needs of districts vary: some rural areas have widely dispersed services which may have been running on a decentralised basis for many years; inner city areas have different problems and approaches to organisation. Nevertheless, most districts in the survey said they were decentralising management structures and delivery of services.

A typical locality-based community unit is shown in simplified form in the diagram. It is led by the unit general manager and divided into a number of geographical areas or localities each headed by a general manager. Within the localities there are various options for organising staff. The diagram shows one possibility – neighbourhood nursing teams and other staff based in the locality accountable directly to the locality manager.



Establishing a philosophy of service

Regardless of differences in structures, community units seem to agree about their approach to providing services. First and foremost, they have adopted a client-focused approach which is based on multidisciplinary working, on the grounds that this is the best way to provide an integrated and co-ordinated service.

Locally-based services are favoured because management is closer to the ground and hence decision-making is speedier and more appropriate. A local base also enables needs to be identified more easily and planning to take account of the information held by fieldworkers in the area. A collaborative approach is emphasised, working across agency boundaries with social services, housing and voluntary organisations. Collaboration between professions is the hallmark of the locality team, which may include district nurses, health visitors and medical officers, as well as midwives, physiotherapists, speech therapists and psychologists, even though they may be managed by other units of the health authority. It is accepted that services should be tailored to meet the needs and wishes of the local population and the involvement of service users in planning is becoming more commonplace. There is also increasing concern to maintain and monitor the quality of services that are being delivered.

The Cumberlege report and neighbourhood nursing

The ideas introduced by the Cumberlege report about how community services should be organised and delivered now have widespread support. The report helped to popularise a locally-focused philosophy among community nurses and it has had an important influence on recent service developments.[6] In its review of community nursing the Community Nursing Review Team identified five main problems.

- The disciplines in community nursing were working with different populations which made it difficult to achieve a common approach.
- This lack of coordination led to gaps in provision and duplication of services.
- Community nurses had little information about local populations and there was no sound basis for service developments.
- Rigid role definition and divisions between the disciplines had stifled development.
- GPs and health authorities often disagreed about boundaries, so the catchment areas of GP practices and the areas covered by health authority staff were not necessarily the same.

These kinds of problems have also been highlighted by other research into primary health care. The literature is full of descriptions of disputes between professions, for example over the leadership of the primary health care team, or over divided loyalties among staff who feel accountable to both the GP and their nurse manager.

The idea of neighbourhood nursing was put forward to overcome these problems. The review team argued that a geographically-organised nursing team could better identify the needs of the local population and emphasised the importance of improving collaboration with GPs, local authority services and voluntary organisations. The multidisciplinary nursing team is central to the Cumberlege approach, and the single neighbourhood nurse manager leading the team is a significant break with tradition. The locality and its population is the focus for moving forward, rather than the development of a profession or discipline.

While less than half of all districts are introducing the neighbourhood team structures described in the Cumberlege report, the majority have felt its impact when questioning the service's aims and assumptions. The Cumberlege philosophy is undeniably sound but some districts have found problems in implementation. For example, what is the right size of nursing team? The report said clearly that managers should have a much smaller span of control but this tends to be difficult to put into practice. There is also tension between general management and professional leadership, which can be felt most acutely by the neighbourhood nursing team manager who must play both roles.

There have been problems breaking down suspicion between the nursing disciplines and getting a mixed team to work together. A lot of thought has been put into preparing for the new role of generic nurse manager but there are basic practical problems about suitable accommodation and resources. Adventurous new developments are difficult to introduce into a service with severely limited resources.

Finally, there has been the resistance to change that is quite normal in all organisations. Introducing new ways of working takes delicate diplomacy, especially when there have been so many other changes recently and more are promised. Many community units have made a large investment in developing an approach that fits with the philosophy of locally-based services tailored to meet local needs, but when putting these ideas into practice have come up against some very practical problems.

Structure and quality

Returning to the question of the relationship between the organisation of services and their quality, what will these new structures do for the quality of community nursing services? It is useful to consider this question from three points of view – that of clients, staff and managers. The focus at this stage must be on process, because it is far too early to look at outcomes.

From the clients' viewpoint indicators of quality might be: an integrated community nursing service, in the sense that they are unaware of structural distinctions between the different parts of the service; their involvement in planning local care, perhaps through membership of a health care association or similar group; and a flexible service that responds easily to different needs.

From the staff's viewpoint, perhaps the most important consideration is that they feel they have a stake in the service. Staff who are not committed to what they are doing may jeopardise service quality. Do they feel part of a team, do they have support from their colleagues? The new structure also ought to offer innovative ways of working and opportunities to learn from colleagues. Being at the 'leading edge' of developments can increase enthusiasm and the new structure should give community nursing a higher profile, which may in itself be a morale booster for staff.

From the managers' viewpoint the new structure offers an expansion of the managerial role. The neighbourhood nurse manager post is likely to be an important career stepping-stone towards either professional leadership or general management. The development of locally-based services and information systems ought to provide a better base for management decision-making and there should also be the bonus of leading an enthusiastic and committed team.

Searching for quality

These are just some of the indicators that could be used to judge whether the new unit structures and nursing teams organised on a neighbourhood basis are enhancing the quality of community health services. However, it is early days yet for these developments and it must be emphasised that much remains to be done. There is still a need to establish clear goals and standards for community nursing services with which everyone is conversant and to which they are committed. Work also needs to be done to create a strong identity for community health services and to build the multidisciplinary teams that are crucial for the delivery of high quality care. This goes hand-in-hand with increasing the status of community services to get them on to an equal footing with other NHS services and to ensure that staff feel their work is recognised and valued.

This search for quality proceeds in an environment of continuing uncertainty. *Working for patients* said a great deal about the directions hospital and family practitioner services should take, but nothing about community health services.[7] *Caring for people* makes proposals that will require renegotiation of relationships between community health services and social services authorities.[8] The full implications for community nursing services are by no means clear but there is undoubtedly more change to come.

In some districts, the service may be allowed to consolidate and build on its achievements; in others, it may be split up with some elements perhaps being transferred to hospitals or to GPs. The implications of this for quality of service are worrying. If it is accepted that the key 'process indicators' of quality are consumer satisfaction with an integrated service, staff commitment and high levels of morale, together with sound management, it is essential that changes proposed in the coming months jeopardise none of these. Progress is being made and it must be safeguarded.

References

1. Donabedian, A. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly* 1966, 44 pt 2, 166-206.
2. Maxwell, R.J. Quality assessment in health. *British Medical Journal*, 1984, **228**, 1470- 72.
3. Department of Health and Social Security. *Patients first. Consultative paper on the structure and management of the National Health Service in England and Wales*, 1979.
4. London Health Planning Consortium. *Primary health care in inner London: report of a study group.* (Chairman: Professor ED Acheson) DHSS, 1981.
5. Scottish Home and Health Department. Circular 1986(Gen)20.
6. Department of Health and Social Security. *Neighbourhood nursing – a focus for care. Report of the Community Nursing Review Team.* (Chairman Julia Cumberlege), 1986.
7. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients*, (Cm 555), 1989.
8. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Caring for people. Community care in the next decade and beyond* (Cm 849), 1989.

The neighbourhood clinical specialist in West Lambeth

In West Lambeth the structure of community nursing services was changed as part of the introduction of general management. Services have been decentralised and neighbourhood nursing teams developed. Because nurses are not necessarily managed by someone qualified in their own discipline, neighbourhood clinical specialist posts have been created to support fieldworkers and to give advice to managers. Experience has shown that nursing advice to general managers is vital, and that innovation in community nursing can flourish under general management.

A general manager for the community unit of West Lambeth Health Authority was appointed in 1986, followed by three service managers responsible for elderly services, child and family services and the service for adults with learning difficulties. West Lambeth's population has many inner city features: it is racially diverse (40% from black and ethnic minority groups); only a small proportion of people are in the professional and managerial occupational classes; there are greater than average proportions of one parent families, unemployed people and low income families. A high priority was to decentralise services into three localities, each with two neighbourhoods of approximately 25,000 population. A director of nursing with an advisory role was appointed, whose brief included developing neighbourhood nursing.

The six neighbourhood managers all have nursing backgrounds and manage all the staff in their patch, as shown in the diagram below. This means that community nurses are not necessarily managed by someone qualified in their discipline. Insecurity among staff led to the interim measure of designating experienced district nurses and health visitors to support their colleagues while neighbourhood team patterns were established.

The neighbourhood managers had two tasks: to localise and manage the neighbourhood health service and to develop neighbourhood nursing. The director of nursing set up a development group which discussed and identified roles. It was decided that fieldworkers should be supported by senior nurses of their own discipline who would:

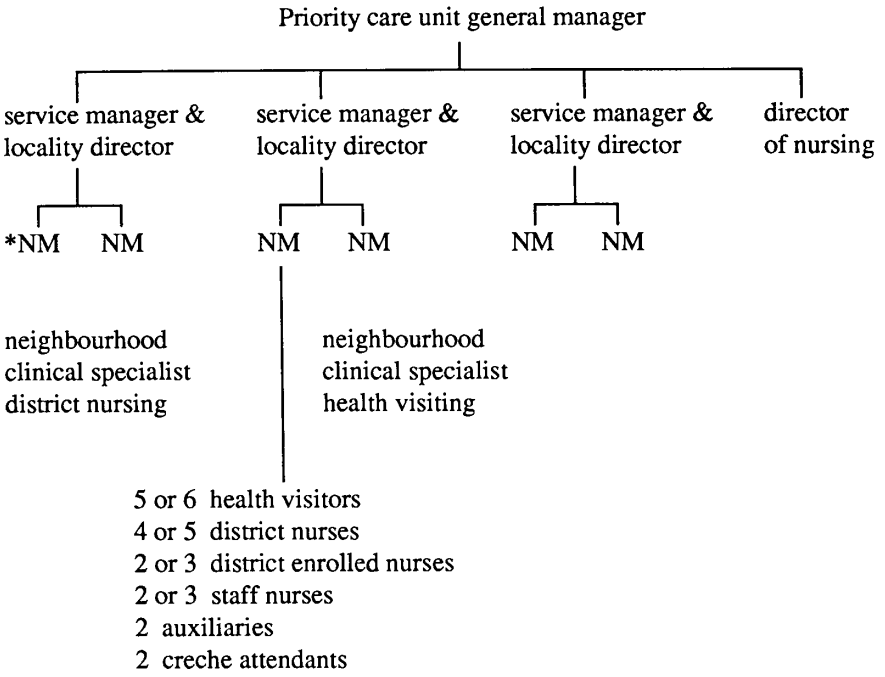
- promote mutual understanding and respect among staff;
- develop good practice in their own discipline;
- encourage specialist knowledge among fieldworkers.

These nurses are called neighbourhood nurse specialists and 100% of their time is spent on clinical issues. Their job descriptions identify three key functions in relation to their own discipline: providing professional support and advice; advising neighbourhood nurse managers on practice and development; and setting and monitoring standards. They also supervise students, are involved in recruitment and inservice education, play a role in service planning and in addition carry a caseload.

The nurse specialists are currently:

- establishing philosophies for their disciplines. This involves working with task forces setting standards for health visiting, district nursing and school nursing.

West Lambeth Health Authority:
structure of community nursing services



and attached but not managed,

1 midwife
1 community psychiatric nurse

* NM - neighbourhood manager

- changing staff attitudes, for example by holding monthly neighbourhood meetings with an emphasis on reporting new developments; exercises in team building; establishing quality circles; encouraging specialist interests relevant to needs identified in the neighbourhoods.

- building neighbourhood teams with an emphasis on maintaining existing good primary health care teams and identifying potential new ones.

To build a neighbourhood service two new tools are essential: an accurate neighbourhood health profile and proper facilities to collect and feedback data. Staff have begun to gather useful population and epidemiological data from the census and other sources as a first step towards compiling health profiles. Caseloads are also being analysed. Health visitors now divide their caseloads into groupings such as – number of antenatal mothers, children under one year, one parent families, children with special needs, and children at risk. District nurses now examine the dependency of each patient and have an index of known diabetic patients and AIDS patients. School nurses collect statistics on children with special needs and children on the child protection register. Comcare is used to gather Korner information in West Lambeth, but feedback from the system to neighbourhoods has not yet been fully implemented.

Initiatives that have been taken by neighbourhood teams include developing health promotion groups and setting up new clinics. Health visitors and district nurses participate in 'Age Well' clinics and groups, and health visitors and CPNs have set up postnatal support groups and groups for depressed mothers. Attitudes are changing and staff are beginning to develop a neighbourhood identity. It has yet to be shown that services have improved, but a framework for achieving that goal has been established.

Contact

Mary Magowan, Child and Family Services, West Lambeth Health Authority, South Western Hospital, Landor Road, London SW9, tel 071 733 7755.

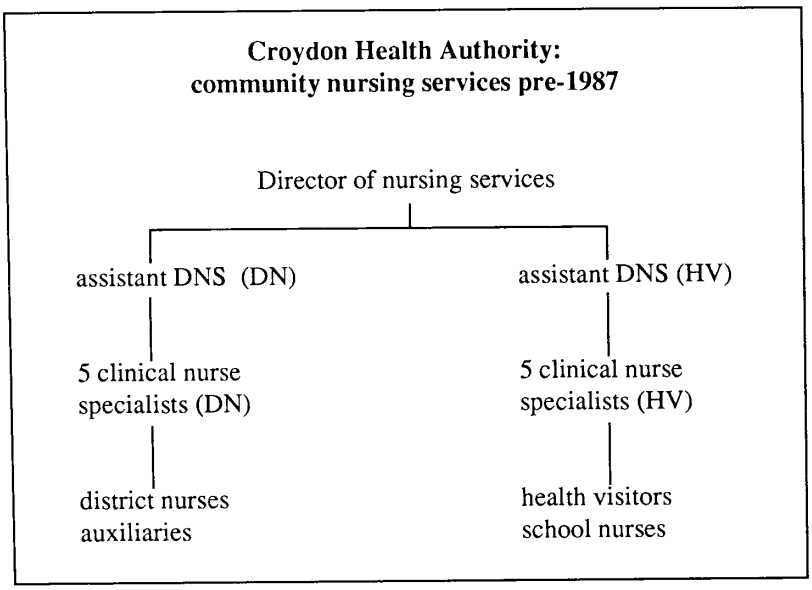
Resources

Job descriptions for clinical specialists in school nursing, district nursing and health visiting.

The Croydon experience of neighbourhood nursing

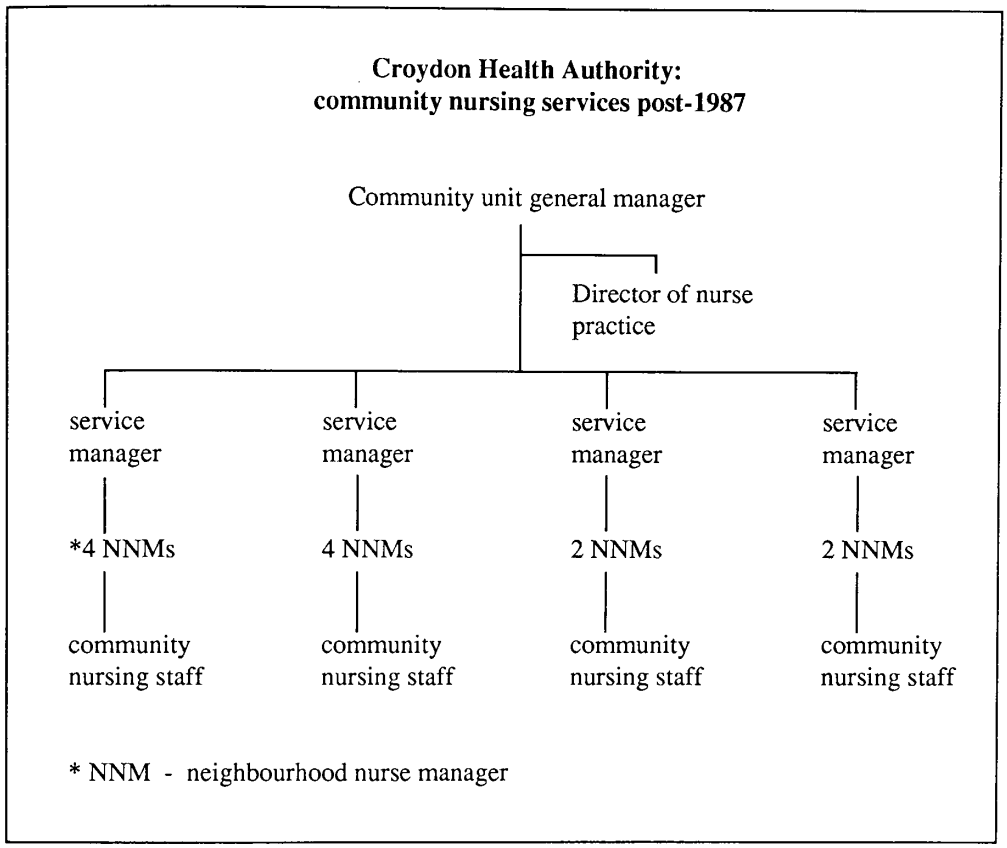
In 1987 community nursing services in Croydon were reorganised into neighbourhood nursing teams along the lines described in the Cumberlege report. This change has had many positive effects: including broadening the outlook of nurses and health visitors; increasing joint discussion of issues; and giving more attention to local needs. On the negative side, neighbourhood nurse managers must find ways of overcoming feelings of isolation among district nurses and clarifying for staff the distinction between professional advice and general management. The consensus, however, is that the changes have benefitted staff and helped to improve services.

Croydon Health Authority is on the southern edge of Greater London and has a population of approximately 300,000. Before 1987 its community nursing services were organised traditionally, with a separate management hierarchy for each discipline, as shown below.



The assistant directors of nursing services were each responsible for five nurse specialists. In health visiting the nurse specialists managed 30-35 health visitors and in district nursing 50-60 nursing staff. Although nurse specialists in each of Croydon's five areas were based in the same building, the health visiting and district nursing services worked separately, with little communication between them.

In 1987 the services were reorganised on a neighbourhood basis, as recommended in the Cumberlege report. This was done in the hope that management would be brought closer to patients and better patient care would result from increased professional cooperation and integration of services at local level.



There are now four areas, each with a service manager (general manager), and 12 neighbourhoods, each with a nurse manager who is responsible for all community nursing staff working in the neighbourhood. As well as managing these staff, the neighbourhood nurse manager's job description includes giving professional advice to another neighbourhood nurse manager with a background in a different discipline. The tasks undertaken by neighbourhood nurse managers also include: building up knowledge of local services; giving professional advice; supporting and appraising staff; attending case conferences; identifying training needs; monitoring standards; maintaining clinical expertise; liaison with local GPs, social services and voluntary organisations; publicising services; and making contact with service users. Individual performance review has been introduced recently and neighbourhood nurse managers now have objectives to meet.

So far neighbourhood nurse managers have initiated activities such as: preparing publicity packs about local services; organising open meetings for consumers and clinical meetings with GPs and practice nurses; giving voluntary organisations space in clinics for their activities; supporting carers and the bereaved; and planning a multicultural resource centre.

Neighbourhood nurse managers consider that the new structure has: broadened their outlook and made them less blinkered; increased the scope for shared discussion on important issues; made them more aware of the roles of nurses in other disciplines; helped them to take a holistic

approach to health throughout the lifecycle; made it easier to identify the needs of a neighbourhood; created less confusion for the public; made working with social services simpler; and given the impression of less people, more individuality and more time.

On the negative side, some staff groups feel isolated from colleagues, for example district nurses who used to work in large groups of 20 or more and now work in teams with three to five members. Attempts are being made to overcome this by organising single discipline meetings for staff from two or three neighbourhoods. Staff also continue to need clarification of management arrangements. There is often confusion about whether an issue should be dealt with by a line manager or professional adviser. Staff are encouraged to discuss with their line manager the most appropriate source of professional advice and managers are responsible for giving advice themselves or seeking it from a colleague of a different discipline.

Croydon has made much progress since the introduction of neighbourhood nursing. Nurses in the teams are encouraged to work together to identify local health needs and to provide appropriate services for their neighbourhood. Another focus for activity has been promoting primary health care teams and building effective working relationships with GPs.

Contacts

Hazel Harrison and Christine Simmons, Neighbourhood Nurse Managers, Croydon Health Authority Community Health Unit, 12-18 Lennard Road, Croydon, Surrey CR0 2UL, tel 081 680 2008.

Resources

Job descriptions for service managers, neighbourhood nurse managers, and the director of nurse practice. Various policy papers concerned with neighbourhood nursing.

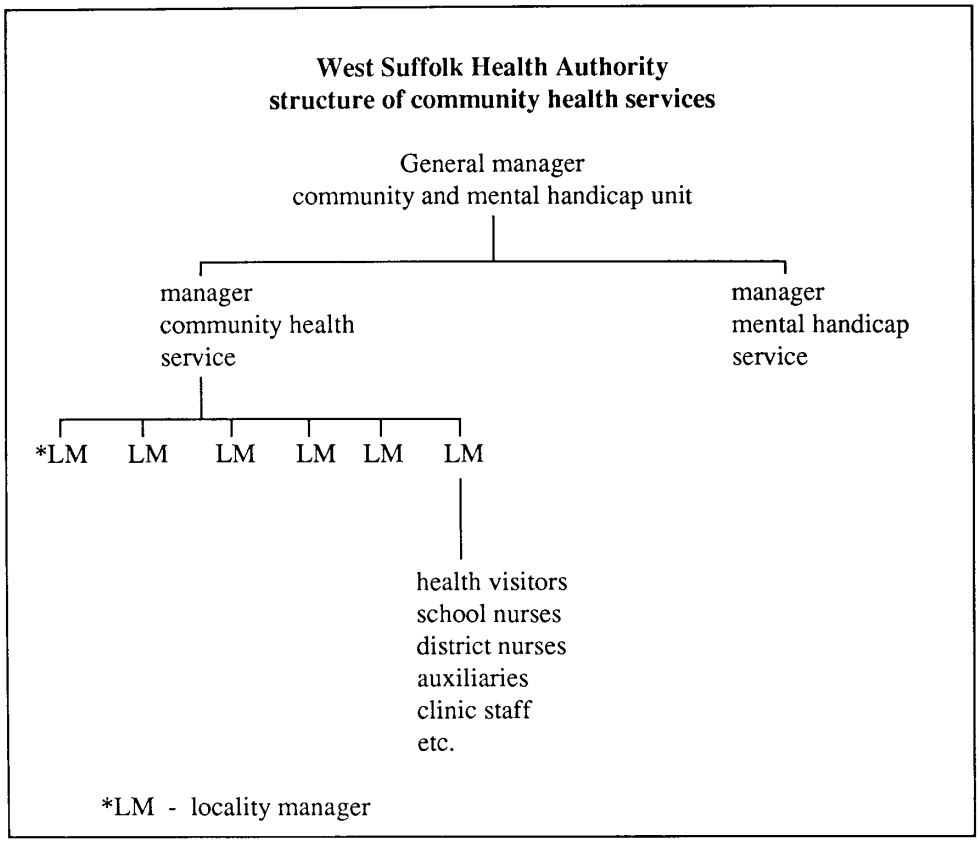
Locality management – West Suffolk style

In 1986 community nursing services in West Suffolk Health Authority were reorganised into six localities, headed by locality managers who have backgrounds in community nursing. The goals were to improve the quality of health care and involve the local community in planning and provision of services. The process of change involved setting objectives, identifying potential problems and taking action to avoid them. The locality managers have taken a number of initiatives including: liaison with GPs; developing locality profiles; organising multidisciplinary 'change' days; and evaluating the new structure. Commitment to locality management is increasing as staff and the public become more aware of the benefits it can bring.

The process of consultation about the new structure for community services in West Suffolk was purposely lengthy and included all grades of community health staff, other organisations and GPs. The localities in West Suffolk are based on the populations served by primary health care teams, so the structure is rather different from that recommended in the Cumberlege report. However, the aims in terms of integrating services and improving patient care are very similar. They are to:

- organise the delivery of all health services so that a comprehensive, integrated network of care is established in each locality;
- establish and clarify formal lines of communication within the health services and with other organisations;
- coordinate the activities relating to health care carried out by the community and by statutory and voluntary agencies;
- to work in partnership with relatives and carers;
- to provide support so that those living in the community maintain as high as possible a quality of life, whatever their health status, and avoid unnecessary admission to hospital.

The population of West Suffolk Health Authority is 228,000. The six localities have populations of 26,000 - 50,000. The locality managers are responsible for managing community nursing and health clinic staff (approximately 20-30 in each locality) and are accountable to the community health services manager. They also have a coordinating role with other community unit staff, including school and child health doctors, speech therapists and chiropodists. They must ensure that services match the needs of the community and are developed in close liaison with other community health services and are compatible with services provided by GPs, hospitals, social services and community agencies.



The new locality managers identified four potential problems: their access to professional advice; the need for management training; the danger of isolation; and professional support for staff and updating of professional skills. Preventive action was taken by:

- identifying an experienced health visitor and district nurse in each locality, on whom the manager could call for professional advice. The advisers are often used to 'act up' for managers and enjoy their role, seeing it as career development.

- organising multidisciplinary training courses; a three day team-building course; attending training sessions outside the district; and 'time-out' sessions as a group at least twice a year.

- all six managers meeting informally every month, to share information and to give each other support and advice.

- staff from each discipline in the district as a whole meet at least twice a year to discuss current professional issues.

One of the main tasks for locality managers has been to foster collaboration. Quarterly locality meetings provide an opportunity to invite colleagues, including staff from other units in the health authority, practice nurses and matrons of residential homes. GPs have been visited regularly by locality managers. The response varies but many have commented that dealing with one local manager is easier and decisions are made more quickly. Slowly barriers are breaking down and in some practices the managers are being seen as members of the primary care team.

Other initiatives include:

- developing locality profiles by gathering data of all kinds, including information from field staff, colleagues in other agencies and service users. Profiles of services for elderly people are being compiled to help identify gaps and needs.

- organising 'co-operation for change' days to bring together representatives from all the agencies working in the community to look at ways of improving services and collaboration. Outcomes include support groups, a volunteer bureau, a feasibility study for a day centre, and most importantly a commitment to continuing cooperation. More days to discuss particular topics are planned.

- appointing specialist nurses to advise, train and support staff. West Suffolk is a second generation site for community resource management and a training officer has been appointed to work with staff and managers and to ensure that training needs identified by individual performance reviews are met.

- organising a response to AIDS.

Managers recognise that there will be variations between localities. The locality system should not be competitive – it provides a chance to share ideals, ideas and visions of an excellent service. The new structure was recently evaluated and the results were presented at a one day seminar for a wide range of participants, who discussed the recommendations in small groups. The aims of the structure are slowly being achieved. This is still the beginning and the managers feel they have lots to offer, much to learn and good staff to learn with.

Contact

Mrs Mary Chapple, Locality Manager, Blomfield House Health Centre, Looms Lane, Bury St Edmunds, Suffolk, tel 0284 63401.

Resources

Job description for locality manager.

More managers or greater personal responsibility for district nurses?

Implementing the Cumberlege report recommendations on neighbourhood nursing teams would greatly increase the number of community nurse managers in most health districts. A study in Wycombe Health Authority has shown that a change agent outside the management structure who works closely with field staff can help them audit and improve their performance, releasing more time for direct patient care. Helping field staff, individually and as a group, to use information was the key to the success of the project. These findings led the researchers to propose that change agents may be of more benefit to the development of community nursing than additional nurse managers.

The Operational Research Unit of Oxford Regional Health Authority has carried out a number of surveys of community nursing services. A method has been developed to collect information about community nurses' work. Staff keep a diary for four weeks recording all their activities and socio-medical details of their patients. The resulting data is processed by computer and it is surprising to discover that ostensibly similar patients receive widely different care.

During the study a change agent/researcher works with staff as they undertake their normal duties. This provides an opportunity for two-way learning: for the researcher about the job and its problems; and for the staff about the survey and the information it will produce.

The aggregated findings are presented to groups of staff, but confidentiality is respected. Each nurse is given her own 'access' number, known only to her and her manager, so that she can compare her performance with that of her colleagues.

The first study in Wycombe revealed extremely wide variations in performance between staff, within grades and between nursing teams. The reasons are not yet fully understood. It may be due to differences in patient dependency, but as all nurses are allocated to GP practices this seems unlikely. Probably the main reason is that, like the rest of us, some work harder than others. The introduction of a scheme of performance related pay may be the most effective remedy, provided quantity is not at the expense of quality.

A second study was carried out in the same district two years later. Time spent on direct patient care had increased. Each nurse made on average three additional home visits per month, which were not at the expense of the amount of time spent with each patient. The improvement seems small, but it is equivalent to almost three extra staff being employed. Almost all those judged to be poor achievers in the first study improved their performance.

Difference in levels of direct patient care 1985 and 1987		
	1985	1987
% contracted hours spent in direct patient care	55.9	58.0
average number of home visits per day	9.1	9.3
average duration of visits (minutes)	25.0	26.4

Change rarely happens spontaneously. Overcoming inertia requires enormous amounts of energy and real commitment, without which any exercise will fail. An information broker, or change agent, can help by understanding problems, designing an acceptable survey and interpreting the results.

Introducing new structures without attention to helping field staff to change and improve their practice is not likely to result in better quality services. Community nurses make independent professional decisions about patients and their needs. Because they work on their own initiative hierarchical managerial supervision is likely to be less effective than providing information about performance and an environment in which each member of staff can learn from his or her own action and that of colleagues. Coordination and monitoring of performance, traditionally a role of managers, can now be done effectively by computer technology. The challenge is to provide field staff with knowledge and information to enable them to develop individually and as a group. Instead of creating new structures with additional managers it is suggested that district nursing staff are organised into small groups and given the opportunity to learn from their own experience and that of other members of the group.

Contact

Sheila Rogers, Operational Research Unit, Oxford Regional Health Authority, Old Road, Headington, Oxford OX3 7LF, tel 0865 64861 ext 444.

Resources

Three reports giving more details of the study described here and others are available from Oxford Regional Health Authority:
Focus on district nursing (1986) by Sheila Rogers and DNs.
Focus on community psychiatric nursing (1988) by Sheila Rogers and CPNs.
Focus on health visiting (1989) by Sheila Rogers and HVs.

Reference

Rogers, S, Barr, L. Organisation of community nursing services. *Health Services Management,* August 1988, 80-81.

Section 2

Managing resources, identifying needs

Managing resources, identifying needs

Using resources effectively and efficiently to meet the health needs of the population is a longstanding concern of managers in the NHS. Many recent developments in community health services involve managers and professionals working together to achieve this aim. A central theme in this section is the importance of information in the quest for quality – information about services that are being provided and about the health needs of the population. Information is a tool that can empower community nurses and their managers – it can be used in planning action to improve service quality and in assessing whether the action has been successful.

Unfortunately, many nursing teams and their managers do not have the accurate and detailed information they require to evaluate the quality of services they are providing. Faced with inflexible information systems and irrelevant or incomprehensible data many nurses have gathered information themselves and used it as a basis for identifying needs and priorities.

In contrast, the Department of Health's resource management initiative began with large investments in information systems. Wendy King's keynote paper describes the progress of resource management in the community. Information for resource managers and the systems necessary to provide it are among the basic requirements for successful resource management. However, the paper illustrates the dangers of placing too much emphasis on gathering information, at the expense of working out how it is to be used. Information technology dominated the first stages of the initiative and in some respects limited progress. More recently, the balance has been redressed and greater attention is being given to the process of resource management, particularly involving and supporting managers in setting objectives and workload targets.

The case study from Halton Health Authority, a second generation site for resource management, illustrates some achievements of the initiative. It shows how accurate, well-presented information can help nursing teams decide whether they are working effectively and using their skills appropriately. Most important of all, nurses empowered by information can monitor their performance and evaluate progress towards meeting objectives that they have set for themselves.

Health visitors and district nurses in a pilot scheme of neighbourhood nursing teams in Hillingdon are responsible for identifying the health needs of the population. They have begun to develop health profiles, collate information about local resources and set targets in discussion with all members of the health care team. Starting from scratch with little assistance was a difficult task, but compiling the profiles has brought changes and benefits, including more interdisciplinary working and greater flexibility of services.

Low immunisation rates in one area in West Birmingham stimulated a review of child health services, particularly their accessibility and acceptability to local people. In response to suggestions from fieldstaff who knew the area and its population well, clinic sessions were reorganised to make them more accessible and friendly, and the changes were publicised. Improvements in immunisation rates demonstrate the success of the initiative.

The theme of identifying and responding to needs is continued in the final report in this section. It is often assumed that a huge'pool' of need exists that is unknown to health professionals, who fear that they may never be able to meet it fully. Researchers from Oxford RHA decided to look

at this question directly. They carried out a household survey to discover people's health needs, with the particular aim of assessing how well community nursing services were performing. The results are reassuring – very little unmet need was found – but the researchers consider it would be useful to continue to monitor needs in this direct way to help plan services and target resources.

Planning quality care in the community: the effective utilisation of resources

Wendy King

This paper discusses the Department of Health's community resource management initiative, the aim of which is to find ways of using resources more effectively. It shows that while a great deal has been achieved there is still some way to go before we can confidently plan quality care in the community.

The community resource management initiative

Since the inception of the NHS there has been concern about competing pressures on limited health service resources. The current Department of Health (DoH) initiative has its roots in the 1983 Griffiths report on NHS management[1] which found a number of problems. There was: no real evaluation of performance; an absence of objectives and targets; no measurement of output in terms of quality or quantity of services; very little evaluation of the effectiveness of clinical care; and even less economic evaluation of services.

It recommended that managers should try to set objectives for the service and to define a means of measuring actual performance in relation to those objectives. In response the DoH funded a pilot project which commenced early in 1985. It was initially concerned primarily with the introduction of management budgeting to community units. Two pilot sites were established – in Bromley and Worcester health authorities. They were finance-led, systems-driven and consequently remote from the day-to-day management of services, their main aim being to cost community health care. Despite the strong finance and systems orientation, they did yield some important benefits – not least showing that it was possible to measure community care and that the effort was worthwhile.

In November 1986 the DoH published a health notice, HN(86)34,[2] which outlined the future extension of resource management, first to a limited number of second generation sites and then to all remaining community health service units, giving target a date of 1991.

The current list of second generation sites includes Blackpool, Bradford, Brighton, Coventry, Halton, Leeds Eastern, Newcastle, Oxfordshire, Plymouth, Portsmouth and West Suffolk health authorities. The initiative was renamed resource management to reflect the change of emphasis away from financial systems towards the management of resources. In the community this effectively means the management of staff time. The revised aims of the initiative are to assist community managers to:

- identify needs in the community and establish priorities to achieve the most effective deployment of resources to meet those needs;
- establish specific targets for individual managers and staff;
- establish budgets for individual managers based on agreed workload;

- monitor actual performance against targets and take action where necessary to keep within the plan.

Criteria for success

There are three basic elements that are required for the success of the initiative and they have been given priority in the second generation sites. First, there must be clearly identified resource managers to whom budgets are devolved. This should be to the lowest possible level, whether to community managers or clinical managers. Managers must know what their budgets are, be accountable for them and be allowed to vire within their budgets. There is no point in devolving budgets and encouraging staff to use resources effectively if savings made to develop services are taken back by districts.

The second element is the budgetary process, with emphasis on moving away from historical budget setting to workload-related budgets. Thus managers are required to assess health care needs in order to determine the resources required to deliver a particular level of service. This implies an agreement that managers meet objectives, account regularly for performance so that progress towards objectives can be assessed and take corrective action if necessary.

The third element required for success is information systems that will report to resource managers the information they need to participate in the resource management process. Information systems should be used to support the process of changing management cultures, including changing traditional views of community services and their delivery. However, for a variety of reasons, not least the requirement to implement the recommendations of the Korner report, work in some of the pilot districts has been dominated by the development and implementation of information systems.

Problems with information systems

A key problem for the resource management project was the short time scale for the implementation of the Korner recommendations. Although the Korner reports acted as a springboard for the introduction of information systems, the tendency was for districts to rush to implement a computer system without sufficient planning and preparation. Consequent difficulties were: a lack of technical support; poor preparation of staff; and the belated discovery that the chosen system was inappropriate or that it could not provide the required feedback or output.

The focus of Korner implementation was to collect minimum data sets to meet the Department of Health deadlines. Very little thought was given to the staff involved in the process, both those who were collecting the data and those who were required to use it. Staff who are not fully informed about the purpose of the information systems and what they actually do may be left feeling that importance is being placed on clerical work at the expense of patient care.

Korner promised an improved information base, more informed decision making, more effective use of resources and a better service for patients. However, the outputs provided from the systems had little obvious application to the way services were delivered and the way

community staff were working. The greatest fear of all was 'nursing by numbers'. There was a tendency to use the information that was available – numbers of activities carried out by district nurses and health visitors – which gave little indication of the services patients were receiving or what they should have been getting, and said nothing about those who were not receiving any services at all.

Another problem with the systems being implemented is that they were seen as sufficient to meet the information requirements for resource management. However, it was realised early on that to manage resources effectively additional information was required, including:

- neighbourhood profiles – to give an assessment of the community to which health services were being delivered;
- analysis of resources – including staff numbers and skill mix, the use being made of buildings and other physical resources, and voluntary services and other community support;
- service targets – specific workload targets against which achievements can be measured;
- costed activity data – in terms of money or staff hours;
- an objective means of classifying patients' dependency;
- objective measures of outcome.

Work on the first four items on the list could begin now in any health authority with sufficient staff time, but the last two are obviously much larger undertakings. To date, the resource management project has tackled the classification of dependency but has not yet looked at measurement of outcomes.

As part of the resource management initiative, the Department of Health has sponsored the development of a dependency classification system for district nursing patients. A great deal of work had already been done on this topic but much of it was found to be unsatisfactory for the project, which aims to assess workload requirements, taking into account patient needs, input by carers, voluntary services, local authority services, etc. The final methodology should be appropriate for other professions working in the community. Once a dependency classification is formulated, attention will be given to measuring the outcomes of care.

Benefits from the project

Despite all the work that remains to be done, the pilot districts have made a great deal of progress. Simply by becoming part of the resource management project, communication between staff, with other units and with GPs has improved. Fieldworkers have become more involved in management decision making.

The projects have also identified areas of waste and inefficiency, although it is important to recognise the point at which more time and resources are needed to eliminate waste than are

saved in the process. Resource use has definitely been improved, particularly in the ways that staff are deployed and used. For example, a health authority assessed the needs of its three areas and tried to match staff numbers and skills to those needs. One area had district nurses excessively involved in unskilled tasks. Consequently, when vacancies arose the skill mix was changed.

Traditional practice is increasingly being questioned, particularly in health visiting, and interest in researching aspects of practice has also grown. This has been helped by the introduction of information systems that enable staff to collect additional items of data. Most of the research has been into traditional areas of community practice, such as breastfeeding patterns and leg ulcer treatment, but there is scope for this to expand.

It was the project's intention to involve GPs, not least because they are gatekeepers to some services and determine how resources are used. However, GP involvement has not been as great as the project team would have liked, although there are some outstanding examples, including a health centre in Halton Health Authority where GPs are using data as fully as many community managers.

These are the benefits and successes that have been achieved with only partial implementation and without full information. With measures of dependency and outcome there is the potential to make even more progress towards delivering efficient, effective and economic community health services.

Many districts are now proceeding with the implementation of resource management and the necessary supporting information technology. Rapid progress has been achieved, although districts have been slower to use data to set workload targets, monitor workload and establish levels of resource input. The keys to success are full involvement of managers at all stages of the project and provision of appropriate education and experienced facilitators to support them.

References

1. Department of Health and Social Security. *NHS Management Inquiry.* (Leader of inquiry Roy Griffiths), 1983.
2. Department of Health and Social Security. *Health services management.* Resource management (management budgetting) in health authorities. Health Notice HN(86)34, November 1986.

Further reading

King, W. Targeting community resources, *Health Service Resource Management.* Supplement to the *Health Service Journal* 1 June 1989, 5-7.

King, W (ed). Ernst and Young, Managing resources in community health, 1989. (Available from Mercia Publications, The Science Park, University of Keele, Keele, Staffs ST5 5BG.)

The end of the beginning: resource management in Halton Health Authority

The experience in Halton is that the emphasis of resource management initiatives, at least initially, should be on people rather than on money. Local ownership of objectives and information systems is essential to ensure reliable information and the success of the scheme. In community nursing services the approach has been to make gradual changes with total staff involvement from the beginning. District nurses and health visitors are setting objectives for their work and deciding priorities for using their time effectively. A locality system for managing services and resources is being developed. While progress has been great, these achievements might be considered only 'the end of the beginning' in terms of resource management.

Good resource management depends on local ownership of objectives and information systems geared to monitoring those objectives. The system should not be imposed from above. It is better to adopt a philosophy of gradual cultural change with staff involvement from the outset. This facilitates ownership, stimulates staff interest and maintains enthusiasm.

Halton's information system

Halton used the 'stepping-stone' approach to introduce a system that is user-friendly, flexible in application and capable of development in step with local experience and technological advances. Initially, the COMWAY 1+ system was implemented, which is staff activity/output based. To introduce a patient-based system would have been too much of a culture shock at the time of implementation in 1986/7, but COMWAY II, a patient-based version, is available and will be introduced in the future.

As well as meeting professional, statutory, Department of Health and Korner requirements, the system is able to provide information identified by managers and staff as important for them to manage their resources more effectively and efficiently. An exciting recent development has been to extend the system to two general practices.

The information system is used to identify what each member of community health staff is doing, to whom, where and with what outcome. It has established a baseline and an appreciation of productivity related to time spent by staff groups and levels of skill. So much information is being produced that the immediate challenge is to ensure that it is made available selectively in response to managers' needs and presented in a format that is easily understood to help accurate interpretation. This challenge should not be underestimated because the majority of managers are not used to dealing with such information. Training for them is essential if the full potential of the system is to be realised.

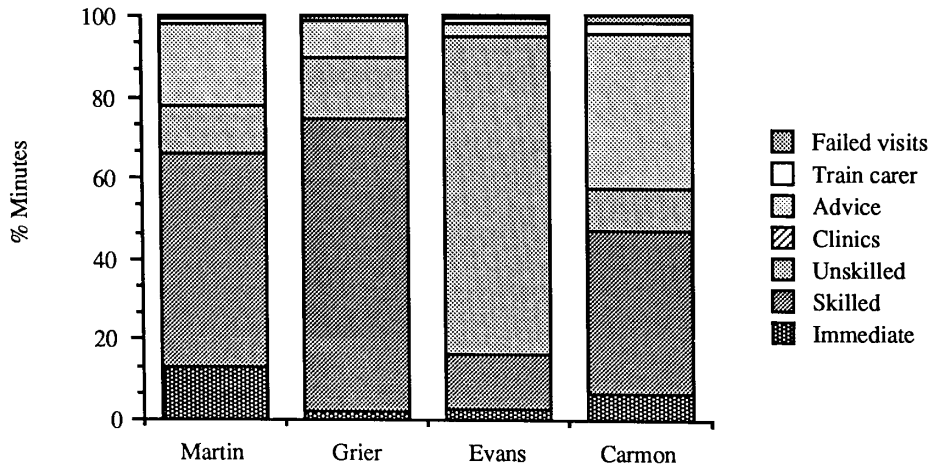
To assess whether resources are being targeted correctly to meet clients' needs information about service provision is supplemented by computer mapping of socio-economic and demographic data, hospital discharges and general practice population profiles. Technology only takes this process so far. It must be linked with decision-making and a simple model for setting objectives is being developed.

The nursing experience

It is essential that district nurses and health visitors set priorities in their work and use their time more effectively. In the past broad service objectives have been set for the district as a whole. Halton is now moving gradually to primary health care teams setting their own objectives.

As a starting point workshops were held for each primary care area in the district. Staff defined their main tasks, determined how much time they spent on various activities, examined factors which influenced their work, and produced objectives to achieve an agreed balance of activities. The workshops showed that district nursing work could be divided fairly easily into five categories: immediate, skilled, unskilled, advice, and support/training of carers. Since the Halton information system is activity-based it is fairly simple to allocate each activity code to one of these categories and analyse nurses' workloads.

The resulting information was presented to staff in a punchy, graphic format. A bar chart showed the percentage of time a nurse spent on each of the five categories of work. The staff themselves decided whether this was appropriate to their grade and whether the skills of the team as a whole were being used properly.



One team decided what percentage of time should be spent on each category of work, given their grades and skills. This is the objective they are now working towards. Progress can be measured and monitored by comparing actual performance with the objective.

Beyond the beginning

Locality management in community nursing is being developed based on groups of two or three general practices, giving a maximum catchment population of 20,000. Each of the 'grouped practice teams' will have a manager responsible for approximately 12 staff and resources dedicated to their patch. There are also initiatives on: sharing information with other agencies; producing small area data profiles; and making information financial by direct computer links to financial systems.

Contacts

Pat Taylor, Manager, Community Nursing and Pre-School Health Services, Community Unit, Halton Health Authority, Victoria House, Holloway, Runcorn, Cheshire WA7 4TH, tel 0928 714567 ext 4153.
Brian Lowey, Service Development Manager, Community Unit, Halton Health Authority, Victoria House, Holloway, Runcorn, Cheshire WA7 4TH, tel 0928 714567 ext 4152.

Resources

Information about COMWAY; examples of information fed back to staff.

Identifying needs and producing health profiles in Hillingdon

In Hillingdon Health Authority health visitors and district nurses in three pilot neighbourhood nursing teams are responsible for identifying the health needs of their local population. They have begun to build up community health profiles and collate information about local resources – using this as a basis for setting annual targets and plans. Introducing the new approach has not been easy, but it has brought changes and benefits, for example more interdisciplinary working and greater flexibility in the way services are offered. One of the most important lessons is that the team at field level needs to 'own' their pilot scheme to make it work. Creating their own database and resources helps to build that sense of ownership.

For many years community nursing staff in Hillingdon Health Authority had been following guidelines and policies imposed by managers who did not work in the neighbourhood. Their work was seen in terms of tasks. Recording numbers of home visits and 'box ticking' had been carried on with little thought as to whether the care given was effective and acceptable to clients.

In January 1988 a decision was taken that has changed the way community nurses approach their work. Three pilot neighbourhood nursing teams were set up, to run for three years. There is a primary health care team model, a health centre model and a health clinic model. In all three teams the health visitors and district nurses are responsible for identifying the health needs of the population. They have begun to build up information about the health of the population and its needs and to make plans for services in the neighbourhood.

A specialist in community medicine met nurses' requests for population data and other statistical information. However, the information they obtained was of limited use – only census data, mortality rates and some morbidity data are available at local level. This was frustrating until the nurses realised that they had data on their own files about the many groups that used the health clinics. GPs age/sex registers are also a valuable source of information if nurses are allowed access to them.

Using information collected by its members, the neighbourhood team decides to concentrate on certain health issues and sets one or two targets for the year, for example increasing the take up of immunisations. The process of setting targets requires discussion with all those involved: the doctor, health visitors and clerks. Once a target is agreed by everyone a statement is made and reviews are held every three months to check progress. These meetings help the team to identitify any obstacles to achieving their target and allow them to refine their plans. A team may set several targets but they should be realistic in terms of time and resources.

Recognising unmet health needs is also important. For example, one neighbourhood has many children with asthma who are receiving hospital treatment. The nurses felt that a local support group might help the children's families find better ways of coping and reducing the frequency of attacks. The team was also interested in looking at the factors that might have contributed to the high prevalence of asthma in the neighbourhood.

Management issues

Once the pilot schemes were underway, manpower planning became an issue for the neighbourhood teams. The amount of extra work generated by identifying health needs had not been anticipated. Because staff found it difficult to relinquish traditional tasks, anything new was added to the existing heavy workload. Some plans, for example sessions for screening elderly people, came unstuck because there were not enough staff to cover them.

Field staff made claims that staffing levels should be increased to give clients a quality service, but they had to prove the need for more staff to the managers. What kind of staff were required? Did all the work have to be done by trained health visitors and district nurses, or could the skills of other team members be used more fully? In one team, examination of existing workload revealed that employing a clinic assistant would help to relieve some of the strain. The assistant, a nursing auxiliary, helps with postnatal group work, baby clinics, clerical work and filing.

More flexibility in the way services were offered was found to be essential. For example, to achieve the target of increasing immunisation rates, a team needs to have the capacity for opportunistic immunisation of children who attend clinics infrequently. Well women's sessions are another example. If the district nurses and health visitors in the neighbourhood team took over these sessions from the nurse who normally came in to do them, they would see women from families with which they already had contact.

Problems and prospects

One of the problems with developing community health profiles in Hillingdon was that the nurses had no-one designated to help them. Collecting relevant information and analysing it takes time and the nurses felt it was time taken away from their clients. Many nurses had received no training in research methods and interpreting data. Team-building workshops provided some of the support they needed. The workshops enabled the nurses to discuss a working philosophy and to gain the confidence and skills needed to compile a neighbourhood profile and identify health needs using a basic research approach. A senior nurse (development) post would have been a valuable asset to the teams through these stages.

Anxiety and stress nearly jeopardised the project. The nurses needed time to explore the positive and negative aspects of changes to their working practice. Very early on they realised that working as a team was essential. In the past there had been very little communication between health visitors and district nurses, but compiling the community health profile brought them together in a joint venture. One of the most important lessons learnt was that the team at field level needed to own the pilot scheme to make it work. Creating their own database and resources helped to build that sense of ownership.

The pilot schemes have been running for eighteen months and each of the three teams is evolving differently. The neighbourhoods have different needs and what works in one setting will not necessarily work in another. There are times when the nurses wonder what they have gained from the community profile because obtaining information has been so frustrating, especially for field staff who already have a full-time job providing a service. There has been very little feedback from service users, who rarely complain or say what they think about

services. The teams are now planning how to tap users' views and they have tried some client questionnaires. Early results indicate that people would value more knowledge about their health.

Contact

Jean Rowe, Senior Nurse (Health Visiting and School Nursing), Hillingdon Health Authority Primary and Community Health Care Services, Peel House, Kingston Lane, Uxbridge, Middx UB8 3PL, tel 0895 58191.

Resources

A guide to information that can be gathered for an 'information and resource file' (about the local environment and facilities/services available); and to analysing health visitors' and district nurses' records to look at different categories of clients. This can be the beginning of a neighbourhood profile.

The neighbourhood nursing schemes will complete their three pilot years in January 1991. The results of the evaluation will be available after that date.

Responding to consumer needs: the Highgate immunisation project in West Birmingham

Adopting a consumer-orientated approach means tailoring services to meet the needs of the people who use them. An illustration of this comes from West Birmingham Health Authority where a project was carried out to increase the uptake of immunisation on a housing estate in a typically deprived inner city area. It started after discussions with local health visitors revealed that parents on the estate had difficulties getting to the nearest clinic because of hills and dual carriageways which are awkward for a pedestrian with a pushchair to negotiate. Clinic sessions were set up on the estate and were publicised. Immunisation rates have greatly improved because of the scheme. However, to maintain such good results the impetus of the project must be kept up because the estate has high mobility rates.

This project was designed to improve the uptake of immunisation in an area where the response to traditional health service provision had been poor. The project team was a full-time health visitor funded by the Birmingham Inner City Partnership, which includes the city council and the health authorities, and a senior clinical medical officer (SCMO). The project lasted for three years, from 1985 to 1988.

The uptake rate for immunisation at the nearest clinic to the estate was only 26.1%. Thirty seven per cent of children were known to have completed the full primary immunisation course (diphtheria, pertussis, tetanus and polio) and only 22% had completed the full primary course and measles immunisation.

The project team decided that these figures might be improved by:

- doing immunisations locally on the estate;
- making the sessions informal – taking them out of the medical setting, reducing queuing to a minimum and generally making them less like a 'cattle market';
- making it possible for the health visitor to arrange appointments;
- making any waiting time involved as pleasant as possible for parents and children.

A meeting was held in the nursery school adjoining the estate to consult with managers, child health staff and the local health visitors. The head of the nursery school recognised the problems on the estate and was very keen to work with health service staff. The annexe of the nursery school was used for various activities and it was agreed that immunisation sessions could be held there every fortnight, overlapping with a mother and toddler group.

All children who had not completed their immunisations were asked to come to the sessions. Children could also be weighed and measured and routine eight-month hearing tests were done there. The health visitor was present to welcome parents and to give general advice. The doctor answered parents' questions. The new session was publicised by leaflets and posters produced by the health promotion department, which were distributed by health visitors and the school.

To gauge how the scheme was being received, parents were encouraged to fill in a short questionnaire when they attended the sessions. All parents commented on the convenient location. None came purely as a result of the leaflets or posters. After six months 47.5% had come following a visit from their health visitor. At this stage it was noticeable that many of the primary immunisations being done were very overdue: 55% were done on children aged two years or over. The table summarises the project's achievements.

Highgate Immunisation Project

	Before the project	After 6m	After 1yr
% children completed full course DPT & polio	37	55.7	70
% children completed full primary course + measles	22	41.8	53
number of children having primary course imms from			
GP	10	11	25
clinic	1	24	26
number of children over 1 year who had no imms	18	12	7

A survey revealed that after six months about 20% of children had moved out of the area and about the same number of new children had moved in. This high rate of mobility may account for the difficulties the health authority's immunisation department has in keeping records up to date. The project team also believe it is important to provide parents with adequate record cards. Some parents had no idea what immunisations their children had received.

Because of the project's success, after its three-year term had ended the health visitor was assigned to the nursery school. Groupwork with parents has continued on topics such as women's health and coping with children's behavioural problems.

Contact

Linda Evitts, Assistant Programme Manager Children's Services, Family and Preventive Services Unit, West Birmingham Health Authority, Carnegie Centre, Hunters Road, Hockley, Birmingham B18 1DR, tel 021 554 3899 ext 219.

Resources

A report of the project and copies of job descriptions are available.

Unmet need – fact or fiction?

Demand for community nursing care is often compared to an iceberg. The tip above water is likened to needs which are already identified and being met by services, and the much larger part underwater represents needs that are as yet unknown. The assumption that there is a huge amount of unmet need was tested in Wycombe Health Authority by researchers from Oxford Regional Health Authority who surveyed a random sample of households in the district. Very little unmet need was discovered and much of it could have been met by a domiciliary chiropodist to keep elderly people mobile. There was a demand for well woman/man clinics, perhaps because of recent publicity. Compliments about services far exceeded critcisms. Although community nursing services appear to be meeting almost all needs in the district, it would be useful to establish a continuing periodic household survey to assess the use being made of services and how demand is evolving.

Oxford Regional Health Authority has carried out a considerable amount of research into community nursing. A great deal of information has been collected about the care being provided, but little is known about needs that are not being met. A study was therefore undertaken to measure unmet need in Wycombe Health Authority.

Wycombe Health Authority is a generally affluent commuter area to the west of London with some pockets of comparative deprivation. The population is 275,000. Staffing levels of community nurses are as good or better than most parts of the country and social services provision is also relatively good.

From recent research in the district a lot is known about the clients of community nurses and the services they currently receive. About 85% of the patients seen by district nurses are over 65 years of age. The majority of their younger patients are chronically sick or terminally ill. Health visitors spend most of their time with children under five, one parent families and ethnic minority families. These patients and client groups are not distributed evenly throughout the district but tend to be concentrated in particular areas. All community nursing staff are attached to general practices, but their deployment does not seem to be related to the characteristics of the population.

There is no universally accepted method of measuring needs. Individual nurses have different thresholds for accepting patients and care regimes can vary widely. Many professionals believe that only they can assess need and that the ordinary person has insufficient knowledge to make a rational decision on his or her own health status.

A pilot study was initially carried out in two adjacent areas of similar size, sex and age structure, but with contrasting social class levels. One hundred and twenty households were selected at random from the electoral register. Half were sent a postal questionnaire and half were interviewed, either by a district nurse or a health visitor who assessed the health needs of members of the household using the same criteria as they would for a referral through the usual channels. The response rate was exceptionally high. In both areas there was similar use of services and virtually no unmet need. Perhaps most surprising of all was that the professionals identified no more need than the postal questionnaire.
Following the success of this small-scale study, a survey of one in ten households in the whole

district was carried out but with reduced professional involvement to prevent disruption of normal work routines. The data has not yet been analysed fully but will be used to provide information about local problems.

Again little unmet need was discovered and as far as possible this has already received attention. Very few additional resources are necessary – a domiciliary chiropodist to keep elderly people mobile would resolve most of the problems. There was a demand for well woman/man clinics, perhaps as a result of recent local and national publicity. Compliments, quite unsolicited, far exceeded criticisms, which were primarily of out-patient services, for example delays in getting appointments and long waits to be seen. In general the NHS seems to be serving its users well. This is pleasantly surprising considering Wycombe's predominantly middle class population, which is articulate and likely to have high expectations of services.

The survey was a 'mini census' which will be a valuable asset for planning purposes. Information about people with chronic illnesses is of special interest to community services, because some of these patients, as yet unknown to district nurses, will require a lot of nursing time in the future.

It is proposed to establish a semi-permanent panel survey (for example 1 in 100 households on a three year rolling basis) to monitor continuously use of existing services and identify the need for others that are not currently available. The information would be analysed periodically to help plan services and target resources.

Contact

Sheila Rogers, Research Officer, Operational Research Unit, Oxford Regional Health Authority, Old Road, Headington, Oxford OX3 7LF, tel 0865 64861.

Resources

Full reports on the pilot and main studies described here have been published by Oxford Regional Health Authority and are available from the address above:

Rogers, S, Barr, A. *Report on a pilot study of met and unmet needs*, 1988.
Rogers, S, Barr, A. *Caring for health*, 1989.

Reference

Barr, A, Rogers, S. A question of meeting needs. *Health Service Journal*, 27 October 1988, 1266-7.

Section 3

Setting standards, reviewing services

Setting standards, reviewing services

The current direction of NHS policy indicates that in the 1990s the level and quality of health services will come under much closer scrutiny than ever before. The NHS white paper has given added impetus to efforts to develop methods of reviewing and auditing services – especially methods that involve measuring and making judgments about the quality of care being provided. These techniques are likely to be refined further as purchasing authorities and service providers begin to negotiate contracts for services.

This section looks at a variety of ways of reviewing community nursing services that are now being used as part of initiatives to enhance quality. The reports describe what is involved and comment on the benefits and drawbacks. All the schemes documented here include establishing explicit criteria against which performance can be measured and progress assessed. They differ, however, in: how the criteria are set, including who decides; the specificity of the criteria; and the monitoring and review process.

In the keynote paper, Helen Kendall describes the West Berkshire programme for setting standards in community nursing services, which has been used as a model by many other districts. The emphasis is on field staff setting their own, very specific, achievable local standards in line with the philosophy of their management unit. The process is seen as positive and developmental. It is a vehicle for introducing new ideas, incorporating service users' views, and motivating staff.

Setting and monitoring standards of care in nursing began as a way of developing professional practice. Standards are now generally considered to be an essential element of quality enhancement, not least because nurses, by reference to standards, can evaluate the care they give to their patients and clients. Belief in the need for standards is growing rapidly in community nursing and many managers and staff are beginning to test the theory in practice.

The new challenge for managers will be to ensure that standards are incorporated into the service contracts that are to be agreed between purchasers and providers. Both parties, and service users, could benefit from specifying how health needs are to be met, building in a method of monitoring quality (including, ideally, measurement of outcomes), and determining the appropriate level of staff and resources. To draw up and fulfil workable service contracts, community nurses and their managers need to learn about standards systems and to gain practical experience of setting and monitoring standards of care.

The short reports in this section describe different ways of reviewing community nursing services. The changes in health visiting that have been introduced in Oxfordshire are discussed in the first report. Managers and representatives of field staff took part in a workshop which reviewed services and devised a new strategy for health visiting. To meet needs more effectively health visitors now compile annual health profiles and set realistic and measurable objectives for their work. A development group led implementation of the changes and staff have been supported by a development worker.

Setting objectives is also a central part of managing and planning community nursing services in Wandsworth, where all staff have individual objectives that are consistent with those of their

neighbourhood team, their professional group and the management unit. Managers and staff are involved in setting and monitoring objectives and related quality initiatives.

In contrast, a small group of experienced professionals formulated a checklist to audit district nursing in Central Nottinghamshire. The checklist was used by an asssessor to measure the quality of care being delivered to a small sample of patients. The study confirmed the belief that quality of nursing care is likely to suffer if nurses have heavy workloads. It also indicated other factors that may influence quality, but these need to be validated by further research. This method of quality assessment produced useful information and highlighted problems, but it had some serious drawbacks that may limit its more general application.

Developing and maintaining standards in the community
Helen Kendall

There is currently intense interest in quality and standards in health care. The impetus for developing standards has come mainly from practising nurses and their managers, but the need for qualitative information now seems to be more widely recognised. The government's white paper, *Working for patients*, will have a profound effect.[1] Reviews and monitoring mechanisms are to be set up throughout the health care system and the new relationships envisaged between suppliers and buyers will require definitions of service quality as well as costs. Utilisation of resources is to be examined in the light of levels of service provision. Descriptions of good quality care must be developed to meet this challenge.

Work on fixing standards in West Berkshire shows that a simple approach is applicable and effective in many different settings and areas of nursing practice. It has been tested at standards workshops in many parts of the country. This paper describes how a system of standard setting can be relevant and useful at practice level, and shows that the agreement of achievable, patient-centred standards can provide a focus for activities which improve care.

Standards and quality assurance

The quality assurance cycle described by Norma Lang has a number of stages: agreement of values through philosophies; identification of standards and criteria; measurement of standards; making interpretations and judgments; choosing and taking a course of action.[2] This model is commonly drawn as a circle and it is important to view it as a continuous process of action, adaptation and redefinition.

The West Berkshire programme for setting standards in nursing was designed to follow this process. Its initial objectives were to familiarise all nurses with the principles of quality assurance, as these applied to their own practice, and to enable nurses to state clearly what they needed to have and to do in order to provide an acceptable level of care which would lead to satisfactory outcomes.[3] To meet these objectives, West Berkshire adopted the approach explained by Donabedian[4] and taken up by the Royal College of Nursing's working party on setting standards.[5,6]

Nurses were shown how to write a standard composed of a standard statement and lists of criteria grouped under the headings – structure, process and outcome. These headings allowed nurses to describe what they needed to have (structure), what they needed to do (process), and to list a variety of outcome indicators (outcome). For example, nurses working with newly-diagnosed diabetic patients wrote a standard statement on self-care. 'The patient and/or his responsible carer will be able to manage his own diabetes before discharge from care.' The outcome column was devoted to patient outcomes. The process column listed nursing actions designed to achieve these, and the structure column listed the prerequisites in terms of availability of nursing time, skills and knowledge.

Setting local standards

It was agreed that the focus of the West Berkshire programme would be on local standards, developed by nurses working with a particular care group or in a particular setting. The format specified the care group and the area where the standard applied. The standard was signed by nurse managers, thus securing agreement that it was in line with the philosophy of the unit, applicable to the care group specified and achievable in that unit by the date given.

Staff were encouraged to choose a topic that they considered relevant and to base their work on the following definitions:

- a standard is a professionally agreed level of performance, appropriate to the population addressed. It is achievable, observable and measurable;
- a standard of nursing care in a particular unit is the level of care agreed by nurses as necessary to achieve the desirable goals for a specific group of patients;
- setting the standard involves taking into account the resources available and the context of the patients' environment, for example at home, in intensive care or in a ward. A date for achievement and a date for review must be agreed and incorporated into the standard.

Standards were set in all areas of nursing practice.[7] They ranged from simple descriptions of good practice to problem orientated mechanisms for improving quality. For example, nurses in a special care baby unit wrote a standard of practice for the care of the family of a baby who dies in the unit. Midwives sought to solve a problem for mothers requiring a perineal repair by developing and achieving a standard for promptness of the repair, relief of pain and increasing the mother's understanding of self-care of the perineum.

The development of standards can be advanced by providing a mechanism for sharing information. An index of standards at unit or district level is useful to give managers and staff access to standards that have already been written. This has proved particularly important for community nurses. The production of an index has enabled them to share standards on the assessment of children on the child abuse register and on the safekeeping and confidentiality of patient records held by the district nurse.

Standards in the community

Local standards can help improve care by describing agreed practice, defining actual outcomes, addressing real problems, identifying deficiencies in structure, process or outcome. It can also offer measures to compare the service provided with the standard set for a particular client group. These reasons for setting standards are reflected in the topics chosen by community nurses, which included: the first visit to patients in their own homes; health visitor liaison arrangements for elderly patients being discharged from hospital; the transfer of health visiting records to school nurses; individualised care for patients with leg ulcers, for patients with diabetes, and for patients who are HIV positive; and patient compliance with treatment at home. Standards have been written by school nurses, Macmillan nurses, family planning nurses and community psychiatric nurses.

There are compelling reasons for developing tools to describe the quality of services in the community. Health visitors have commented on the limitations of Korner information because it quantifies contacts or interventions rather than the effectiveness of a planned health visiting input, which may have been deliberately spaced or targeted.

One approach is to set a local standard when there is evidence of local need. For example, health visitors in a mining area found from a survey that only 14% of babies were being breastfed at the age of one month. A standard could be set, based on stating specific outcomes for increasing the proportion of mothers who breastfeed and the length of time breastfeeding continues. The group decision would determine the process appropriate in that context, for instance increasing home visiting before one month, introducing antenatal intervention or preconceptual teaching.

The usefulness of the standard lies in: the shared objective it has established; the specification of good practice; the generation of information about the type of staff input required; and the provision of a tool to measure the effectiveness of the intervention. Some health visiting objectives are very long-term and standards can be helpful in setting a variety of interim outcome measures. Outcomes can be about changes in the health or well-being of the client, client satisfaction, and improvements in the environment or services.

Another approach is to focus on a particular group of clients, and some community nurses have seen this as an important development and have worked on standards to define the desired level of care. For example, health visitors have developed a standard on provision of nutritional advice to elderly clients at home, and district nurses have agreed a standard for home visits to patients discharged after myocardial infarction to reinforce health maintenance advice.

A positive approach to quality

Nurses are increasingly using standards to assess and improve quality. Describing agreed practice sets expectations and highlights deficiencies. For example, a church hall too cold to allow health visitors to undress babies means that they cannot meet standards set for weighing them accurately. Having a standard specifying that patients discharged from hospital after a heart attack receive a visit within a week from a community nurse to reinforce health advice allows a comparison to be made between the service provided and the standard that has been set.

Standard-setting can address the part of quality assurance that is positive and developmental. It is not confined to checking, criticising and correcting but is directed at defining the best possible care. Standards can be used to introduce new ideas and to extend the parameters of care. For example, standards set in an intensive care unit have led to the introduction of rest and relaxation periods for patients, and improved sensory input through the use of massage, music and aromatherapy.

Incorporating the consumer's view

Recently greater attention has been paid to making the service more responsive to the consumer and information about consumers' views has been incorporated into standards programmes. The service user's view may suggest the topic for a standard, especially when the organisation of

care, communication and information are being considered. Standards may be set in response to complaints, the result of surveys, or views expressed in consumer satisfaction questionnaires.

Patients' views have led to standards being set in one health authority on the following topics: waiting in an outpatient department; care and information for relatives of patients in intensive care units; and achieving individual sleep patterns for patients in hospital. Repeated surveys can help to measure whether the standards are being achieved.

There seems to be less information about the views of users of community health services. Studies have focused mainly on patients' experiences of GP services. However, in a general practice in the Oxford region a critical incident interviewing technique produced 14 favourable comments about health visitors, district nurses and practice nurses and two unfavourable comments. The customers' agenda for good practice included time and interest taken in new babies and children by nurses and health visitors, and reliability in keeping to arrangements by nurses and health visitors.

Maintaining standards

There is no shortage of ideas for developing local standards. Indeed, a standards programme is relatively easy to introduce but it is also important to describe what is required to maintain it.

A broad philosophical framework is necessary, which could be a philosophy statement expressing shared values, for example: 'The patient is central to the care provided, he/she is viewed as a whole person, as a unique individual and as an active participant in his/her care.' Some broad standards can then be developed from the philosophy, to establish expectations about care and to provide a framework for locally-based standards on topics such as client participation in health care plans.

The activities of setting, monitoring and reviewing standards must be firmly embedded into the organisation by defining the roles of managers, clinical nurses and educators in the standard system. Implementation of this process requires a resource of skills and knowledge which may be provided by a designated facilitator, through workshops for staff and a source of reference material, such as an information pack.

It is important to spread good practice and make standards available to staff. The system chosen should be designed to inform, to publicise standards and to reward staff. It should support adaptation and adoption of agreed standards and provide a mechanism for review of standards. A simple computerised index is an ideal basis. Local steering groups can help to keep standards on everyone's agenda and can produce an exhibition of standards or a news-sheet.

The local nursing policy group should play a role in coordinating the standards with other guidance, such as policies, procedures or practice guidelines. Standards have proved to be an economical way of publicising existing policies and of introducing new ideas into practice.

Monitoring quality

Standards developed locally can be related to other quality activities. For example, a number of health authorities have used 'Monitor' as a quality monitoring tool in hospital settings. 'Monitor' uses trained observers to assess the process of care and is now available for district nursing and psychiatric nursing. The use of 'Monitor' to scan across the spectrum of delivery of care and to produce a score has often led the participating groups to focus on setting some specific standards. The key factor for success is the involvement of the staff who are implementing the standards.

Monitoring standards calls for a variety of methods, such as observing care, asking patients or checking records. Each nurse has a responsibility to provide care according to the agreed local standard and to draw attention to difficulties in achieving it.

Nurses are learning when and how to monitor standards and how to use the information gained. The questions to ask when setting up a monitoring programme are how, who, when, how often, which criteria, what standard of achievement to expect and what to do with the results.

Macmillan nurses used a questionnaire to colleagues to monitor part of a standard which describes their role as members of the primary health care team. Senior nurses in district nursing have monitored a standard on safety of injections given at home by examining outcomes.

Evaluating standards programmes

Evaluation of the success of standards programmes requires the original objectives to be tested. Then the topics and the content of the standards set should be scrutinised for their relevance to the philosophy and to consumers' views. Is the standard clear, relevant, applicable, valued and achievable in the practice setting? If there have been changes in knowledge or practice, has the standard been updated? Standards must be kept current and should take account of new information.

Managing a standards system

To maintain a dynamic and relevant programme, managers can check review and achievement dates and can obtain reports on the use being made of standards to secure improvements.

One of the advantages of local standards is that staff have a sense of 'ownership'. The programme should be kept simple and patient-focused and should become an integral part of practitioners' activity. Standards evaluate the care given to patients and clients and make current and relevant information about quality available to practitioners. Information derived from monitoring standards can be used for planning purposes or for educational programmes. Feedback mechanisms, possibly provided by a quality assurance steering group, are needed to ensure that information reaches the appropriate managers, educators and planners. The pace is determined locally in the light of priorities and the programme should establish its own momentum.

Meeting the challenge

Most nurses involved in standard setting programmes have responded with imagination and with a strong sense of what is achievable with a reasonable amount of effort. The challenge issued to them is to find the tools to assess their practice and to assure a quality service. They should use what is available and appropriate to set standards at an achievable level for their own work. They are urged to focus on what they can do to improve and maintain care, to draw attention to good practice as well as to problems, and to share ideas and to involve others.

References

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients* (Cm 555), 1989.
2. Lang, N. *Issues in quality assurance in nursing*, American Nurses Association, 1976.
3. Kendall, H, Kitson, A. Rest assured, *Nursing Times*, 1986, **82**, pt 35, 28-31.
4. Donabedian, A. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly*, 1966, **44** pt 2, 166-206.
5. Royal College of Nursing. *Standards of nursing care*, 1980.
6. Royal College of Nursing. *Towards standards*, 1981.
7. Kendall, H. Raising the standards: the West Berkshire approach. *Nursing Times*, 1988, **84**, pt 27, 33-34.

Further reading

Quality in the community

Houghton, D. Development of caseload and community profiles, *Health Visitor*, 1987, **60**, 298.
King, W. Quality in the community. *Health Visitor*, 1987, **60**, 120.
World Health Organisation. *Targets for health for all: implications for nursing/midwifery*, WHO Regional Office for Europe, 1986.

The consumer view

Carr-Hill, R et al. *The NHS and its customers*. University of York Centre for Health Economics, 1989.
International Hospital Federation. *And what would they know about it? The issues, options and implications of seeking the patient's point of view*, 1988.
Jones, L et al. Consumer feedback for the NHS, *A literature review*, King's Fund, 1987.
Sinna, L, Sherer, K. Ask the patients, *Nursing Times*, 1987, **83**, pt 45, 40-42.

A change for the better: health visiting in Oxfordshire

Health visitors in Oxfordshire are developing their practice to provide a service that is responsive to the needs of individuals and populations, while working within a systematic framework. A new strategy for health visiting, 'A change for the better', was devised at a five-day workshop for health visitor representatives and their managers. Two key changes being implemented are that health visitors search systematically for health needs and offer a needs-based service to their clients. This means identifying unmet needs by compiling annual health profiles; abandoning routine visiting and developing more appropriate programmes of health care; and working in partnership with clients. Ways are being sought of measuring health visitors' work and the service's achievements more appropriately. The new approach is considered more relevant to today's needs. The profile and annual assessment of objectives provides a framework for health visitors and managers to review services regularly and control workloads.

The need for change in Oxfordshire's health visiting service was identified by field staff and managers in 1985 following the health authority's decision to cut the health visiting service to elderly people to make financial savings. One reason for this decision was the health visiting service's inability to demonstrate its effect on the health of the elderly population. Health visitors had no systematic way of identifying health needs and felt under increasing pressure to take on more work.

A five-day residential workshop was therefore organised for seven health visitors, nominated and briefed by their colleagues, and three managers. It was led by two clinical practice development workers. The outcome was a new strategy for health visiting in the district, which has been accepted by the majority of health visitors and is now being implemented.

The strategy

The strategy makes explicit the beliefs on which the health visiting service is based. It specifies that the role of the health visitor should be to promote health, prevent ill-health, identify health needs and recognise unmet needs in a specific community using an epidemiological approach. Health visitors should have contact with all age groups and the focus of their work must change from routine home visiting to more appropriate programmes of health care.

The method proposed to achieve this is for health visitors to compile annual health profiles for people registered with each primary health care team. Priorities are selected from the profiles, preferably in conjunction with the primary health care team; objectives and action plans are set and evaluated annually. By setting clear objectives outcomes should be measureable. The health visitor is accountable for the year's programme.

Nurse managers coordinate the annual programmes in their geographical sector. They inform the Director of Nursing Services (Community) and make clear statements of unmet health needs that have been identified. The programmes contribute to setting objectives for community health services as a whole.
Health assessments are used to identify individual needs and to ensure that the service is directed

towards those who require it. Initially, the focus for contact with individuals will remain on the pre-school child and family – all children in Oxfordshire being offered a minimum programme of health assessments at the primary birth visit, at eight weeks, eight months, 18 months and three years. Health visitors aim to work in partnership with clients to enable them to promote and maintain their own and their families' health. To help build a partnership clients are given information about what health visitors do. They agree a contract with the health visitor and share their health records. This approach must be underpinned by the accepted philosophy of using an open and honest approach with clients of all ages.

Implementation

The participants in the original workshop became the development group which worked out how to implement the new strategy. Communication with staff about the proposals was considered particularly important and the group felt the clinical practice development worker for health visiting had an essential role to play. A description of the role was written and the group's recommendation that the post should be extended was accepted.

The new strategy was implemented across the whole district and not as a pilot scheme, because the change in the health visitor's role is a professional development not an experiment. Changes are being introduced gradually, using a normative education approach, which allows people to examine their own values, norms and attitudes before change takes place. It is envisaged that the strategy will take up to five years to implement fully.

The development group identified immediate staff training needs and re-wrote the health visitor job description. The next move was to devise a workable format for the health profile and to develop a tool for assessing individual health needs. Workshops were planned to educate staff about compiling health profiles and about forming annual programmes, including setting realistic and measurable objectives. The next stage was to explore the changes needed in practice that would enable health visitors to work in partnership with clients.

Nurse managers had their own workshops to identify what additional support staff would need from them while the strategy was being implemented, how their role would have to change to reflect the health visitors' systematic needs-based approach, and how to meet the needs that health visitors had already identified.

Progress

In April 1989 all health visitors completed their third annual health profile and set objectives to meet some of the health needs that they had identified. Those which cannot be met are in effect a 'waiting list' for the health visiting service, or they are the responsibility of other agencies to which information is passed on.

Despite a low ratio of health visitors to population, health visitors are broadening their approach and becoming involved in health promotion with people of all ages, mainly through working with groups. Groups such as healthy lifestyle, stress reduction, post-natal and other support groups are being well-received and used. The service to elderly people is again being offered in some areas, although it continues to feature frequently on the list of unmet need. None of these

activities is original, but the process of systematic planning is new.

Despite the planned reduction in home visits, breastfeeding rates and immunisation rates continue to rise. These are examples of how the service is moving away from measuring its achievements by counting the number of visits made towards examining more meaningful measures. Contact with the public is now much greater and clinic sessions have been extended. Accessibility is an important issue and health visitors make the service as flexible as possible.

Change has not been easy. Accepting that practice had to be altered was threatening. Major changes have occurred because of the commitment of the majority of health visitors and managers. The development worker has led 120 workshops in the last two and a half years. It is apparent that health visiting is a carefully considered, important and valued service. The reward has been an increase of three and a half posts in the health visiting establishment.

Contact

Jane Dauncey, Clinical Practice Development Worker for Health Visiting, East Oxfordshire Health Centre, Cowley Road, Oxford OX4 1XD, tel 0865 240153.

Resources

Oxfordshire's strategy for health visiting: a change for the better, Oxfordshire Health Authority, 1989 (third edition). Price £2.00 (Cheques to HV Development Fund). This document includes: a detailed description of how the strategy was developed; the schedule for implementation; a health profile checklist; details of the health assessment tool; discussion of implications for managers; a philosophy of health visiting; and job descriptions for health visitor and clinical practice development worker.

Study days are advertised nationally.

Reference

Dauncey, J. A positive response. *Nursing Times* 1988, **84**, pt 42, 75-6.

Setting objectives at local level in Wandsworth

Wandsworth Health Authority is an inner London district with a population of 180,000. Its community services have a decentralised structure, with three localities managed by general managers. Each locality has several neighbourhood health care teams, managed by generic neighbourhood nurse managers. The strategy for community services is to develop in cooperation with services provided by family practitioners, other members of primary health care teams, the local authority and voluntary organisations. The unit as a whole has a set of objectives and localities and neighbourhood teams are also encouraged to set their own objectives. A neighbourhood team should identify what needs to be done to ensure that its members work as a high performing team. This involves discussing what has to be done, when it has to be done, who should do it and how it is to be done.

The process of setting objectives is the foundation of good management practice. All members of the neighbourhood health care teams in Wandsworth have individual objectives, which are set within the context of corporate goals of the neighbourhood and the objectives of the community health services as a whole. Setting objectives regularly with a manager helps both the manager and member of staff to get clear messages about mutual expectations. Setting objectives as a team enables the team to know where they are going in terms of meeting neighbourhood needs. Objectives for individuals and teams are reviewed every six months.

Examples of neighbourhood team objectives are:

- *To integrate the district nurses, health visitors and school nurses into one nursing team* by office sharing; developing an understanding of each other's roles by formal and informal discussion and observation; joint meetings; using each other's skills; and socialising at lunchtimes and at informal meetings.

- *To consult with all members of the primary health care team* by meetings with neighbourhood GPs; user meetings with all the therapists, paramedics and medical officers; meetings with local social services; and inviting nurses from other units, eg community psychiatric nurses and midwives.

- *To identify local need* by developing a neighbourhood profile; workload profile; caseload profiles; testing consumer opinion; and using a team approach to identify need and adjust services to meet need.

- *To produce a directory of neighbourhood services* by assigning a part-time health visitor to interview all those providing community health services, to write a brief account of their roles and list the times of clinics and sessions in all the neighbourhoods.

- *To maintain contact and develop links with voluntary organisations* by organising regular meetings with all the members of the neighbourhood health care team.

- *To set up neighbourhood health care associations* by initially piloting in one neighbourhood an association involving five health care professionals and five members of the local community.

- *To work to agreed standards of care* by employing a professional development officer to set up a quality assurance programme for all grades of staff in the community.

Over the past two years most of these objectives have been achieved, although health care associations have not yet been developed in all neighbourhoods.

Individual members of staff set their own objectives in the context of the objectives of the neighbourhood health care team (above) and the goals for health visitors, district nurses, family planning nurses or school nurses agreed by each staff group. The goals for health visitors are reproduced as an example below. This initiative is part of a quality assurance programme which is vital to the delivery of a high standard of service. Standards of care are being set with the method of monitoring included in the standard. Monitoring may include peer review, management appraisal and consumer satisfaction. Neighbourhood nurse managers have agreed standards for staff development and setting objectives.

Health visiting

The goals for health visitors are:

- To work as mutually supportive members of the neighbourhood health care team, identifying and responding to changing needs and people's expectations.

- To promote health (rather than cure disease) within all sections of the population, working with both individuals and groups.

- To involve families and individuals in making decisions about their own health and helping them to carry these through.

- To be accountable for his/her practice being based on research and a consensus of professional opinion and maintaining his/her specialist skills and knowledge.

- To work within the UKCC professional code of conduct.

Health visitors set objectives with their clients individually and for groups of clients. They are piloting a new type of record to facilitate this partnership. It is completed in consultation with the client and identifies the client's perception of problems. Health visitors also set objectives for themselves as health visitors and as individuals.

Contacts

Rachel Scragg, Senior Locality Manager and Community Nurse Adviser, Wandsworth Health Authority Community Health Services, Clare House, St George's Hospital, Blackshaw Road, London SW17 0QT, tel 081 672 9999.
Pat Spooner, Professional Development Officer, Continuing Care Unit, Wandsworth Health Authority, Clare House, St George's Hospital, Blackshaw Road, London SW17 0QT, tel 081 672 9999.

Resources

Information about the development of neighbourhood health care and setting objectives in Wandsworth. For details, including price, please contact Mrs Irene Goring, Senior Administrative Assistant, Continuing Care Unit, address and phone number as above.

References

Wilson, C.R.M. *Hospital-wide quality assurance: models for implementation and development,* Company, 1987.
Spooner, P. Theory into practice. *Nursing Standard,* 1989, **34**, 3.

Measuring district nursing workloads and assessing quality in Central Nottinghamshire

Until fairly recently Central Nottinghamshire Health Authority, in common with many other districts, had little information that allowed activity in community nursing services to be evaluated. A computerised system for recording nursing activity was developed in the district, which enables the percentage of time spent on various activities to be calculated and allows managers to forecast manpower requirements. An initiative has also been taken to audit the quality of district nursing care. A working group developed a checklist of 200 questions which was used by a quality assurance assessor to audit the nursing care received by a sample of ten patients. A strong negative correlation was found between workload and quality of care. The analysis also identified eight factors that significantly influenced quality. This system was found to be flexible and it produced detailed and meaningful data. However, it is time-consuming and expensive, stressful and tedious for the assessor, and intimidating for the nurse being assessed.

Measuring district nursing activity

In the absence of 'meaningful' information about district nursing activity, managers tend to rely on their intuition to assess staffing needs. They require data about current services which can be analysed to provide useful information for monitoring and planning.

To meet these requirements many districts have invested large sums of money in computer systems and have been disappointed by the results. In Central Nottinghamshire the community unit did not rush into buying commercial computer systems because the district's information technology strategy required an integrated approach. Using a microcomputer, a system was devised to process Korner data and nursing activity data was also collected. The information generated was very useful. Later the system was improved by changing from a spreadsheet to a database model and by using an optical mark reader to reduce clerical time.

From the information gathered it is possible to estimate the number of hours nurses spend on various activities and to express this as a percentage of total hours worked. It also gives a measure of workload by comparing actual hours on duty to hours worked calculated from activity data. Managers can look at the work being done by each grade of staff and make decisions about skill mix. It also allows managers to carry out 'what if' analyses, for example changing one element of nurses' workloads to see what happens to the rest.

Analysing the quality of nursing care

A small working group was formed by an experienced district nurse, an experienced health visitor and a researcher to design, test and implement a system for auditing district nursing care. A checklist of 200 questions was generated using a framework that combined elements from the nursing process and Donabedian's principle of considering structure, process and outcome. The working group organised a series of seminars about the system to ensure the support of managers and others.

The quality assurance assessor – a very experienced district nurse and fieldwork teacher – then systematically answered all 200 questions for a sample of 10 patients. This was done by observing the nursing care they received, interviewing the patient and relative, checking the nursing records, and finally interviewing the nurse. Audit of the 10 patients took about three days.

The reliability and validity of the audit checklist were tested with good results. A particular problem is the Hawthorne effect. It is difficult for anyone being observed not to change their behaviour. However, the effect seems to wane after about half a day. Unfortunately this means that data collected in the first half day may have to be abandoned if the assessor believes they are unrepresentative.

The audit checklist gives a measure of quality for the four aspects of care (assessment, planning, implementation and evaluation) and an overall QA score. A typical pattern was lower scores for planning and evaluation than for assessment and implementation.

Using information from the nursing activity system, the relationship between quality scores and nurses' workloads was examined. Because the study had selected one nurse from each of ten practices, it was possible to plot practice workload against QA score. A negative correlation was found – as practice workload increased, the quality score decreased. Nurses appear to be cutting corners as workloads increase and aspects of care that might be considered the 'icing on the cake' seem to suffer most.

The data were also analysed to discover factors that had a significant positive or negative effect on quality. Eight factors were found to be important. The two factors associated with high quality care were a nurse spending time reassessing a patient and giving support and advice to the patient. The factors negatively associated with quality were poor assessment, poor planning, poor implementation, poor evaluation, high patient dependency and reduced amount of direct care. The analysis gave no support for the assumption that time spent on non-productive activities, such as travelling and 'no access' visits, affects quality of care.

The advantages of auditing nursing care in this way are: that it produces detailed and meaningful information; it is flexible; and the quality measure can be combined with most community workload analyses. The disadvantages are: that the method is expensive – about £120 per round of assessment; it is demanding, stressful and tedious for the assessor; it is intimidating for the nurse being assessed; analysis of the data requires sophisticated computer hardware and software; and the system could not be used for school nursing and health visiting without being rewritten. There is also the Forth Bridge syndrome – when one round of assessments is complete it is time to start again.

Similar studies in other authorities are now needed to check the validity of these findings. Once there is certainty about the factors that contribute to quality in community nursing, action can be taken to improve patient care.

Contacts

Keith Hurst and David Costin, Central Nottinghamshire Health Authority Priority Care Unit (Community Services), Pine House, Ransom Hospital, Rainworth, Nr Mansfield, Nottinghamshire NG21 0ER, tel 0623 22515 ext 4647/4651.

Resources

Keith Hurst and David Costin will give advice on developing computer systems and on writing bespoke audit checklists.

Reference

Donabedian, A. *The definition of quality and approaches to its assessment*, 1980.

Section 4

Collaboration to enhance quality

Collaboration to enhance quality

Health care workers, their managers and service users all say that collaboration is an essential part of good community health care. The difficulty seems to be putting this belief into practice. A great deal has been written about how agencies, professions and disciplines fail to work together and the consequences for their clients. Reports of successful collaboration are more difficult to find and usually feature specially-established multidisciplinary projects rather than mainstream services. They confirm that teamwork flourishes in settings with appropriate structures, sufficient resources and highly motivated staff. We need to learn more about how to remove the obstacles that keep busy staff in routine jobs apart from their colleagues in other disciplines and to find ways of sustaining teamwork in difficult circumstances.

For community nurses collaboration takes many forms. A primary concern is to establish partnerships with patients, clients and their carers. Working closely with colleagues of the same and other nursing disciplines – perhaps in a neighbourhood nursing team – can provide essential practical and personal support. Building a wider team, for example with hospital staff, professionals in other statutory agencies, general practitioners and workers in the voluntary and private sectors, may present more challenges. However, teamwork on this broader scale has become a significant part of government policies for primary and community care. The three white papers, *Promoting better health, Working for patients* and *Caring for people*, all include proposals that the government hopes will 'reinforce the incentives towards collaboration'. It remains to be seen whether the new GP contract, which separates purchasers and providers of health care and clarifies community care responsibilities, will succeed in promoting interprofessional relationships and improving integration of services.

In this section's keynote paper, Gillian Dalley reviews policy on collaboration in community care and examines why it seems to fail so often in practice. She suggests that we might find more effective solutions if difficulties caused by conflicts of professional attitudes and beliefs could be distinguished from practical, organisational problems. Attempts to promote collaboration are likely to be most successful if they involve workers in a locality or neighbourhood. They should include: building effective methods of communication; multidisciplinary training; and developing standards of care which define specific areas of responsibility.

Explicit agreements about goals and tasks are central features of two successful collaborative projects described in this section. Both involve nurses and GPs increasing the preventive services offered to the GPs' patients and show the importance of establishing a clear structure within which to work together. These particular examples look only at interprofessional collaboration and do not explore the important question of how to build partnerships with patients and clients. In an attempt to redress the balance a brief description has been included of how health visitors in Oxfordshire are using a health assessment tool and parent-held records to develop more open relationships with their clients.

In Tower Hamlets careful planning was required to launch a scheme involving the health authority, family practitioner committee and GPs. Health promotion nurses, funded jointly by the three parties, carry out an agreed programme of preventive work with adult patients. A lesson from this example of collaboration between agencies is the importance of giving close attention to the management arrangements for staff in newly-created joint posts.

The Oxford Prevention of Heart Attack and Stroke Project pioneered the use of an independent facilitator to increase preventive work in general practice. Facilitators offer primary care teams an 'off the shelf' method for opportunistic screening and practical, on-the-spot assistance with practice organisation and staff training to help the team get started. This approach has been remarkably successful with established teams and is now being tried in inner city practices.

The final report in this section offers neighbourhood nurse managers' views of building multidisciplinary neighbourhood nursing teams in Islington. Three case studies show how they used insights from their training in leadership and managing change to help groups of staff come together to work as teams. The nurse managers, themselves from a variety of backgrounds, have formed a strong peer group that they rely on as a resource and for support.

Collaboration in community health care
Gillian Dalley

Collaboration between agencies and between professionals involved in the provision of community health care is generally believed to be an essential component of a high quality service. This paper is about the process of achieving collaboration. It examines where exhortations to collaboration have come from, the factors that prevent collaboration, and the measures that can be taken to improve it.

Definitions and policies

The broadest definition of collaboration in community health care includes all the agencies providing community services: health authorities, particularly their community and priority services; family practitioner services; local authority services, particularly social services and housing departments; and voluntary organisations. Collaboration also involves the professionals who work for these agencies, and includes district nurses, health visitors, community psychiatric nurses, midwives, remedial therapists of various kinds, GPs, social workers and home helps/ home carers.

Over the years, a stream of policy documents has called for agencies and professionals to collaborate. The Harding report on the primary health care team urged members of the team to work together more closely.[1] The problems of fragmentation of services and the waste of effort and resources involved were pointed out by the Acheson report on primary health care in inner London.[2] The Cumberlege report encouraged the community nursing disciplines to work together.[3] Gaps in provision and duplication of services between agencies were a particular concern of the Griffiths report on community care.[4] More recently, the Butler-Sloss inquiry suggested that the only way through the problems that had been encountered in Cleveland was to develop better multidisciplinary approaches to child protection.[5]

Each of these reports had a slightly different angle on collabobration. Harding and Acheson were both concerned with collaboration between the different professional groups working in primary health care. Acheson also raised questions about inter-agency collaboration between family practitioner services and health authorities. Griffiths and Butler-Sloss considered agency boundaries, particularly between health and local authorities, and collaboration between the professionals employed by these agencies. Cumberlege focused on intraprofessional collaboration – suggesting how those with nursing backgrounds could get together and form a team. All the reports wanted to prevent gaps in the provision of care and unnecessary duplication of services, which can be a difficult course to steer.

Collaboration, along with cooperation and communication, was a popular theme of policy documents in the 1970s. In the 1980s, however, three other themes have greater prominence – efficiency, economy and effectiveness. Preventing duplication of services is an eighties' concern in the sense that it is part of the search for economy and efficiency. However, to achieve this and to avoid gaps in services opening up as a result, agencies must ensure that they communicate and collaborate fully.

Reasons for failure

The problems that have been identified as causing failure of collaboration and fragmentation of services can be divided into three categories: professional ideologies, tribal differences and cultural differences.[6]

Professional ideologies refer to the approaches that professionals take to their work, based on their differing theoretical frameworks. There are many examples in the literature of how doctors, nurses and social workers see a patient or client's problems differently and would make different interventions according to their understanding of the causes of the problems. The moment training starts these differences come into play. Doctors, for example, are frequently said to be too concerned with the 'medical model' of explanation, whereby ill health is seen as the outcome of individual, largely physical, pathology. Social workers, it is said, are inclined to psychosocial explanations of ill-health, while nurses are conditioned by their deferential relationship to doctors and unquestioning acceptance of medical diagnosis. There may, however, be a danger of making too much of these differences. In practice they may not be as great a barrier as they are portrayed in the literature.

Tribal loyalties may cause more difficulties in terms of limiting collaboration. Professionals tend to assume ideological differences exist and consequently believe that colleagues in other professions will think and act differently from them. For example, social workers tend to assume that doctors will never consider the social components of a client's medical problems and that nurses will be trapped in equally narrow ways of interpreting problems.

However, when attitudes are explored in detail there are often few real distinctions between professional groups. Professionals are conditioned to believe in stereotypes of each other's professions; and these stereotypes applied by one group to another stem from a group or tribal loyalty. They reinforce feelings of group membership by emphasising differences from other professional groups, whether or not the differences exist in practice.

Cultural differences are not based on false assumptions, they refer to the distinctive ways professional groups have of doing things, for example ways of organising services and styles of management. These are real differences and lead to practical difficulties that may hinder collaboration. Four sets of common problems involve communication, priorities, boundaries of responsibility, and organisational differences.

Common problems

Problems of communication always seem to be at the top of the list. This is partly because it is difficult to communicate with someone who comes from a different background – you may see things differently (there may be real ideological differences). However, organisation and routines may be equally frustrating barriers – one group of staff is in the office at nine in the morning, another is not available until four in the afternoon, so how are they to speak to each other on the phone? It is frequently impossible to synchronise diaries to arrange meetings between members of several different professions and agencies. Last minute cancellations or withdrawals do nothing to enhance working relationships.

Differences in priorities, in terms of client groups or the emphasis on treatment or prevention, tend to divide rather than bring professionals together. It is often said that health service staff are less concerned with maintaining people in the community than social services staff, but these kinds of distinctions may be perceived differences rather than real ones. More real, however, are the differing and competing pressures placed on professions and agencies. Social work departments, for example, find it difficult to devote sufficient resources, in terms of staff and money, to client groups such as elderly or physically disabled people when faced with the enormous problems relating to child abuse. Likewise, health visitors are often reluctant to get involved with older people at the expense of their work with families with young children.

Different boundaries of responsibility can cause problems, especially if it is not clear exactly where the boundaries lie. There may be feelings of 'treading on toes' or of being in totally separate camps with no common ground. Social workers and health visitors are sometimes said to fall into this dilemma. What, some might ask, are the differences between home care workers employed by local authorities and nursing auxiliaries employed by health authorities.

Organisational differences, such as working with different populations, being based in different buildings, having different sources of information, all make working together more difficult. It has been recognised for a long time that staff sharing accommodation build up better relationships than those who are physically separated, but separation is more often the rule. The different structures of health authorities and local authorities create their own problems. Local authority departments have to work within boundaries of political acceptability, often with the active involvement of elected members. In the health sector political involvement is much less explicit and there is a more complicated relationship between officers and members of the health authority.

Finding solutions

Research in this field is good at identifying the problems and difficulties, but less good at offering solutions. We have to assume that collaboration and cooperation is a good thing and that our efforts to promote them should not slacken. However, it is important to evaluate attempts to improve collaboration so that effective methods can be spread more widely. Below are some ideas for promoting collaboration but this is by no means a comprehensive list.

It is essential to identify and acknowledge the problems of collaboration. Recognising that professionals are members of different groups; that there are traditional hostilities to overcome; and that it will be difficult to do so is part of the process. Identifying whether the problems are due to ideological, tribal or cultural differences might also help in terms of spelling things out clearly and finding practical solutions.

One solution might be to adopt a local approach to promoting better relationships between professionals. This has been advocated by many of the policy reports mentioned earlier. The Griffiths report emphasised that innovation and experimentation are more successful at the local level and should be encouraged by senior managers. It helps if all staff are providing services to the same population and are allowed to work out their own solutions to problems jointly.

Communication, and the familiarity that accompanies it, is vital. Formal and informal contacts need to be developed. Making time to talk to colleagues is difficult in an over-stretched service but it is the best way of getting to know each other. Learning about each other's routines (for example, convenient times to phone), exchanging information about practical arrangements, and having joint meetings all help to promote communication. But there has to be a commitment to achieving results – otherwise the very real difficulties in getting together will remain.

Joint training and education should be encouraged. There is not enough effort at national level to promote joint basic professional education, but local in-service training on a multidisciplinary basis might be easier to set up. However, care needs to be taken that the training does not further entrench negative attitudes – it should provide good, positive experiences of learning together.

Goals and standards are necessary so that each group knows where it stands in relation to others. The goals and standards should be discussed and common agreement reached. Protocols which specify the service being offered and where responsibilities lie are likely to become increasingly important in the future. The new purchasing authorities will need to know what they are buying, so that they can plan and integrate a full range of services. Those providing services need to be clear about what they can do with a certain level of resources.

Boundaries of responsibility should be clearly defined. It is important to know when not to tread on other people's territory. Managers are likely to be keen to establish definitions because if their staff are taking on other's responsibilities they are using their own service's resources unnecessarily.

The last two points are two sides of the same coin. Agreeing common goals and standards will involve specifying the services being offered, identifying responsibilities and drawing boundaries to ensure that there are no gaps and that duplication is avoided.

Conclusion

Failures of collaboration have characterised community care for many years. There have been frequent exhortations to improve collaboration, but the weight of suspicion, entrenched ways of doing things and of sheer pressure of work and responsibility make it difficult to do so. Understanding the problems may be a first step to overcoming them. By distinguishing difficulties caused by differences of belief and attitude from problems created by practical, organisational differences, it may be possible to devise appropriate means of tackling them. Learning about each other's ideological and tribal beliefs may be a way of lessening their importance. Establishing effective communication between all parties is a sound basis for constructing collaborative systems that work successfully. For high quality community care to become a reality mutual understanding and practical response are both essential.

References

1. DHSS Standing Medical Advisory Committee and Standing Nursing and Midwifery Advisory Committee. *The primary health care team: report of a joint working group*, (Chairman Dr W.G Harding), 1981.
2. London Health Planning Consortium. *Primary health care in inner London: report of a study q group*, (Chairman Professor E.D Acheson), 1981.
3. Department of Health and Social Security. *Neighbourhood nursing – a focus for care. Report of the Community Nursing Review Team.* (Chairman Julia Cumberlege), 1986.
4. Griffiths, R. *Community care: agenda for action. A report to the Secretary of State for Social Services*, 1988.
5. Department of Health and Social Security. *Report of the inquiry into child abuse in Cleveland 1987.* (Chairman Lord Justice Elizabeth Butler-Sloss),1988.
6. Dalley, G. Professional ideology or organisational tribalism? The health service-social work divide. In: Taylor, R, Forde, J. (eds) *Social work and health care. Research highlights in social work no 19*, 1989.

Sharing with clients: an example from Oxfordshire

In Oxfordshire two things are used to help create an open and sharing relationship between health visitors and clients. A health assessment tool is used at the primary birth visit and at the eight month, 18 month and three year developmental checks and parents are given their child's primary health record to keep at home. This record replaces the former 'clinic card' and does not affect health visitors' or general practitioners' records.

At the primary birth visit parents are given their child's health record. The health visitor explains that although other records are kept, this is the main health and development record and needs to be available whenever the child is seen. She also describes the health visiting record and shows it to the parents. The majority of health visitors now write up both the parent-held record and the health visiting record in the home after agreeing what to write with the parents. Sometimes this means some duplication of information, but usually a distinction can be made between information useful to parents and that needed by health visitors. For example, at a health assessment parents usually appreciate detailed notes of their child's progress; the health visitor needs to know that the assessment has been carried out and to note any action she will be taking, such as date for a further review.

The health assessment tool is explained to parents, so that they know exactly what help their health visitor will be able to offer. At the moment the assessment tool can only be used for families with young children, but it is planned to extend its use to other groups, such as adults and elderly people.

When the assessment has been made, the health visitor and family agree areas of concern and make plans to address them. Goals may be set and noted in the parent-held record.

Contact

Kate Saffin, School Nursing Clinical Development Worker, East Oxford Health Centre, Cowley Road, Oxford, tel 0865 240153.

Resources

Further details of the health assessment tool can be found in *Oxfordshire's Strategy for Health Visiting: A Change for the Better*, Oxfordshire Health Authority, 1989 (third edition). Price £2.00 (cheques to HV Development Fund).

Collaboration with FPCs: health promotion nurses in Tower Hamlets

A scheme to employ health promotion nurses to work in general practices was developed jointly by Tower Hamlets Health Authority and City and East London Family Practitioner Committee. The nurses carry out an agreed programme of work with patients aged 30-65 years, giving them personal advice on risks to their health, with special emphasis on coronary heart disease prevention and cervical cytology. The costs are met by the FPC (59.5%), the general practice (25.5%) and the DHA (15%). Lessons learned from the scheme include the importance of clear management arrangements, of planning training carefully, and of recognising the hidden costs that must be budgeted for. Advantages of the scheme are that it has increased the numbers of primary care staff, in particular giving more resources for prevention; it provides a service for the 30-65 age group that would not otherwise be available; and it has shown GPs and nurses the value of working together.

City and East London FPC was keen to collaborate with Tower Hamlets Health Authority to improve the quality of services in the district. FPC officers and nurse managers had a good relationship, a clear understanding of local health needs and a shared determination to do more to meet them. GPs in Tower Hamlets employ very few ancillary staff. If they employed their full quota it would add significantly to primary care resources in the district. The FPC was keen to increase employment of ancillary staff by GPs, not least because of anxiety about FPC budgets being cash limited.

One practice keen to develop health promotion had obtained outside funding to computerise its records and had begun to explore the possiblity of screening patients with a view to preventing coronary heart disease. The proposal to employ a health promotion nurse was discussed with the director of nursing services, who was asked to help provide training and management support.

It was agreed that this should be a joint scheme, in which the health authority paid 30% of the nurse's salary and the remaining 70% was picked up by the GP and FPC. A policy agreement was developed for this arrangement. The scheme was evaluated and the first results were very encouraging. Nurses and GPs working together on an area of common interest was very beneficial – roles were clarified, credibility increased, and skills were identified. The practice made a case for employing a second health promotion nurse.

The scheme was extended when the health authority provided new money for community nursing. Five health promotion nurses were employed with the DHA contributing 15% of each salary. A steering group was set up to manage the scheme. Its members were the director of nursing services, a specialist in community nursing, two health promotion nurses, a senior nurse manager, and a GP from each of the five practices. This group identified areas of health promotion to be tackled; developed protocols and joint job descriptions; organised training; and wrote a policy for the scheme and its future operation.

The policy set out the objectives for the scheme, which are:

- to plan and implement organisational procedures which provide every adult member of the practice population aged between 30 and 65 years with regular personal advice on risks to their health;

The role of the primary care facilitator

Elaine Fullard has been working as a facilitator of prevention in primary care in Oxfordshire Health Authority since 1982. She developed this role with the Oxford Prevention of Heart Attack and Stroke Project, testing the contribution that could be made to the initial organisation and training needed to extend prevention into general practice. This project was successful in getting GPs to increase their preventive activities and now more than 100 health authorities throughout the country employ a facilitator whose role has been modelled on this approach.

The Royal College of GPs and the Community Nursing Review Team recommend a systematic approach to prevention by primary care teams. At least 90% of a practice population consult their GP every five years. By capitalising on this opportunity practice teams can offer their adult patients a free health check to ensure that risk factors for arterial disease are spotted and managed. This is known as the opportunistic approach to screening. Facilitators aim to help the team to:

- ensure that every adult patient has his or her blood pressure recorded every five years;
- offer individual advice and help with giving up smoking;
- guide and inform people about the changes needed in reducing the saturated fat content of their diet;
- identify people with a family history of early death and offer them a lipid test;
- identify and manage diabetes;
- advise women who are combining oral contraceptives with smoking.

The facilitator acts as a temporary guest and informal adviser in practices interested in setting up a screening programme. The facilitator's tasks include:

- *Introducing the method to the GPs, district nurses, health visitors, practice nurses*, the practice manager and the receptionists. Some practice nurses and/or health visitors will have already screened the practice by writing to invite patients for a check, so the opportunistic method can catch patients who have recently moved into the area or who are not on the age/sex register. Some teams want to know more about how to do a one in ten audit to assess the percentage of adults who have already been screened, for example, for hypertension. Facilitators can offer help in selecting the sample and supplying audit guidelines. Some practices employ temporary help for the audit, often a nurse or a receptionist. It should not be a mammoth task. For example, it took a practice with 9,000 patients only 26 hours to do a one in ten sample audit on their middle-aged patients. This provided them with a baseline before starting the full programme and cost less than £20 (after allowing for FPC reimbursement and tax relief). A 'Rent-an-Audit' team can also be hired by Oxfordshire practices at a flat rate of £25 per audit. This has been very popular with 55 practices 'renting' the team. Facilitators in other areas have established similar auditing teams.

- *Meeting receptionists and, if needed, helping them to invite the first few patients.* Since receptionists have a vital role in identifying and recruiting the patients for health checks, it is important that they feel an integral part of the screening programme.

- *Meeting the practice nurse/health visitor to discuss who should do the screening.* Several practices decided to employ a part-time 'preventive nurse' who was then offered appropriate training.

- *Providing a back-up service* by, for example: supplying coloured height/weight charts as teaching aids in weight reduction; drafting invitation hand-outs; and providing examples of recall letters for people with mild hypertension.

- *Preparing for hypertension screening.* Facilitators offer informal revision of blood pressure measurement techniques; help to get the screening programme underway; and help to sort out teething problems.

Of the 82 practices in Oxfordshire 63 are now offering a systematic approach to identifying risk factors. Other districts have similar levels of commitment by primary health care teams. The aim is to enable everyone in the UK to benefit from prevention and to reduce the risk of the disability and misery of premature strokes and the pain of early bereavement that heart disease often brings. The facilitator's role is to mobilise the energy and enthusiasm of primary health care teams in tackling the epidemic of arterial disease.

The focus now needs to be on assisting inner city practices to develop their preventive activities. Further research is required to evaluate whether screening is beneficial in terms of reducing people's risk factors and this is the brief of the 'Ox-check' trial in several general practices in Luton.

Contact

Elaine Fullard, The Oxford Prevention of Heart Attack and Stroke Project, The Oxford Centre for Prevention in Primary Care, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE, tel 0865 249891 ext 4627/4300.

Resources

Guidelines for the appointment of facilitators by Elaine Fullard, Aislinn O'Dwyer and Andrea Hopkins.

Visitors' days are held monthly by the Oxford Project to demonstrate the approach to screening and the role of the facilitator. All members of primary health care teams and health authority representatives are welcome.

Elaine Fullard now has a national role to assist districts to appoint facilitators. Aislinn O'Dwyer has a national brief for training facilitators with Andrea Hopkins, who is based in Leeds University Department of General Practice, and Claire Lloyd, who is based in the Department of Primary Care at the Whittington Hospital in Islington, London.

- to devise and implement follow-up programmes for those at high risk of developing conditions amenable to prevention;

- to provide advice on the minimisation of risks to health and general health education information in a way that enables people to make informed choices about their health.

It also explains the philosophy of care, how referrals are made, training and management arrangements, and how the scheme is monitored.

Once the scheme was underway the steering group disbanded and was replaced by a management group which meets three times a year and includes GP representatives from each practice; health promotion nurse representatives; the director of nursing services; a senior nurse manager; and coopted members as necessary. The management group is advised on operational aspects of the scheme by two professional forums: the health promotion nurse forum, including all health promotion nurses and their manager; and the general practitioner forum, for all doctors associated with practices participating in the scheme. The two forums meet together every two months.

Lessons learned

Management arrangements must be clear and include details such as cover for maternity leave. Training needs to be carefully planned – who will organise it, who should be involved?

The funding arrangements were not quite so simple as originally thought. The health authority's 15% contribution is straightforward but the remaining 85% is split 70:30 between FPC and GP (70% reimbursement of cost of employing ancillary staff) which means the GP pays 25.5% of the actual total cost of employing the nurse. However, GPs can claim fees for some of the work carried out by the nurse, such as cervical smears and immunisations. There are also hidden costs to the health authority including recruitment (writing the job description, advertising, etc), equipment and furniture, training, and management time.

The advantages of the scheme from the health authority's point of view are: that more primary care staff are employed at very low cost; health needs are being met; and nurses and GPs are working together which increases mutual understanding of roles. The main disadvantage to GPs is that they must meet their share of the cost of employing the nurse from their own income.

Future developments

The white paper on primary health care creates new possibilities for developing the scheme but may also bring limitations. The scheme could be expanded to include employing psychologists, physiotherapists, dieticians and occupational therapists. Seventy per cent reimbursement of the costs of employing ancillary staff will no longer be fixed, so a higher level of subsidy could be provided by the FPC. However, much will depend on whether FPC budgets are cash limited and on the policies of individual FPCs. The income of inner city GPs may decline because of greater emphasis on capitation fees in their remuneration. The promised 'deprivation weighting' may offset this, although no figure has yet been set.

Contact

Anne Woods, Senior Nurse Manager, Tower Hamlets Health Authority Community Health Services, Tredegar House, 97-99 Bow Road, London E3, tel 071 377 7926.

Resources

Copies of the policy document *Health promotion in primary care* and the health promotion nurse job description are available.

Reference

Robson, J et al. Using nurses for preventive activities with computer assisted follow up: a randomised control trial. *British Medical Journal,* 1989, **298**, 433-6.

References

This report is based on

Fullard E.M. The role of the primary care facilitator, *Community View*, 1987.
Fullard E.M. First in the field, *Community View*, 1987.

Other sources

Fullard E.M, Fowler G.H, Gray J.A.M. Facilitating prevention in primary care. *British Medical Journal*, 1984, **298**, 1582-7.
Fullard E.M, Fowler G.H, Gray J.A.M. Promoting prevention in primary care, controlled trial of low technology, low cost approach, *British Medical Journal*, 1987, **294**, 1080-2.

Creating and maintaining nursing teams in the community: the experience in Islington

One of the aims of Islington's neighbourhood nurse managers is to build multidisciplinary community nursing teams. To help them with this task they received training in leadership and managing change. Their experience of creating teams has varied because of their own and their teams' different backgrounds and different needs. However, the nurse managers feel they have enough in common to form a strong peer group that offers resources and provides support. This has helped them work with their staff to 'turn the impossible into the inevitable' and give the vision of multidisciplinary nursing teams 'the crackle of success'.

In May 1986 services in Islington's Community and Continuing Care Unit were decentralised into five localities, each with a locality manager. Neighbourhood nursing teams with generic managers, modelled on the proposals in the Cumberlege report, were introduced in 1988. Each locality has two neighbourhood nursing teams, which relate to two or three social services patches. A team comprises 15-20 nurses (health visitors, district nurses, nurse advisers to elderly people, clinic nurses and school nurses). Teams are based in health centres and cover a defined geographical area with a population of approximately 15,000.

Of the nine neighbourhood nurse managers in post, two have both health visiting and district nursing qualifications; one has a background in school nursing; two in district nursing and four in health visiting. When they were appointed, community nurses had been working in the same buildings for years without getting to know more about each other than the face and the discipline. The managers knew that building a team was likely to involve more than merely placing nurses with the ideal mix of skills under the same roof. As part of their induction course the nurse managers were given training on leadership and managing change. They found the week of workshops, seminars and participative exercises most valuable in helping to develop their ideas about how to build teams within the framework of a democratic style of management.

Their subsequent experience of putting their ideas into practice has been very varied. They inherited teams with different histories, different structures and varying readiness to make changes. Here three of the neighbourhood nurse managers look back at their early experiences of working with the new teams.

Beating defensive retreat

The first neighbourhood nurse manager was previously district nurse coordinator in the same health centre, so he was acquainted with most of his team. When he was appointed his staff showed the range of emotions and behaviour which characterise people reacting to change. These are described in the diagram below.

Emotions

	Self Experience	Orientation to reality	Attitude/feelings	Thought processes
Shock	Threat	Denial	Helplessness Anger	Unwillingness to reason
Defensive Retreat	Dive for cover (e.g. defend old structures	Still too nasty to think about	Heavy cynicism	Planning for subversion
Resigned Adjustment	Discomfort/ head over the parapet	Passive acceptance	"Well, maybe" i.e. suspended belief	"You tell me what to do!"
Constructive adaptation	Sense of security	Active engagement	Belief	Personal planning for change

He particularly saw examples of 'defensive retreat', including nurses stopping taking responsibility for routine organisational matters, such as arranging cover for clinics, and needing managers to step in to resolve the problems that arose as a result. Another example involved two teams in one health centre who for over a year delayed a move from separate to multidisciplinary offices. Suitable accommodation had been found and a date for moving agreed. However, the nurses asked for a communicating door to be made between the two team offices. It was then discovered that there were insufficient keys for all the office doors, so new locks and keys were ordered. It took some time for the locks to be fitted and then the keys 'went missing'. More were ordered and on the day they arrived the first set of keys were found. Eventually, the move went ahead and the teams arranged their furniture so that the communicating door could not be used!

Managers must recognise that some people are not keen on the idea of being part of a team, because of the connotations of competitiveness. But a team also implies common purpose and cohesion – conditions which have to be actively worked for: they are unlikely to 'just happen'. Each member of the team must have equality of information and opportunity and must be encouraged to feel that they have something of value to offer. Without these basic understandings a nursing team might just as well be a group of people trapped in a lift.

Coping with loss and change

The second neighbourhood nurse manager was previously a school nurse in a different part of Islington and so knew only a few faces in her team. The team was warm, welcoming and supportive but they seemed to have an air of loss. When she investigated further she found that each discipline had been disrupted, depleted or rearranged. Many members of the team had also suffered personal loss such as bereavement or had experienced major changes in their personal

lives. She decided that this was neither the time nor the place to be too heartily innovative, or to be too enthusiatic about what was likely to be viewed by the team as imposed change. After all, the service had been running smoothly before neighbourhood nursing was introduced. It seemed more fitting to ensure that everyone in the team was quite sure about the philosophy and principles that would help them to implement any planned changes in the future. Many of the nurses welcomed this opportunity to discuss and clarify what had happened since the initial decentralisation of community services. It helped the team members to get to know each other, to arrive at a common definition of terms and to feel secure as a team.

Setting team objectives

The third neighbourhood nurse manager has both health visiting and district nursing qualifications and came to Islington from another health authority. She has a team which is split between two health centres. To start the process of team building, this manager ensured that:

- she was easily *available* to her staff for professional advice and support;

- there was an effective system of *communication* for the team. Initially she held individual meetings with each member of the team to discuss key areas of work, ideas for developing the service, and needs for training and management support. There were also team meetings. The whole team agreed to meet every month for two hours to discuss management issues. Each nursing discipline also met every six weeks to discuss topics of special relevance to their work;

- the team agreed its *shared aim* – to develop and maintain a flexible, cohesive team that is achieving its agreed goals. Deciding what can be achieved helps build a sense of ownership, shared responsibility and dedication. The first objectives set by the team were fairly easily achievable and included starting to compile a neighbourhood profile.

Agents of change

The neighbourhood nurse managers and locality managers realised that it was important to demonstrate their commitment to the team approach. They identified a number of ways in which they could do this. First, they must make time for team building – if necessary, cancelling clinics or using agency or bank staff to allow all nurses to take part in team activities. Second, they organised workshops, with facilitators, at which staff could voice opinions, share ideas and stop being polite. Analysing the group dynamics of these sessions was an important part of the process. Third, they undertook to evaluate what they were doing, to allow teams to build on their successes and learn from mistakes. Finally, they recognised that all staff needed feedback from managers; particularly positive feedback about their work.

The managers were acting as agents of change, a role which demands a range of skills, not least the ability to plan and to provide leadership. They found they had to make careful judgments about the rate of change – a slower, incremental pace often proved more effective. All teams have a mixture of abilities and personalities. Although it may be rewarding and exciting to work with the enthusiastic 'early adopters', patience and sensitivity are needed to bring along the 'late adopters' who have difficulty accepting the new. Plans for achieving tasks also had to take into

account the development of team members. Giving more responsibility to staff offers opportunities for personal growth.

The managers learnt that change agents need enormous amounts of energy and enthusiasm to maintain the momentum of new developments. Teams need encouragement – they may especially appreciate praise for the small achievements that often get overlooked in the general upheaval of organisational change.

Making progress

Although the neighbourhood nurse managers are all coping with different situations and have teams with different needs, they also have a great deal in common. Their training helped them to recognise the shared elements in their job and to form a peer group that is a resource and provides support.

It is less than a year since neighbourhood nursing was introduced in Islington, so much of the story is anecdotal. The nursing teams will continue to meet challenges such as more intersectoral collaboration and working with the specialist advisers on child protection, continence and diabetes.

Contact

Neighbourhood Nurse Managers or Professional Development Officer, Islington Health Authority Community and Continuing Care Unit, Insurance House, Insurance Street, London WC1X 0JB, tel 071 278 2323.

Resources

Job description for neighbourhood nurse manager. Details of team workshops, which were organised with and facilitated by the district training department.

Section 5

Assessing individual performance

Assessing individual performance

The performance of individual practitioners contributes to the overall quality of health services. Methods of assessing individual performance include peer review, appraisal by managers and appraisal by patients or clients. The process of assessing performance includes: defining responsibilities; setting objectives, targets or standards; making plans to achieve them; measuring progress; and feeding back information about results. These can help to increase motivation, identify training needs, assist professional development and keep service developments on the right course.

Appraisal of staff by managers, with the emphasis on setting and achieving performance targets, is now firmly part of management culture in the NHS. The challenge is to ensure that this approach meshes with and reinforces other approaches to enhancing quality of care.

The keynote paper by Hilary Rowland looks specifically at the system of individual performance review (IPR) that has been introduced for managers in the NHS. IPR can help managers achieve objectives but it has serious limitations as a mechanism for enhancing service quality. Objectives that are set in IPR tend to be quantitative rather than qualitative. The 'process' dimensions of service quality – how objectives are achieved – are particularly difficult to incorporate and may be impossible to measure with current information systems. For community health services, where service quality invariably depends on multidisciplinary effort, a major drawback of IPR is that it cannot assess team performance.

Rowland concludes that IPR can raise awareness about quality issues but alone cannot enhance service quality. It should be one element in a programme of change to make quality part of the culture of the NHS.

Two of the short reports in this section discuss the practical aspects of assessing individual performance.

The first case study, of community practice teachers, makes the case for involving in assessment all those with an interest in the teacher-learner relationship. Community practice teacher, learner, course tutor and senior nurse manager all have different and complementary roles to play. Increasingly, community practice teachers are forming peer 'support groups', with management backing, to monitor and review their practice and teaching.

The second case study is of nursing auxiliaries, whose performance is rarely monitored systematically. As a result of an investigation into nursing auxiliaries' needs for support and development, Merton and Sutton Health Authority has introduced: an induction programme for new recruits; training courses; a system for district nurses to monitor auxiliaries' work; and individual performance review. These changes have increased nursing auxiliaries' knowledge and improved relationships in the nursing team.

The final report in this section explores the effects of stress on nurses' performance and describes approaches to reducing and coping with stress in nursing. One important way in which managers can help to reduce stress and prevent 'burn out' is to develop structures for supporting field staff. This may include making available personal counselling and setting up peer support groups of various kinds. Working in a constantly changing NHS is a source of stress that should

not be underestimated. Effective management of change is therefore an essential part of reducing stress and maximising staff performance.

Staff performance reviews – indicators of quality?
Hilary Rowland

This paper describes the system of individual performance review (IPR) that has been introduced for managers in the NHS. The experience of introducing IPR in Islington is discussed and an evaluation made of the possibilities and limitations of using IPR as a mechanism for assessing quality.

The background

One of the reasons for introducing a national health service in 1948 was to eliminate financial barriers to access to the caring professions, thus allowing them to care for all those in need. In the following 25 years, professionalisation proceeded apace and the professions increased their influence in the welfare sector. In the expansionary 50s and 60s, when demands for health care appeared to be infinite and resources were only loosely constrained, professionals were paramount in deciding how health services should develop.

However, by the 1974 NHS reorganisation the oil crisis had caused a reduction in public sector spending. Politicians also reasserted their power to make the NHS more accountable. These trends imposed considerable strains on professional groups making decisions by consensus, and a change in management style was required.

The introduction of general management into the NHS was an attempt to balance the conflicts of limited resources and increasing demands and to shift the balance between professional and organisational values. General managers were expected to give the service overall direction and coherence, resolve conflicts of professional interest and set priorities within limited resources. This has led to the production of mission statements to which managers and professionals can subscribe, and to attempts to incorporate professionals into management.

Better management, better health called on managers to exercise 'proper responsibility for the direction, quantity and quality as well as the cost of care'.[1] It points out that 'managers cannot therefore avoid involvement in questions of professional practice and there are no easy ways of handling the tensions and conflicts that can arise. Negotiations have to take place on the use of scarce resources. There needs to be more collaboration on review of information relating to performance.' A performance review system was recommended for all health authorities, making managers responsible for setting clear standards of performance for their staff, monitoring progress towards those targets and providing help and guidance where necessary. So individual performance review (IPR) was born.

Authorities which already had a system of performance review were not required to adopt IPR as long as they could provide ratings for performance related pay. IPR was not seen as the only system of performance review in the health service and many other systems continue to co-exist with it. Nurses and others who had appraisal systems in operation tended to introduce IPR only for senior managers.

Individual performance review

IPR is a three stage cycle which is intended to run over 12 months. Stage one begins with the manager and jobholder together agreeing a statement about the overall purpose of the job. Experience in Islington has been that this is valuable and necessary because it helps to clarify the role and define an individual's limits of responsibility. Without this it is very difficult to move on to the next step, agreeing objectives (statements of what is to be achieved), followed by actions or targets (statements about how the objectives are to be achieved). A personal development plan is drawn up, identifying learning and development needs arising from the objectives and relating to career development.

Stage two involves regular meetings between the manager and jobholder to monitor progress towards achieving the objectives. Objectives and actions may have to be revised in the light of experience or unforeseen circumstances. Problems and shortfalls are remedied as they occur. The aim of this stage is to help the manager and jobholder to keep in touch with what is going on in the job and to maintain an overview which is much broader than day-to-day operational issues.

Stage three is the major performance review which enables both parties to assess the achievement of objectives and to relate performance to rewards if the post is covered by performance related pay.

The intention of IPR is to ensure that managers are clear about the objectives they are to attain; that they know how their objectives relate to the work of others and that they get feedback and an explicit assessment of their performance. IPR should also be a coherent, systematic way of identifying training and development needs. It is a mechanism for achieving a greater degree of managerial control through the promotion of a results oriented management culture, with clear responsibility and accountability.

As with all appraisal systems, reaping full benefits depends on the interpersonal skills of those carrying out interviews. An essential feature is that the system is based on an open style of management and the catch phrase used in connection with IPR is 'no surprises'. The objectives should cover the whole job, the day-to-day routine as well as special projects, and should reflect quality and quantity of work. It has been said that IPR should not be about pressurising managers to do more and more, but that pressure may be difficult to resist because it is easier to measure quantity than quality.

IPR differs from many traditional appraisal systems in that it is not a personality-oriented or personality trait rating system. It has more in common with management by objectives (MBO) in that specific objectives are integrated with the goals of the organisation by a cascade process, objectives are quantified as far as possible, and goal-setting and appraisal are carried out on a one-to-one basis between jobholder and manager. In the perfect MBO system each member of staff should know where he or she is going, the rate of progress and how his or her efforts relate to the efforts of other members of the organisation. In theory this should result in high personal commitment by employees throughout the organisation.

IPR in Islington

In Islington about 300 people have been trained using the course developed by Training and Development Approaches and the standard NHSTA documentation with some modification. Everyone who is to be involved in IPR, as an appraiser or appraisee, must attend the course and there are about 250 people in that category. For example, in the administrative and clerical grades, training has gone as far as general administrative assistant and in nursing grades as far as sisters.

Two years after IPR was introduced it was decided to evaluate its progress and some surprising results were obtained. Seventy-five per cent of those who responded to the questionnaire claimed competence in objective setting, 80% were satisfied with the level of interpersonal skill displayed in the interviews, and 88% said they were able to be open about their difficulties. However, a third said that managers did not discuss training and development and another third indicated that where training and development had been discussed it had not actually taken place. While these results are generally encouraging, it may still be too early to assess how well IPR has taken hold, because only a quarter of the respondents had completed at least one IPR cycle.

Approaches to quality

Like performance review, quality is an issue that received renewed emphasis as a result of the Griffiths report on management in the NHS, which highlighted the absence of an explicit, systematic and continuous process of assessment of quality.[2] Although there is a broad consensus about what constitutes a good health service, there are unresolved questions about how to apply quality assurance in the NHS. There are some useful methods for quality assessment and assurance but lack of managerial and financial resources may make them unattainable.

Philip Crosby is a name linked to the quality management movement in America and he has had a major impact on American manufacturing policy.[3] While the quality issues in manufacturing are considerably simpler because the product is easier to identify, he makes some points about the management of quality that can be applied to a service industry.

He maintains that where management does not provide a clear performance standard or definition of quality, employees develop their own and the operation settles on a level of incompetence. Doing things wrong costs money. It costs nothing to do things right, but managers do not know the price of non-conformity with standards. Further, management denies that it is the cause of the problem and most efforts at quality improvement are aimed at the lower levels of the organisation, which is why they fail.

The effort is called a programme rather than a process and one programme is replaced by another. Quality assurance should be a continuous process of cultural change which involves changing attitudes, values and providing role models. Crosby argues that management has three basic tasks – to establish the requirements employees are to meet; supply the wherewithall employees need to meet the requirements; and to spend time encouraging and helping employees to meet requirements.

A problem in the NHS is the lack of what Edmonstone has termed 'public service orientation', in which services are seen from the point of view of the customer and the citizen.[4] To gain this orientation in the health service will require a radical rethink of the way in which many services are provided.

An example of services moving in this direction comes from the review of child health services which was carried out in Islington. A statement of intent was produced which included the item: 'Services should be sensitive to the needs of children and their families. Parents will be encouraged to participate actively in decisions relating to the care and treatment of their children.' This was changed by the consultant paediatrician to: 'The parent is the primary health care giver.' For services to reflect this value an attitudinal shift among staff would be required, which would be a major management of change issue for managers, requiring training and education.

Managers need to spell out clear organisational values which reflect a concern for quality and to devise strategies for a process of quality improvement. This means senior managers must have quality on the agenda all the time and must understand and use the aspects of NHS culture that will facilitate a commitment to quality at all levels of the organisation. Quality assurance experts in the organisation also need to understand its culture and should be able to influence and support senior managers appropriately. Many professionals in the NHS have strong service values which led them to join the health service in the first place and most would say they want to do a good job. If we are concerned with harnessing that motivation and empowering them to do so, we need to look at what gets in the way. What are people in the NHS rewarded for?

IPR and quality

There is no doubt that the NHS is becoming task and results orientated and IPR is one of the contributing factors. Managers are judged by and rewarded for their ability to achieve objectives. Process – how the objectives are achieved – is likely to be forgotten unless it is brought into the IPR assessment. Although managerial effectiveness depends on attention to process, it is difficult to appraise and measure in IPR terms. Dimensions of service quality such as acceptability are linked to process issues, for example the personal interactions between consumers and providers, which will probably not be assessed by IPR unless specific standards can be set.

In the Islington IPR survey, 69% of respondents indicated that their objectives included measures of quality as well as quantity. This probably paints a far too rosy picture – the reality is likely to be that managers and staff have no idea how to measure quality in their service. Other research has shown that only 7% of managers' objectives had to do with effectiveness and quality. Even if objectives about quality are set, lack of information makes it difficult to assess whether they have been achieved. Another problem is that assessment is always after the event. Crosby emphasises that it is always better to prevent mistakes than to take action afterwards. IPR is not intended to focus only on the past, time should be spent planning for the future. This aspect of IPR may help to make prevention part of quality improvement.

When IPR is used as a way of evaluating poor performance, many managers avoid communicating this to employees. They may bend over backwards to try to be nice, because

they have had bad experiences of appraisal in the past. This avoidance of the negative aspects of IPR may account for the optimistic picture that emerged from the survey. However, it may be difficult for managers to identify bad performance if objectives and targets have substantial changes made to them in the course of the yearly cycle. There may be very good reasons for failing to achieve targets, such as interventions from the centre like clinical nurse grading, but genuine reasons and poor performance can sometimes be hard to untangle.

It is unrealistic to expect IPR alone to change the organisational climate and generate concern about quality. IPR is not yet part of the culture, 'the way we do things around here'. In 1985 a survey showed that while 85% of private companies were using performance appraisal, only 50% of the public sector was using it. Extending perfomance related pay is likely to increase commitment to IPR, in the minds if not the hearts of NHS managers.

Appraisal can become part of an organisation's change activity, particularly if it focusses on the work team and is conducted in a participative and transactional manner. This means individuals making a contribution to setting goals, and performance being evaluated in the light of all the forces that may affect it, including the impact of the manager, the team and the organisation as a whole.[5] Much of this is built into the IPR system but it is weakest at assessing the performance and contribution of the team. IPR is about the individual, although it recognises that individuals may share responsibility for achieving an objective. There is no mechanism in IPR for assessing team performance. Since service quality always depends on team effort, this is a major difficulty with IPR as a quality assurance mechanism.

A culture of quality

Although IPR is a good system, it is not a good indicator of quality. Knowledge about quality in the NHS is growing rapidly but the knowledge managers have lags far behind, particularly how to set objectives which measure quality. Many managers feel that information systems are inadequate to enable them to set and monitor these types of objectives. Cultural change is needed to introduce concern for quality into the NHS but IPR is not the most effective tool to do this. The most that IPR can achieve in the quest for quality of service is to raise awareness, begin the dialogue and raise questions that need to be asked of individuals, professional groups, service users and managers in order for quality to become 'everyone's business'.

References

1. National Health Service Training Authority. *Better management, better health*, 1986.
2. Department of Health and Social Security. *NHS Management Inquiry* (Leader of inquiry R Griffiths), 1983.
3. Crosby P.B. *Quality without teams*, 1987.
4. Edmonstone, J. *When will they ever learn? Problems with the 'learning organisation' concept in the public sector.* Unpublished paper for the 6th Lancaster University conference on education and training in organisations, 1988.
5. Huczynski, A. *Encyclopaedia of organisational change methods*, 1987.

Assessing the performance of the community practice teacher

Traditionally, teachers in all spheres of education have been evaluated by the success of their students. The English National Board for Nursing, Midwifery and Health Visiting has attempted to move away from this approach and to find ways in which community practice teaching can be monitored, reviewed and enhanced. This involves examining the roles of the three main actors (the community practice teacher, course tutor and senior nurse manager) in monitoring the quality of community practice teaching and learner development. Some criteria for assessing community practice teacher performance are suggested as a starting point for discussion. The role of the community practice teacher could be enhanced by building in a system of self and colleague review. There might be considerable benefits for practice and teaching if community practice teachers were given responsibility for monitoring students' learning environments.

'Community practice teacher' is a title that includes practical work teachers, fieldwork teachers and the supervisors of community psychiatric nurses and community mental handicap nurses, all of whom have completed the English National Board community practice teacher course.

Criteria for selection to the course help to set a standard for future practice as a teacher. Factors taken into account are experience, qualifications, motivation, resources, work environment and an interest in learners. The usual starting point for selection is the recommendation of a practitioner's immediate manager. This implies good knowledge of the practitioner's skills and standard of practice. However, this may no longer be the case where functional management has been replaced by a generic model or where managers are not in close day-to-day contact with the practitioner.

Responsibility for the learner rests firmly with the course tutor, who delegates responsibility for teaching and assessment of practice to the community practice teacher. The course tutor makes the final decision on the placement of the learner, although it is common to find that the senior nurse manager places the student and then informs the course tutor.

The senior nurse manager, course tutor, personal tutor and community practice teacher are all involved in the placement, teaching and assessment of the learner. However, they have not been as active in monitoring the performance of the community practice teacher, although they all have a legitimate role in promoting standards of practice and teaching. Each could make a different contribution and they are interdependent.

Community practice teachers run a risk of becoming isolated from their colleagues because of the nature of community nursing practice. Increasingly community practice teachers are forming peer 'support groups' with management backing not only to identify and resolve problems, but also for purposeful monitoring and review of practice and teaching.

Senior nurse managers have a responsibility to ensure that community practice teaching is adequately resourced, effective and efficient. They are not responsible for teaching and assessment of the learner, but educational issues invariably have management immplications.

Course tutors are responsible for the totality of the learner's experience. Their visits to learners during taught practice will include monitoring of the learning environment as well as assessing the learner's progress.

Learners can also make a contribution to improving the standard of practice and teaching. Often the community practice teacher and learner will evaluate the learner's experience informally as the period of taught practice progresses. By a positive and nonthreatening exchange of views and experiences the performance of both can be reviewed and modified.

Criteria for assessing community practice teacher performance might include the following:

- informs managers of workload demands and other related matters that affect practice and teaching functions.
- has a clear understanding of contemporary practice
- sets appropriate objectives and means of achieving them.
- promotes independence in the learner.
- makes effective use of time in meeting competing demands of teaching and practice.
- offers and is able to receive constructive criticism.
- identifies learner difficulties and takes early action to remedy them wherever possible.
- is able to draw on colleagues and other team members making use of their knowledge and skills where appropriate.
- accepts responsibility for the learner's experience in taught practice and accountability to the examination board.
- makes full use of available resources in planning and implementing a learning programme.
- is able to use own initiative and be innovative in the teaching and learning process.
- maintains appropriate records of learner progress and appraises the course leader accordingly.

Contact

Tom Langlands, Education Officer, English National Board for Nursing, Midwifery and Health Visiting, Victory House, 170 Tottenham Court Road, London W1P 0HA, tel 071 388 3131.

Monitoring and supporting nursing auxiliaries in Merton and Sutton

The Assistant Director of Nursing Services in the Community Unit of Merton and Sutton Health Authority set out to discover more about the workforce of nursing auxiliaries in the community and their needs for support and development. She found they were a very varied group who were offered no organised training and given little support within the district nursing team. Their work was not being monitored systematically. An induction programme for new recruits was therefore developed. Training courses for nursing auxiliaries were devised. A system was set up for district nurses to monitor auxiliaries' work, and individual performance review was introduced. As a result, nursing auxiliaries' knowledge and motivation have increased. They have a better understanding of their role in the nursing team, and relationships in the team have improved.

Nursing auxiliaries working in the community in Merton and Sutton are a varied group. Their ages range from 26 to 52 years. Some are educated to degree level while others have few formal educational qualifications, although most have been carers. Their previous jobs include occupations as diverse as teaching and bar work. The ADNS spent time with a number of auxiliaries in the district, to see them in action and to learn from them more about what their job involved, the problems and how things might be improved.

She discovered that they had no organised training; they were given little introduction to the work, learned on the job and had few opportunities for further training. Their work was not monitored properly. The reasons they gave for becoming nursing auxiliaries were that: they wanted to do something worthwhile; they liked working with people; they could use their own initiative at times; they wanted to nurse but did not have the necessary educational qualifications; they saw the job as a stepping-stone to nursing; and the hours were convenient to their family requirements. Most of the auxiliaries were working part time from 10 to 30 hours a week, mainly in the mornings and evenings but rarely at weekends. There was one full-time jobshare post.

It therefore seemed vital to organise proper induction and basic training for recruits to auxiliary nursing, and to develop a system for monitoring auxiliaries' work.

A programme for a nursing auxiliary's first day was devised which begins in the personnel department. There the auxiliary is given a folder containing: a description of the district; a 'family tree' of the management structure; copies of the disciplinary and grievance procedures; and forms necessary to the post. Then, in the community unit, she is shown a short film on lifting and given copies of books and the policy on lifting. She collects her uniform and equipment. She meets community nurse managers and is given an introduction to the unit. She meets the district nursing team, including her 'mentor', who makes her welcome and shows her vital practical things such as where to make tea, the toilet facilities and how to fill in forms. The new recruit can rely on her mentor to be there to answer any questions in the first few weeks.

An orientation programme was developed with the following aims:

- to assist the nursing auxiliary to acquire skills appropriate to the area in which he/she is working within the job description;

- to increase knowledge of patient care;

- to create an awareness of his/her role as part of the nursing team within the neighbourhood community team;

- to create an understanding of the roles of other team members including statutory and voluntary services.

The programme includes explaining and discussing the roles of the nursing auxiliary and other community staff; admission of new patients to the nursing team's list; an introduction to visiting clients in their own homes; activities of daily living; individualised patient care; policy and procedures for lifting; control of infection; health and safety; caring for terminally ill people; preventing home accidents; simple first aid; and aspects of nutrition.

A 5-day course about caring for elderly patients has also been developed within the school of nursing.

A framework for monitoring the nursing auxiliary's work has been established as follows:

- Every day the nursing team meets to discuss work allocation and to arrange meeting places when two people are required to provide care. They also discuss the previous day's workload.

- The district nurse or the district enrolled nurse regularly carries out visits with the nursing auxiliary.

- Every six months the district nurse assesses the nursing auxiliary. This is a time to be positive, to look at what has been done, problem areas and training needs. The auxiliary and district nurse see their manager together to discuss the findings and agree solutions. They all agree future action and sign the assessment form.

- The nursing auxiliary also attends weekly team meetings and monthly group meetings of all staff and managers.

A system of individual performance review has been set up which gives the manager and nursing auxiliary time to discuss past performance constructively. It also highlights potential, identifies training needs, shows up organisational shortfalls, avoids favouritism, allows information exchange, and enables an action plan to be agreed that forms the basis of the next review meeting.

As a result of these changes, nursing auxiliaries' knowledge and motivation has increased; they have a clearer understanding of their role and function in the nursing team; and relationships in the team have improved. They no longer see themselves as 'the lady who comes to bath me'. Attending staff meetings keeps the nursing auxiliaries informed about national and local developments and enables them to discuss their worries about changes that may affect their role.

Contact

Mrs Wilma Vlok, Director of Nursing Services, Community Health Services Unit, Merton and Sutton Health Authority, Community House, 124 Middleton Road, Morden, Surrey SM4 6RW, tel 081 685 9922.

Minimising stress and burn out – maximising staff performance

This workshop discussed the effects of stress in an organisation and on individual members of staff. Models of intervention to prevent stress or lessen its effects were described, including support groups such as those held for health visitors in Tower Hamlets Health Authority. Current pressures on community nurses include frequent reorganisation of services and the upheaval and anxiety this causes. Effective management of change is therefore a vital measure to reduce stress and maximise staff performance.

There are many potential signs and effects of stress in organisations and individuals. In an organisation stress may produce higher rates of absenteeism, staff turnover and wastage, sickness absence, accidents and low morale. In individuals stress can lead to sleep and digestive disorders, obsessional or impulsive emotional behaviour, poor work performance and low self-esteem.

There are two main sources of stress at work:

- *factors intrinsic to the job*, which include poor physical working conditions, shift work, job overload/underload and physical danger;

- *factors intrinsic to the organisation*, which include conflicting demands and expectations of peers, professionals and public; reorganisation and change; and a rigid, hierarchical management structure.

Stressors specfic to nursing include: dealing with life and death; inability to share problems outside work because of confidentiality; conflicting demands of job and family; adverse publicity when things go wrong; working in isolation from colleagues; the threat of violence; frequent organisational change; and the demands of professional accountability.

Supporting nurses under stress

Support for nurses under stress ranges from initiatives directed towards individuals, such as counselling or referral to a psychiatrist or psychologist, to more systematic organisational solutions which may try to tackle and prevent the causes of stress, as well as helping individuals to cope. These include the many varieties of support groups in which community nursing staff take part, such as single discipline peer groups, multidisciplinary groups (ie for a neighbourhood nursing team), multiprofessional groups (ie for all staff working with a particular group of patients or clients) or groups which are open to those working in one clinic or practice.

Groups may have a leader or facilitator from outside or this role may be taken by a group member. In some districts staff have been taught about coping with stress or have attended workshops on stress management and coping strategies.

In Tower Hamlets support for health visitors has been built into the organisation. Discussion groups, which are either clinic based or for a particular group such as first year health visitors, have been offered for some years. Managers have also responded to health visitors' needs for support with aspects of work in the district that are particularly stressful. For example, some

health visitors in the district have caseloads with a majority of non-English speaking clients. A two-day workshop was organised by several of these health visitors to discuss their problems and decide how to tackle them. The workshop was a great success and boosted the morale of those who took part, as well as generating some practical ideas that were subsequently taken forward by the health visitors and their managers.

Individuals can help to reduce stress in themselves by: learning how to identify negative signs of stress; planning and preparing their work; and building up skills by taking further training in relaxation, time management, running meetings, assertion training, problem solving and decision making.

Managers have a responsibility to do all they can to reduce stress in their staff. They can try to ensure that the right balance is struck between the amount of pressure and individual resources for dealing with it. They can prevent the organisation adding to stress by developing an open style of management, by building up good communication with their staff, and by ensuring everyone has clear job descriptions and regular appraisals. A factor that particularly causes stress in the NHS is the seemingly constant reorgnisation and change and the associated anxiety for staff. Effective management of change is therefore a vital measure to reduce stress and maximise staff performance.

Contact

Mary Burd, Principal Clinical Psychologist, Community and Primary Care, Tower Hamlets Health Authority, Steel's Lane Health Centre, 384-398 Commercial Road, London E1 0LR, tel 081 790 7171.

References

Owen, G. *Coping with stress – support network for professional carers in the health service in the United Kingdom*, 1989.
Stress in the Public Sector. Report of the High Stress Occupations Working Party, 1988.

Primary Health Care Group Publications

A Brave Attempt. Team working between health visitors and social workers on an inner city estate.
Hessie Sachs *May 90*
ISBN 0 903060 76 1 £9.50
Chronicles the experience of health visitors working in a team of social workers and community workers on a problem housing estate. Will interest all those concerned with developing workable policies for community care in the 1990's.

The Consumer's View: Elderly people and community health services.
Cornwell J. *Dec 89*
ISBN 0 903060 39 6 £5.00
Looks at services from a consumer perspective; discusses negative attitudes to old age and how they affect health care. Offers guidelines and resources for action. Of interest to both managers and practitioners, and those who train them.

The Future of Community Health Services.
Hughes J. *Aug 89*
ISBN 0 903060 19 1 £3.75
Describes improvements and impetus for change in community health services and analyses current threats to continued progress. Of interest to all concerned with implementing policies for primary and community care.

Planning Primary Care.
Marks L. *Feb 89*
ISBN 0 903060 12 4 £5.00
Links between FPCs and DHAs are analysed as well as some of the hurdles to creating a coherent primary care service. Describes four initiatives, including an FPC-based community physician and an experiment in Regional review.

Working Towards Racial Equality in Health Care. The Haringey experience.
Kalsi N and Constantinides P. *March 89*
ISBN 0 903060 07 8 £5.00
Useful lessons from the experience of Haringey Health Authority, committed to equal opportunities in employment and racial equality in health care. Aimed at helping other authorities, describes problems as well as progress. Includes job descriptions and an example of an equal opportunities policy.

Making Use of Community Health Services Information.
Winn K.E and King C. *Sept 86*
£1.50
Two case studies of ways in which information is used to review, plan and manage services.

Changing School Health Services.
Brown P, Gordon P and Hughes J. *Jan 88*
ISBN 0 903060 03 5 £8.50
An information pack of particular interest to managers seeking to review and develop school health services. Includes policy reviews, case studies, objective setting, bibliography.

User Friendly Services. Guidelines for managers of community health services.
Winn E and Quick A. *Oct 89*
ISBN 0 903060 36 1 £9.75
Practical help on making services user friendly. Detailed case studies on 'getting started', common pitfalls and the particular problems of consumer surveys.

Breaking New Ground: The Lambeth Community Care Centre.
Winn K.E and King C. *Nov 87*
KFC 87/138 £1.50
Describes a small, community-based, GP hospital in inner London with valuable lessons about patient autonomy, involving local users and the need to clarify and communicate objectives.

Cumberlege in Action.
Brown P and Gordon P. *Apr 87*
KFC 87/67 £2.50
A directory of good practice that influenced the Community Nursing Review Team.

The Management Response to Childhoood Accidents.
Constantinides P. *June 87*
ISBN 0 900889 98 5 £3.50
A guide for managers to the effective use of NHS information and resources to prevent accident injuries in childhood.

Decentralising Community Health Services.
Dalley G, Hughes J and King C. *Nov 87*
ISBN 0 903060 02 7 £2.50
Report of a national workshop to chart the progress being made on decentralising community health services.

Pimlico Patch Committee. An experiment in locality planning.
Dunford H and Hughes J. *Aug 88*
ISBN 0 903060 06 X £5.00
An experiment involving consumers and both statutory and voluntary service providers, planning for their locality. Includes lessons and recommendations.

Primary Health Care on the Agenda? A discussion document.
Marks L. *July 87*
£2.50
Outlines the management challenges facing primary health care, including raising standards and assessing quality of services.

The Emperor's New Clothes. Family Practitioner Committees in the 1980s.
Allsop J and May A. *1986*
£8.00
Analyses the political climate in which FPCs operate, their influence on primary care and potential for development. Essential reference text.

An Experiment in Advocacy. The Hackney multi-ethnic women's health project.
Cornwell J and Gordon P. *Dec 84*
KFC 84/237 £1.50
Describes how this influential project was planned and established and how the workers operate. Discusses the differences between advocacy and interpreting.

Series of Working Papers for Managers

Coordinating Change in Child Health Services.
Working paper for managers: 1
Winn K.E *Jan 88 KFC 88/5* *£2.00*
How Newham Community Unit set about decentralising the administration its clinics and health centres and the benefits that resulted.

Preparing for Cumberlege.
Working paper for managers: 2
Brown P. *Feb 88 KFC 88/4* *£2.00*
Lessons from workshops for district nurse and health visitor managers working together. Focusses on caring for elderly people at home. Includes checklist for running similar workshops.

Introducing Neighbourhood Nursing: The Management of Change.
Working paper for managers: 3
Dalley G and Brown P. Mar 88 KFC 88/17 £2.00
Examines the difficulties of transition to a decentralised nursing service.

Can 'Cumberlege' Work in the Inner City: The Wandsworth View.
Working paper managers: 4
Dalley G. *July 88 KFC 88/34* *£2.00*
Report of a workshop on Wandsworth's experience of introducing neighbourhood nursing teams in the inner city.

Locality Management. From proposals to practice in Lewisham and North Southwark.
Working paper for managers: 5
Morgan D. Aug 89 ISBN 0 903060 35 3 £3.50
Describes the process of decentralising health services in a Priority Care Unit. Includes consultation exercise, objectives for patch managers and financial considerations.

Decentralising community health services in Islington.
Working paper for managers No: 6.
Dalley G. Jan 90 ISBN 0 903060 68 X £3.50
This is the latest in a series of working papers for managers from the Primary Health Care Group and describes the steps by which one health authority decentralised its community health services. It discusses the management process, consultation exercises and the scope and aims of evaluation. It also discusses some of the issues and options surrounding "patch management" as a means of improving the quality of primary health

Details of ordering

Postal sales only from:
Bailey Distribution Ltd, Department D/KFP,
Warner House, Bowles Well Gardens,
West Bay Road, Folkestone, Kent, CT19 6JP.
Cheques to Bailey Ltd., plus 10% p+p.

Counter sales only from:
King's Fund Centre,
126 Albert Street, London NW1 7NF.
Tel: 071 267 6111.

If you have any difficulty please contact the Primary Health Care Group direct at the King's Fund Centre.

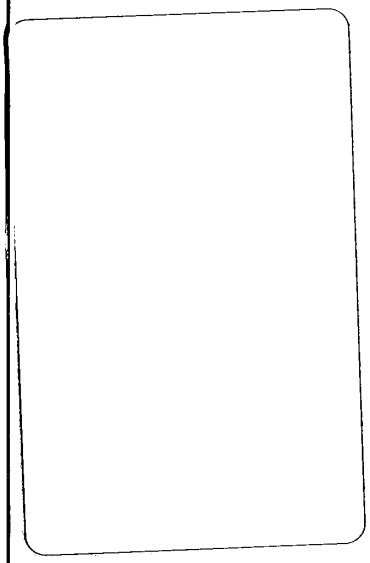
Keynote paper authors

Gillian Dalley is a researcher with interests in the organisation of community health services and interprofessional collaboration. She has worked with the Primary Health Care Group at the King's Fund Centre, at the Centre for Health Economics, University of York. She is now at the Policy Studies Institute.

Helen Kendall is strategic consultancy manager of the Strategic Consultancy Team, Management Services, Oxford Regional Health Authority.

Wendy King is a management consultant with Ernst and Young. She was formerly national co-ordinator of community resource management at the Department of Health.

Hilary Rowland is director of training, Islington Health Authority.



Enhancing the Quality of Community Nursing

How do you achieve a high quality community nursing service? Work on assessing the quality of nursing care generally has been advancing rapidly and in 1989 The King's Fund Primary Health Care Group held a series of three conferences to discuss quality in community nursing. *Enhancing the Quality of Community Nursing* is a selection of the keynote papers and reports from the workshops. They describe impressive examples of good practice which concern management structures, staff performance, and ways of identifying patient needs and planning and reviewing services.

Price £9.00

ISBN 0 903060 74 4