The future of Community Health Services

Edited by
Jane Hughes

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ISBN 0 903060 19 1

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Acknowledgements

This report is based on a conference held at the Kings Fund Centre in November 1988 which was organised by Gillian Dalley, Pat Gordon and Liz Winn. Special thanks for their contributions are due to the Chairman, Ken Judge; to the speakers, Gillian Dalley, Keith Houghton and Peter Westland; to the workshop leaders, Pearl Brown, Judy Hargadon, David Hunter, Tessa Jowell, Leila Lessof, Linda Marks, David St George, Jillian Stern, Mary Whitty and Andrew Wilson; and to the rapporteurs, Ami David, Mike Fox, David Law, Rachel Scragg and Liz Winn for their copious notes. Thanks also to the many participants who enlivened the discussions.

Preface

This conference to discuss the future of community health services was held at a time that can now be recognised as a watershed for community units and their managers. The confidence and impetus for change that had been built up under general management was being eroded by growing uncertainty about the direction of health policy nationally. Speculation and anxiety about the destiny of community health services had been heightened by publication of a series of reports which offered incomplete and often conflicting glimpses of the future. The Cumberlege report[1]; the green and white papers on primary health care[2,3]; and the Griffiths review of community care[4] provided analyses of longstanding problems and suggested radical solutions. However, even the most inventive reader could not piece together from them a coherent vision of how community health services should develop.

At the time the conference was held the results of the government's review of the NHS as a whole were eagerly awaited in the hope that its recommendations would resolve the confusion and dispel gathering doubts about the fate of community units. In the event, the white paper, *Working for patients,* published in January 1989, offered broad-brush proposals that raised even more questions about their future[5]. It did nothing to reduce uncertainty and its emphasis on acute hospitals and general practice reinforced the feeling that community services were still the 'poor relation', filling the gaps left by more prestigious services and institutions.

One of the main aims of the conference was to give those working in community health services, or closely associated with them, an opportunity to express their views about the directions the services should take. This report therefore makes a contribution to the continuing high-level policy debates, and in some respects is an antidote to them. The ideas and views it reflects were formed mainly at the 'grassroots': from the practicalities of managing the service or from working with community health staff. The speakers' presentations and discussion during the day illuminated a number of themes that are central to developing workable policies for primary and community care.

A growing sense of purpose

Under general management, community units in many districts increased their visibility if not their budgets and managers began making changes at an unprecedented pace. Most districts now have an ambitious programme of developments planned, such as reforms inspired by the Cumberlege proposals or broader changes including devolution of management to localities or neighbourhoods. There is general agreement about the ideas that underpin these changes, with an emphasis on locally-based, multidisciplinary, collaborative and consumer-responsive services and attention to maintaining service quality. The orientation at this stage is still towards the processes of service delivery, although managers now recognise that they must also be concerned

with effectiveness and outcomes for patients, and accountability.

Despite the growing sense of purpose in community units, policy-makers at district, regional and national levels appear not to have improved their understanding of community services' contribution to health care. At the points where strategic decisions are taken there is no clear vision of where the services are going and how they will relate to other service sectors in the future. While this has hindered the development of community health services, an even greater threat is posed by the government's plans for the NHS. Managers' attempts to give identity and coherence to the disparate services in community units would count for little in the 'contract culture' of the reformed NHS. A likely future is that community services would be fragmented and dispersed: the most attractive and 'marketable' elements may have to make links with hospital services; GPs may employ their own community care staff; and services seen as non-essential and costly may simply be allowed to wither away.

Waiting for Griffiths

Community health services provide a significant element of 'community care' for elderly people and those with mental illnesses, learning disabilities and physical disabilities. For effective community care health and social services must work together, and the proposals in the Griffiths report are intended to make this happen more often in practice. If they are accepted by the government the proposals will have an important influence on the future shape and role of community health services.

The conference welcomed the attempt to resolve conflict and confusion in this area of care but sounded a note of warning about the practicalities of the Griffiths' prescription. The insistence on a rigid division of responsibilities between health and social services; the dangers of expanding the private sector without adequate regulation; the consequences of ringfencing budgets; and the ambiguities of the care manager role could all create new problems. Of equal concern to the conference participants, however, was the 'planning blight' paralysing community care developments - caused by the government's delay in responding to the report it had commissioned.

Hand-in-hand with FPCs

Family practitioner committees are grappling with the enormous task of fulfilling their new roles in managing, planning and monitoring the quality of family practitioner services. They have already made great strides from 'pay and rations' authorities towards the strategic role envisaged in the 1987 white paper, but with their limited resources progress has been piecemeal and slow.

The 1989 white paper and the new GP contract[6] reemphasise the government's intentions to make independent contractors more accountable. FPCs are to have greater powers and more flexibility in their use of resources. However, clear messages from

the centre and stronger FPCs will not in themselves improve primary health care. All enterprising FPCs have found that to devise and implement realistic plans they must work closely with health authorities, particularly community units. The path towards collaboration may be smoothed by the new management arrangements, in which FPCs will be accountable to regional health authorities, but practical achievements may depend on how quickly RHAs will take the lead on primary health care strategy.

Time for change?

The 1989 NHS white paper offers new possibilities for further structural change in the NHS. For example, it paves the way for 'mergers' between FPCs and what remains of local health services once hospitals have become self-governing. This was just one of the possible structural reforms discussed with apprehension at the conference. Altering structures usually means shifting boundaries rather than abolishing them. A plea was made to 'let boundaries melt a bit' to give flexibility in providing services and solving problems. There is little evidence that administrative reorganisation in the health service leads to improvements in services. The experience of many conference participants had been that it caused upheaval, delayed much-needed developments, and stifled innovation.

However, it seems that managers in community health services must gather their energy for more change. The government's determination to reform the NHS by introducing self-governing hospitals and by making GPs more competitive and accountable means that the roles and relationships between health care providers must be redefined. Some dangers for community health services and their users are apparent. The services will be especially vulnerable to fragmentation; coordination and integration will be more difficult; and the cooperation that has been built up between agencies and professions may be broken down. Community services, with a responsibility to provide services to clearly defined populations, have struggled to find ways of giving priority to disadvantaged groups such as homeless families, ethnic minorities and housebound elderly people. If contracts are to be awarded for provision of specific services, will an overview of the care received by all groups in the community be lost? Who will champion the penniless and powerless?

The white paper comes at a time when we are beginning to see the benefits of agencies and professions working together with the shared aim of providing and planning comprehensive primary and community health care for defined populations. This is the basis for all current developments, and some of the government's proposals - in particular the emphasis on ensuring quality of care by setting standards and monitoring performance - could greatly strengthen this framework for improving services. However, further progress is unlikely if we cannot preserve the foundations on which our present achievements are built.

Jane Hughes

May 1989.

Introduction

The future of community health services was the title of a conference, held on 17 November 1988, organised by the Primary Health Care Group at the King's Fund Centre for Health Services Development. It was chaired by Ken Judge, Director of the King's Fund Institute, and the speakers were Gillian Dalley, Development Worker at the King's Fund Centre; Keith Houghton, Administrator of Derbyshire FPC; and Peter Westland, Under Secretary at the Association of Metropolitan Authorities. Participants included community services general managers, nurse managers, administrators and members of FPCs, GPs and community physicians.

The report follows the format of the conference. The first three chapters are the speaker's presentations. In chapter one Gillian Dalley sets the scene by reviewing developments in community health services since 1982. Peter Westland discusses the relationship between health and social services in the light of the Griffiths report in chapter two. The view from a family practitioner committee is given in chapter three by Keith Houghton.

The following five chapters are reports of the discussions that took place in the afternoon workshops, in which small groups of participants examined in detail issues of particular relevance to the future of community health services.

Some of the most exciting recent developments have been in community nursing services, and were stimulated by the timely and popular Cumberlege report. Introducing neighbourhood nursing teams is discussed in chapter four, including a proposal to combine nursing teams and general practice. Managers in community units have become used to coping with change and chapter five describes how the principles of managing change can be applied, with evident success, to community services.

There has always been a close association between community medicine and community health services. Chapter six explores how the specialty could make a greater contribution to policy development, planning, monitoring and evaluation in primary and community care. Family practitioner committees must now also tackle these tasks, which are part of their strategic role. How they are getting to grips with their new responsibilities is analysed in chapter seven.

The final chapter is about the Griffiths report and its implications. An example of putting community care ideas into practice - the Birmingham Special Action Project - is described and the likely negative effects of the Griffiths proposals are examined.

Community health services today

***Gillian Dalley**, Development Worker at the King's Fund Centre for Health Services Development, presented a review of changes in community health services since 1982. She described how managers have recognised the value of decentralising service organisation and management; have begun to build a stronger identity for their units; and are formulating a clearer philosophy of service delivery. New challenges lie ahead, particularly setting clear goals and standards against which to measure the quality of services. However, the current uncertainty about NHS policy nationally is unsettling for community health services - after a period of rapid change managers and staff now need time to consolidate developments.*

In the last five years there have been great changes in community health services. Most of those working in the services feel that improvements are being made and that a positive new identity is being established. However, this sense of achievement is accompanied by uncertainty, as changes in policy at national level raise important questions about the future of community health services. It therefore seems timely to take stock of what has been achieved so far; to identify what still remains to be done; and to think imaginatively about future possibilities.

Community health services provided by district health authorities have a low profile within the NHS: the acute hospital sector has much greater visibility and prestige. Community services give support, care and treatment to people living in the community and cover the spectrum from prevention of ill-health to care in times of chronic and even acute illness. Services encompass the range from social care to medical care and include the remedial therapies and nursing services. Clients include new born babies, terminally ill elderly people, children in school and elderly people living in old people's homes. The services are very diverse and this is one reason why it is difficult to find any common identity. Historically, community health services have been 'passed around' - many were originally the responsibility of local authorities, and some have been closely linked organisationally with hospital services which overshadowed them. In the early 1980s, however, community health services began to establish an identity of their own.

Well-recognised problems of community health services are fragmentation and lack of coordination, which may lead to duplication and gaps in services. Delivering an integrated service is made more difficult by differences between the agencies that provide community and primary care and because collaboration is required between professions with different points of view and styles of working. Most community services have developed in a haphazard way, without adequate planning, and the greater prestige of the acute hospital sector has limited the transfer of resources from hospitals to community health services. Many of the changes that have taken place since 1980 have been attempts to remedy these problems and to give community health services more coherence and direction.

Milestones for community health services

A new era for community health services began with the creation of units of management in district health authorities. *Patients First* was the policy document that led to this reorganisation and it also contained ideas about consumerism and decentralisation.[7] It emphasised the need to make decisions local: '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.'

The directive that followed suggested that one way of organising community services would be to bring them into discrete units of management.[8] A similar view was put forward in the Acheson report's recommendations to improve primary health care in inner London: 'Each district health authority should give priority to the establishment of a unit of management for the community services of the whole district. This will give the community services a single and authoritative voice.'[9]

Community units were created in most health authorities in the 1982 NHS reorganisation and this was followed several years later by the introduction of general management, first at district and then at unit level. The new community unit general managers' (UGMs) first task was to set up effective management structures and to develop a philosophy of providing community services. Those who were attracted to organising services on a locality basis found support in the report of the community nursing review team - the Cumberlege report - which was published in 1986. It offered an explicit philosophy of community nursing based on a generic approach to the provision of care to the clients in defined neighbourhoods. Community nursing is the largest component of community health services and the report has been a major influence on its development, although not every district has decided to implement the recommendations.

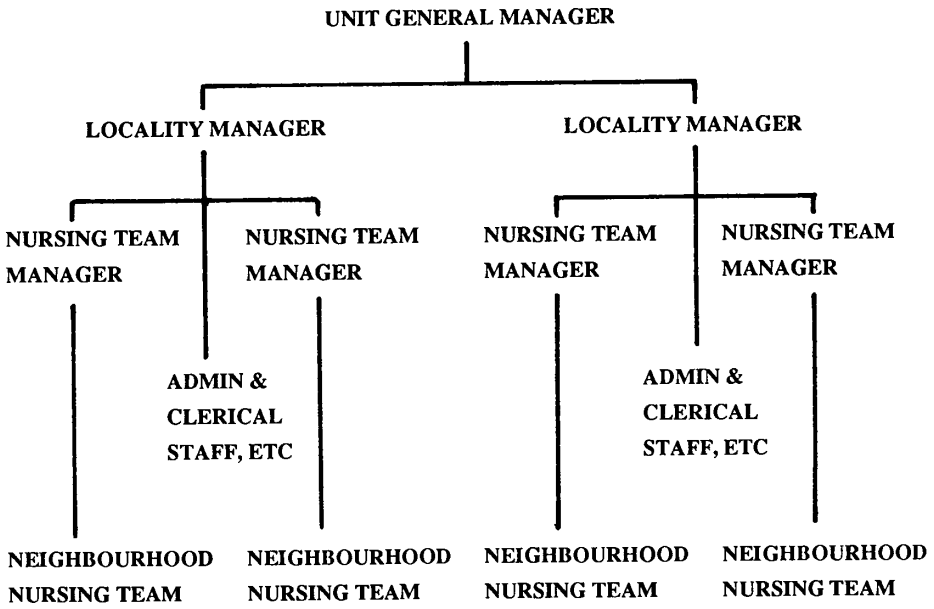
The services today

Many managers have opted to decentralise management of community health services, although this takes a variety of forms. Since the services are dispersed in the community and have a geographical focus, there is administrative logic in organising on a geographical basis - into localities, sectors or areas. In some units the principle of general management has been overlaid onto this structure, with each locality headed up by a locality general manager accountable to the UGM. This knits very well with the Cumberlege approach, based on multidisciplinary nursing teams with a single nursing manager in each neighbourhood. These neighbourhood nursing teams are beginning to form the building blocks of locality structure, as shown in simplified form in the diagram. There are many variations on this theme but all have in common geographical or locality organisation; generic management within the community unit; and an emphasis on multidisciplinary team working.

A common core of philosophy is evolving to accompany these organisational structures. Most community managers would agree that there should be:

- a multidisciplinary approach to providing services which are focussed on the needs of clients;
- a move towards more locally-based decision-making and planning, based on identification of the needs of populations;
- a greater collaboration across agency boundaries (with GPs and FPCs, local authorities and voluntary organisations), between the professions which provide services in the community, and between units in the health authority;
- more emphasis on responding to the needs of service users - although 'consumerism' in health care may be easier to discuss than to achieve in practice;
- increased attention to service quality and to establishing standards against which quality can be measured.

A LOCALITY BASED COMMUNITY UNIT



This 'philosophy' is the basis for the aims and objectives which most managers have set for themselves and their units. However, they are trying to meet these aims in a demanding and uncertain environment which influences and constrains what can be achieved. Many of the longstanding problems of providing community health services which were described above remain unresolved and a new set of difficulties have been added to them in recent years. These difficulties include:

- pressure to keep people in the community and the introduction of policies for early discharge from hospital which put additional demands on community health services. When services are under such pressure it is difficult to maintain and improve their quality.

- competing priorities. Community health services are expected to change in response to issues that are given importance nationally while developing in line with local priorities and plans. For example, in health visiting a national crisis gave urgency to formulating adequate child protection policies and time had to be given to this at the expense of other issues that may have been given priority locally.

- uncertain national policy. Managers have worked hard to establish community units, develop philosophies of service delivery and set priorities, but they now feel unsure about what the future holds for them and for community health services.

Strengthening services

Despite these difficulties, progress is being made towards the aims that managers have set for their units. A number of areas can be identified for further work to strengthen what has been achieved so far. Setting clear goals and standards is vital for the development of community health services and it is likely to be one of the most important areas for future activity. Work is also needed to build a strong identity for community health services and to achieve equal status with other sectors of the NHS, although this may prove difficult at a time of change and uncertainty. The teambuilding that is happening in some units is an important way of tackling the continuing problems of gaps and duplication in services and of overcoming hostility between professions. Everyone working in community health services needs to have their contribution valued and their achievements recognised. After going through so many changes community health services now need time for consolidation, not further disruption.

A local authority perspective on community health services

***Peter Westland**, Under Secretary, Association of Metropolitan Authorities, described how community health services and social services departments tend to view some aspects of each other's work with mutual suspicion. He speculated about how relationships between the two services would change if proposals in the Griffiths report on community care were implemented. He welcomed the report's emphasis on integration of planning; coordination and flexibility of services; and the idea of a new worker to cover the 'middle ground' of supporting people at home, but pointed out the problems that might arise from a rigid definition of health service responsibilities; 'ringfenced' budgets; and care managers in social services departments. He assessed the possibilities for change and concluded that restructuring alone would not bring better integration of care - it needed confidence on both sides to 'let the boundaries melt a bit'.*

Views from all sides

It is difficult to give a simple account of how community health services are seen because neither the social services world nor the health services as a whole has a consistent view of them. In addition, health authorities themselves do not seem to have a clear vision of the future development of community services in relation to changing patterns of health care. The description that follows is an attempt to illustrate how social services and community health services see some aspects of each other's work. It is not based on extensive research, but on recent discussions and observations.

The local authority view

If the average director of social services was asked about community health services he would list district nurses, health visitors, nursing auxiliaries and, depending on the area, domiciliary occupational therapists, a home bathing service, chiropody and dentistry. In most places he would expect to find nursing support for residential and day care establishments for children and elderly people. However, the director would not be very clear about the distinction between his own day centres for confused elderly people and any similar day hospitals run either by the community health team or the geriatric team, which itself may or may not be part of community health services. The director would look to health visitors for active support in the field of child abuse and child protection and would be aware that in recent years their attitudes towards this work and the cooperation it requires had become much more positive.

Long-serving directors of social services - and there are not many of these - will remember when district nurses and health visitors were employed by local authorities and how they practically disappeared from view after being taken over by a largely

indifferent NHS in 1974. The community nursing service subsequently had a crisis of confidence and identity. Then Julia Cumberlege came along and community nursing was lucky to find such a champion.

The average director of social services will also know that some health visitors and district nurses are attached to GPs and will wonder (without doing anything to find out) how attached nurses relate to the rest of community health services. He will be aware too that in some districts internal boundaries have been changed to make health localities or neighbourhoods coterminous with social services area teams. Directors of social services will regard the community nursing service and probably community health services as a good thing. They probably think that it needs major reinforcement because social services staff often have to do work which should be done by community health services or some other arm of the district health authority.

The community health services view of social services

The views about social services expressed by managers in community health services are the mirror image of those described above, which indicates some real problems.

A unit general manager said: 'My staff resent being used to get patients out of their beds so that they can go to a social services day centre.' Another manager, resentful that the local authority could find funds for some health promotion work when she had none said: 'health promotion is part of health care - it can't be part of non-health care.' 'We ought to have some auxiliaries to do the bathing and feeding of the elderly at home. These are essential parts of health care' said another locality manager.

The fact that locality managers seem poorly paid - they earn about the same as a probationary police constable - and therefore feel junior to social services area officers and almost everyone else in sight, does not help cement relationships.

A community care unit general manager said: ' The health care in local authority residential establishments is very poor indeed...research has shown that there are large numbers of elderly people in local authority residential care with treatable conditions who aren't getting treatment.' This raises many questions about relationships between health and social services, not least who is responsible for this state of affairs.

There is much common ground between community health services and social services where care for individual clients is concerned. It is precisely because the territory is shared and because the two sets of staff have different institutional loyalties and traditions that they struggle to carve out separate identities. Some elements of the identities are clearly different, but they coalesce in the middle where social care and health care are virtually indistinguishable. In this territory the quest for separate identities and organisations can be counterproductive, especially attempts to give a national prescription for identities and roles. At best national prescriptions should pin *responsibility* on a particular authority to ensure that work is being done - it should be a

fail-safe prescription. Accountability does not necessarily mean doing the work yourself, merely that you are responsible for ensuring that it gets done by someone.

Finally, there's a word on democracy from a locality manager: 'Local authorities are too bureaucratic - they are not cost-conscious and they spend a lot of time placating councillors - they pander too much to pressure from the community....whereas the community health service can concentrate on individuals and the health care which they need.'

While this illustrates just one approach to managing community health services, it shows how great the gulf between health and social services can be. Equally worryingly, it demonstrates the spread of a management style in the NHS that ignores public opinion and what is going on in the community.

The implications of the Griffiths report

In the Griffiths report the emphasis is on health and local authorities planning together: 'There must be a clear framework within which local and health authorities are working out their own processes of coordination.' 'In order to get a specific ringfenced grant from central government local authorities will have to show that health authorities' commitment and contribution have been secured.'

Flexibility of services and management of individual cases is given prime importance, rather than allocating responsibility for particular client groups to one authority or the other. 'SSDs should be reorientated towards ensuring that individuals' needs are identified; packages of care devised and services coordinated.'

Griffiths also saw a need 'for a new multi-purpose auxiliary force with limited training' who would combine the skills of nursing auxiliaries, home helps, care assistants, home carers, crossroads attendants, etc.

It makes a great deal of sense for a new multipurpose worker with limited training to cover the middle ground in terms of supporting people at home; and for the report to focus on training, integration of planning, secure funding arrangements, coordination and flexibility of services rather than on which organisation should employ people or take the lead responsibility. There are however some problems with the Griffiths recommendations.

Defining responsibilities

Sir Roy Griffiths thought that 'medically required community health services' should continue to be the responsibility of health authorities. These services are described as 'investigation, diagnosis, treatment and rehabilitation undertaken by a doctor or other professional staff to whom a doctor has referred the patient'. This begs many questions and, if the definition was taken literally, 90% of the work of social services

departments would be passed over to health authorities. What, for example, is rehabilitation? If a doctor has referred a patient with a recent amputation to the local authority occupational therapy service is the occupational therapist's input to the patient's rehabilitation health service or local authority work? Could the occupational therapist be seen as accountable to the doctor or, though it might be revolutionary, to the patient? In the first case occupational therapy is a health service, in the second case manifestly it is not.

Griffiths also says that long-term care for those with a medical condition or with needs arising from a medical condition, plus those with disabilities affecting their normal acute health care, are the continuing responsibility of the health service.

These definitions are extremely complex and illustrate the problems of trying to separate health and social services responsibilities. But rigid definitions will not help to solve the difficulties in the relationship between health and social services. It is as well that the rest of the Griffiths report emphasises the need for flexibility and avoidance of rigid definitions of who does what. However, it is vital that there should be a clear definition of who is responsible in an *individual* case, although achieving that accountability in the present and foreseeable organisational structure of health and social services poses problems. Work with individual people who need services is not amenable to even a finely tuned national prescription: the flexibility and integration required locally will demand energy, intelligence, altruism and an uncharacteristic willingness to cede territory and money to others.

Ringfencing budgets

The Griffiths report says that the 'contribution to community care of RHAs and DHAs should be separately identified in their plans and budgets and ringfenced' (ie protected). This is one of the more worrying recommendations because there is a danger that the community health services budget will be regarded by health authorities as their only contribution to community care.

While there are some obvious advantages in ringfencing the finance for longstay hospitals for mentally ill people and for those with learning difficulties in order to protect the current and future use of that expenditure, there are also some real dangers. One of these is that ringfenced expenditure is likely to be regarded as the maximum NHS liability. In practice, because of underinvestment of capital and more particularly of revenue in longstay hospitals, this amount may be less than is required to provide an adequate service. At best therefore it should be regarded as a contribution and not as a sum which is likely without augmentation to provide good community care. In the same way there might be pressure to regard the community health services budget as ringfenced in the negative sense of being limited rather than protected.

If this happens, and community health services continue to compete with acute services in an underfunded NHS, community care could be seriously damaged. There are

different decisions to be made within the NHS about the relationship between community health services and acute care. It is blindingly obvious that increased turnover - a shorter stay in hospital and speedier transfer into the community - is leading to rapidly growing demands on community health services and local authorities. Because so many acute patients are elderly, the difficulty could become a crisis if not handled properly. Rapid acute care also increases acute care costs. How can competition for funds be avoided? Good community health services are essential to the efficient running of acute services. If the NHS is to have internal markets and independently managed hospitals there will be new challenges for community health services and changes in the way its contribution is costed and valued. Whatever happens, every authority will need a major rethink of how community health services relate on the one hand to acute hospital services and on the other to social and other community services. Changes in structure will inevitably lead to a redrawing of boundaries of responsibility and these will not necessarily be in the best interests of patients.

Options for change

There are four possibilities for change to improve community care that are worth examining.

Managerial integration at the local level

If community services are organised on a locality basis and are managed as a separate unit in the health authority, then there is a strong case for integration with social services teams covering the same patches to provide a coherent and comprehensive community care service. This does not necessarily mean that local authorities should reabsorb community health services, but a case could be made for it. Horizontal integration would have the following advantages:

- It would put control of community care resources under one management.
- It would facilitate control and support for residential care including nursing homes.
- It would enable service planning to take place in a simpler network than now and make it easier for the team to put together the most appropriate response in individual cases, which also ought to reduce the professionals' complaints about doing someone else's work.
- It would facilitate flexibility in the provision of types of service. For example, if a locality needed more district nurses then money could be switched from, say, social work posts into district nurse posts. Thus services could respond quickly as the needs of an area changed.

There are of course problems with this model: not least, who would be in charge? If the local authority was in charge would it heighten the problems caused by lack of vertical

continuity between primary and secondary health care? Would it widen the split between FPCs and other aspects of community health care? If it was managed by the health authority would it create new boundaries in community care? If the job of the NHS was to deal with health problems as defined in the Griffiths report there would certainly be a lot of people who would not be eligible for help from the new body if it was part of the health service. Could it be sufficiently accountable to the local community if it was managed by the NHS? The NHS has no real accountability to local communities at the moment. Would it be able to wring funds from acute care or even to protect itself from hostile financial raiders?

A community care agency

Another possibility for horizontal integration would be to create a third organisation, a local community care agency. However, the arguments against this are well-rehearsed, and it has been rejected by most commentators. It is a hybrid solution which creates more problems than it solves, and politically it seems a nonstarter.

Vertical integration

The other major option is vertical integration and there are already some working models: for example, community psychiatric nurses who work in a way which is well integrated with the district psychiatric hospital; and some community child health services are part of a combined paediatric team. There are obvious advantages: financial flexibility between acute and community care would be achieved at a stroke - the manager of the service could pour money into the community if that was where it was needed. The main problem is that this series of discrete specialist services would have no chance of seeing the community as a whole. But if vertical integration went as far as including social care we might see a totally new way of delivering services. At last consultants would be accountable to managers - they would be only one link in a considerable network of activity focussing on the care of an individual. Would more experience in the community open consultants' eyes to problems in the community and make them more human and less omniscient? Vertical integration has problems but all authorities will have to review services to see whether some would perform better with integration between community and acute care.

Muddling through

The fourth and final option is muddling through and hoping that community health services will develop a closer working relationship with local authority services by adopting a compatible neighbourhood or locality pattern and working in partnership on assessment, planning and coordination of community care. To achieve this something must be done about the status of NHS localities vis-a-vis social services areas - the seniority and pay of NHS managers is part of this problem. Closer relationships may mean some sacrifice of independence for each service, for example working from the same building in the future.

Experience has shown that it is possible for organisations to collaborate successfully. Some years ago it seemed a remote fantasy that the police and social workers could work together harmoniously on child abuse. Now attitudes have changed on both sides and they do cooperate - neither organisation has lost its identity or sense of purpose and each has a clearer understanding of the other's role. The challenge to community health services is to achieve that kind of understanding with social services and to be free of anxiety about who is being pushed into doing the other's job. Community health services need confidence that their professional identity will not be lost if closer relationships are formed with local authority services - confidence is needed on both sides to let the boundaries melt a bit.

But muddling through is not without problems. If the Griffiths' concept of appointing a care manager in more difficult cases is adopted it is more than likely that this role will be taken by someone in or accountable to social services. People requiring care managers are almost certain to need a community health service of one kind or another. The care manager will not have control of the health authority's budget or staff but will be charged with the responsibility of securing appropriate levels of health service care. She will not be buying in that care - she will have to rely on her skills of persuasion and cajolery to secure services. In relation to the services over which the care manager has control there is no problem: she will be judge and jury in assessment of need for and allocation of services. In relation to services supplied by others, however, the care manager can only be an advocate for the client unless she has money to buy in the service. She will need a good deal of skill if those from whom she is seeking services on behalf of a client are not to think that these services are required only because of shortcomings in social services provision. This may create tensions at locality level.

A resolution of this kind of difficulty might lie in the most recent Disabled Persons Act and its extension to those who receive services from local and health authorities.[10] Once that act is fully implemented people who fall within certain criteria will be entitled to statements of the assessment of their needs made by the care manager. They will be entitled to make representations, through an advocate if necessary, about the adequacy of the assessment or the services prescribed to meet the condition. The idea of client rights may be difficult for the health service to tolerate, but it could help to overcome the discomfort of the dual role which the care manager may have to take.

These are just some of the problems posed by the recommendations of the Griffiths report. Raising questions about the report should not be taken to imply that Griffiths' prescription is too complicated. In fact it is the only credible report produced in the last ten years which has any likelihood of improving community services. But it will not be trouble free. To make the prescription work, health and local authorities must cooperate not only at the strategic level but also at the point of assessment and delivery of services to individuals. It is important that cooperation should not just take place at senior management levels, where managers may not understand what is happening on the ground and tend to deal first with issues that affect them most closely. A more consumer-conscious approach to health care should be introduced to the NHS and this in turn should mean an enhanced role for community health services.

Family practitioner committees and community health services

Keith Houghton, Administrator of Derbyshire FPC, described the new responsibilities and challenges FPCs had taken on since becoming independent authorities in 1985. The white paper on primary health care looked at unresolved problems in primary care and proposed changes that would give FPCs a new role and greater powers. He gave examples from Derbyshire to show how FPCs and community health services can work together to overcome problems by producing strategy statements, making joint appointments, and developing joint plans. To achieve the role envisaged for them in the white paper FPCs need a different mix of skills among their staff and a new approach to planning. Wider consultation is important, to achieve a corporate view on strategic issues with local GPs. Many GPs are keen to produce plans for their own practices and FPCs and community health services should give them all the help they can.

In 1983 John Patten, then Under Secretary of State for Health and Personal Social Services, announced to an enthusiastic audience at the Society of FPCs conference that FPCs were to become independent authorities. He indicated that there would be an end to FPCs as 'pay and rations' organisations. They would become directly accountable to DHSS; take on a planning role and become more responsive to patients needs; become more concerned with value for money; collaborate with other bodies; and make the public more aware of the services offered by independent contractors. This new and very wide remit was welcomed, but the extent of the changes it implies have only gradually become apparent since FPCs became independent authorities in 1985.

Another well-known landmark in the recent development of FPCs was the green paper on primary health care published in 1986. This was the first review of primary health care for many years and it examined how services were organised and delivered; collaboration between family practitioner services and those provided by health authorities; responsiveness to need; and how to improve service quality, especially through changes in the remuneration of independent contractors.

Unresolved problems

The green paper explored a number of unresolved problems in primary health care. It proposed changes, which were confirmed in the white paper that followed in 1987, that will significantly alter relationships between independent contractors, FPCs and community health services. The problems identified included:

- the low standard of some general practice premises. The 1987 white paper recognised that good premises are the foundation of high quality care and there are now enough opportunities and incentives for FPCs to work with GPs to raise standards.

- variations in the quantity and quality of services available. This raises questions about how to define good quality primary health care, which FPCs will need to address if they are to take a greater role in setting standards and monitoring service provision.

- the unclear accountability of GPs. If GPs are asked to whom they are accountable, their answers vary - the local medical committee, the British Medical Association, the profession; some say the family practitioner committee, but not many say their patients. The question of accountability is a major theme in the 1987 white paper.

- lack of information for patients. The 1987 white paper puts great emphasis on giving patients more information about services that are available to them. It also includes provisions to enable patients to change their GPs more easily. The idea is that the well-informed patient will be able to exercise more choice, creating competition between GPs, and that this will put pressure on GPs to improve the quality of services they offer.

- value for money. In future FPCs will be concerned not just about saving money, but also about the quality of services in relation to their cost. This means examining who should provide different types of care and the economic outcomes of treatment. Variations between practices in prescribing costs and referral rates to secondary care are likely to come under close scrutiny. At the moment, GPs are getting similar payments for providing widely different services. In future there will be more incentives to undertake preventive care.

- concern about the open-ended FPC budget, especially about increasing prescribing costs. Cash-limiting the FPC budget is one of the major changes in the 1987 white paper. There will also be cash limits on ancillary staff costs, but the positive side of this is that GPs will be able to employ a wider range of staff and the FPC and community health services must work together to use these resources effectively.

- uneasy relationships between FPCs and community health services. A primary care authority may be the answer to these problems but it is a long-term solution. In the short-term, FPCs and community health services need to collaborate to resolve problems, for example duplication in provision of services, such as family planning, immunisation and vaccination, and cervical cytology, to see who does what and who does it well and then to rationalise services to achieve a better use of resources. This process can be threatening to both organisations but there are positive examples of collaboration.

The importance of collaboration

In South Derbyshire managers from the FPC met their colleagues from community health services because lines of collaboration were felt to be weak. However, the group was able to list an impressive number of initiatives that were already underway. They were jointly developing protocols for primary health care teams; a health promotion

strategy; and a computing strategy. There was liaison with a consultant diabetician to establish mini diabetic clinics in general practice. The FPC had appointed a health promotion facilitator and an Asian nurse linkworker, who was working mainly with GPs of Asian origin in Derby City, auditing their practice records, developing preventive care and diabetic screening. Part of the initiative required close collaboration with clinic staff. There was also a joint training scheme for practice nurses. Collaboration on cervical cytology was very successful and family planning services were being discussed.

To establish joint schemes such as these, there must be the will to collaborate in both organisations. However, these new developments may threaten GPs and some resistance from them might be expected. One approach to overcoming this is to devise local joint policies and plans that are realistic and not too daunting.

In Barnsley and Derbyshire the first step towards developing the FPC's planning role was to formulate a strategy statement and put it out for consultation. The Derbyshire FPC statement reads:

1. To deliver and support plans that are responsive to the needs of patients and can be achieved through contribution from the professions and their staff.

2. We desire to see a move to the provision of a comprehensive primary care service through the contractor professions that achieve a high quality and complement hospital and community services whilst at the same time avoiding unnecessary duplication.

In Derbyshire, therefore, the FPC is keen to see the development of primary health care teams. Perhaps there should be a more general shift on the part of community health services to letting GPs take on more of the preventive work for which they currently get paid. This is the direction that has been agreed with community health services in Southern Derbyshire Health Authority.

Skill mix in the FPC

If FPCs are to achieve the new role outlined for them in the 1987 white paper, their staff will need a range of new and different skills. For example, the Derbyshire FPC team now includes the following:

- *Director of research and information*, who is coordinating planning and collaboration.
- *Financial director*, who is developing financial controls.
- *Corporate manager* (practice premises), who is monitoring corporate services, eg. deputising services.

- *Computer and database manager*, a post important for future information sharing activities.
- *Health promotion facilitator*, a former health visitor, who is encouraging GPs to employ practice nurses and offer health checks to patients.
- *Training and public relations officer*, about 85% of whose time is devoted to practice nurse and GP receptionist training.
- *Asian linkworker*, who is working with ethnic community groups.
- *GP computer adviser*. GPs and their staff can come to the FPC office to see the range of practice computers that are available and test them without pressure from company representatives.

In addition to this staff team a number of specialist consultants have been appointed, drawn mainly from forward-looking practices in the area. Among them is a GP who works on a consultancy basis as an independent medical adviser to the FPC. The RMO from the Department of Health is also being employed for one day a week for a pilot period to give advice on prescribing and premises. There are a number of innovative projects which involve Derbyshire general practitioners undertaking consultancies - one can achieve much on one's own patch! A number of practices are piloting Reflotron machines (blood cholesterol monitors) and others are piloting annual report packs.

The FPC runs an award scheme for innovation for staff employed by general practitioners, which gives some financial support for the development of practice-based projects. Patient surveys can help GPs to find out what their patients want and the FPC is offering assistance with this. Practice nurse training is also being evaluated by surveying patients' views.

Planning with GPs

The 1987 white paper envisages a much stronger management and planning role for FPCs. Since GPs are independent contractors, perhaps the best that an FPC can aim for is a corporate view on strategic issues with doctors in the area - to get their support for the FPC's plans. In turn FPC staff can give GPs support to develop their services in these strategic directions. Now the FPC is a planning authority it is important to look at how plans are formulated. It is not enough anymore just to forward to the Department of Health the local medical committee (LMC) view on an issue or to consult only the LMC about FPC plans. FPCs should make their own independent assessments and decisions, then ask the LMC, among others, to comment. The LMC has an important part to play but it does not always represent the views of all GPs, so the FPC must make sure that plans are known to all practices and enlist their support.

For planning purposes Derbyshire FPC has a range of working groups concerned with ancillary staff, practice nurses, performance indicators, the annual programme, and

control of infection, plus a computer forum and a health promotion steering group. The FPC is keen to get GPs producing their own programmes and action plans. A survey of GPs found that 75% were interested in planning but needed help to begin. An information pack giving guidance and assistance is now being piloted in several practices. It was designed jointly by Derbyshire GPs and the Department of General Practice at the University of Nottingham.

The FPC is also assisting team development, with help from the Health Education Authority, and has organised three seminars for primary health care teams, which run for three days to give GPs and their teams an opportunity to meet together to set their own agendas, targets and objectives. The community services make an input, since their attached staff are involved.

Derbyshire FPC is not alone in the progress that it has made. Many other FPCs are going down the same road, hand in hand with community health services, to meet the challenges ahead. If services are to continue to develop, collaboration must be seen to work.

Health care units and neighbourhood nursing: variations on a theme

The workshop was introduced by ***Andrew Wilson****, a GP and lecturer in the Department of General Practice at Nottingham University, who described the idea of health care units, which may offer a way of combining the strengths of neighbourhood nursing and primary health care teams, and* ***Pearl Brown****, Assistant General Manager in the Community and Continuing Care Unit of Islington Health Authority, who talked about the process of implementing neighbourhood nursing in Islington, a London district with locality management. Most of the discussion was about the nuts and bolts of setting up neighbourhood nursing teams, and in particular how to work successfully with GPs.*

Health care units

The Cumberlege report stimulated a great deal of thought and discussion about how best to organise community nursing services. As a result many districts are in the process of making changes to their services. One of the key concerns is how to incorporate the idea of neighbourhood nursing with existing primary health care teams based on general practice. Neighbourhood nursing and primary health care teams are commonly seen as competing forms of organisation and each is reckoned to have its own strengths and weaknesses.

Positive aspects of neighbourhood nursing are the devolution of nurse management to a more local level; small-scale neighbourhoods, which are appropriate to developing planned care; integration of roles in the nursing team; and increased planning and monitoring of services. However, defining neighbourhoods can be a problem, especially where they cut across existing primary care teams. The threat of having existing teams dismantled has been the cause of much opposition from GPs to the ideas in the Cumberlege report.

Positive aspects of primary health care teams are that they can obtain high rates of uptake of preventive services, because a personal approach from the GP is usually most effective; general practice is a very flexible form of organisation; and patients value personal doctoring, staying with their GPs for many years. Primary care teams encourage close working relationships between a small number of professionals, an atmosphere in which trust and understanding can develop. However, there has been much criticism of the failings of primary health care teams, including poor communication in health centres; lack of mutual understanding of roles; little outreach into the community; and the continuing separation of GPs and community health services. Teams based on general practice also seem to be better at secondary prevention (early detection of disease) than primary prevention.

The best of both worlds might be had by developing the idea of health care units, based on aggregates of 15-20,000 patients and 5-10 GPs.[11] The GPs would not necessarily be a group working from one health centre. Health authorities and FPCs could help to bring practices together and many variations would be possible. Each unit would have a community GP, analogous to a neighbourhood nurse manager, who would establish the medical needs of the unit and work with the doctors or practices involved to develop and implement policies. This could be a post that combined clinical work and research to provide an epidemiological base for planning services. A nursing care unit would serve the same population as the GPs, with nurses and GPs making their own contractual arrangements. Each unit would develop paediatric screening and other preventive work and there would be negotiation between the GPs and nurse managers about nursing and medical roles. There would be liaison with other services provided by the health authority, such as mental handicap teams, chiropody and school nursing. Each unit would also be encouraged to have its own 'user group', so that the patients' voice could be heard. The catchment area for a health care unit would be decided by the team. With time they would develop towards a geographical, neighbourhood base.

Adoption of rigid zoning into geographical neighbourhoods might militate against other, less tangible, but equally important developments in primary care. There is a need to experiment with alternatives and evaluate schemes over several years. It would be a disaster if the implementation of neighbourhood nursing teams further alienated GPs from community nurses; the health care unit proposal is put forward as one way of bringing the two closer together.

Neighbourhood nursing in Islington

Neighbourhood nursing is being implemented in Islington as part of a programme of decentralising community health services.[12] There are five localities, each with a population of around 30,000 and boundaries matching those of social services. Within localities, each neighbourhood nursing team covers two social services patches and includes health visitors, district nurses, school nurses and health advisers for the elderly.

GPs have not shown much consternation about neighbourhood nursing - Islington's six primary health care teams have been preserved and the policy is to develop teams where possible. All GPs have been visited by neighbourhood nurse managers and it is hoped that the managers' enthusiasm and fresh approach will stimulate local initiatives to improve services. Four practices have decided to zone their catchment areas to match nursing neighbourhoods. Staff attached to primary health care teams work within neighbourhood boundaries, referring patients outside their area on to the appropriate neighbourhood nursing team. This arrangement is working satisfactorily.

Implementation of neighbourhood nursing is not a 'once and for all' activity. Developments need to be kept under regular review and in Islington locality managers will play a key role in this process. However, a great deal is expected of them, and it

may be unrealistic to think that locality managers can keep up the momentum for change across their wide range of responsibilities.

Introducing neighbourhood nursing

Relationships with GPs

Once the decision to introduce neighbourhood nursing has been taken, the first problem encountered in most districts is how to draw the neighbourhood boundaries. Should they be geographical or based on general practice populations? What is to be done where there are many single handed GPs with widespread catchment areas? The solutions do not seem to be any easier in small towns than big cities and a variety of structures have been developed.

The problems can be eased if GPs agree to 'zone' their catchment areas, and they can begin to do this by only accepting new patients within certain boundaries. Plymouth and Walsall have used general practice populations as the basis for neighbourhood nursing teams. In Walsall the nurses also work within defined boundaries, which resulted in a saving of £50,000, through reduced travel costs.

From the point of view of a group practice with seven partners in Worcester, the introduction of neighbourhood nursing was not a great success. The existing primary care team was dismantled and although the practice still has attached staff they work within a defined area. For patients outside that area the GPs must refer to the appropriate nursing team.

Many GPs still have doubts about neighbourhood nursing and one of the challenges of implementation is to get GPs fully involved. One way is to build on the special interests of individual GPs, for example by providing nursing input into developments they initiate, such as diabetic care.

Vocationally-trained GPs can be a resource for community health services. Some are interested in epidemiology and may be prepared to become involved in planning and monitoring services. Even better is a network of GPs in a locality who can make links with the FPC and cooperate with nurse managers to improve services.

Neighbourhood nurse managers

In most districts, the successful introduction of neighbourhood nursing requires additional nurse manager posts for which funding may not be available. One solution is to 'phase in' neighbourhood nursing and spread the costs. Another, which several districts are trying, is for the neighbourhood nurse managers to retain some clinical involvement. A more general constraint on implementation is the general shortage of trained nurse managers to take posts once they are established.

Effects on consumers

There is still very little evidence to link the organisation of services with the quality of patient care. However, if information about neighbourhoods and the names and location of nurse managers are well publicised, neighbourhood nursing should improve access to community services. In Cambridge there has been more feedback about services from the public since neighbourhood nursing was introduced, including more complaints. This has been welcomed, because it does not necessarily mean services are worse, just that it is easier now for people to make their views known.

Towards nurse practitioners?

The Cumberlege report recommended that the nurse practitioner post should be developed and established. Accountability is a key problem and the UKCC has a working party on the role of nurse practitioners. However, some specialist nursing staff in community health services are already crossing traditional boundaries between nursing and medical roles. In Walsall there is a specialist in wound care, who gives the GP advice about the patient and then the GP decides on treatment. In some districts family planning nurses have been trained to insert IUDs and are extending their role towards that of nurse practitioner.

Prevention offers great scope for nurses to work independently. In Tower Hamlets health promotion nurse posts have been created, funded 70% by the FPC and 30% by the health authority. They work on the model of the Oxford prevention of heart disease and stroke project, but are also concerned with chronic diseases such as diabetes and asthma.

Coping with change in community units

*The workshop was introduced by **Judy Hargadon**, Community Unit General Manager in Croydon Health Authority, who discussed the theory of managing change and how this could be put into practice in community health services. **Jillian Stern**, Chair of Ealing, Hammersmith and Hounslow FPC, opened the group discussion on coping with change, which showed that managers had learnt how important it is to prepare, inform, involve and support staff through the introduction of new developments. With so much change already in progress, the group felt that further structural reorganisation of community health services at this point would do more harm than good.*

In recent years community units have experienced many changes, not least those arising from the implementation of general management, and stimulated by ideas about decentralisation of services and neighbourhood nursing. There are now new reports and proposals - the Griffiths report, the white paper on primary health care and the forthcoming white paper on the NHS - that promise further changes for community services. The growing number of elderly people has also had an impact on services, increasing the need for care at home and the development of nursing homes. As policies of treatment alter, people are being discharged earlier into the community and the work of community health services staff is becoming heavier, more technical and more demanding.

The seemingly endless stream of changes has generated a high degree of uncertainty about the future. Despite this services must continue to be delivered: there are dressings to be done; clinics to organise; children who need vaccination. A central part of management is to cope with change and, just as importantly, to help staff to change.

In management theory, the effect of change is described as turbulence. The turbulence experienced by an organisation can be assessed by dividing the amount and significance of change by its state of readiness for the change. Thus staff need to be prepared for change and the uncertainties it will bring. The following points are important for managers who are guiding and supporting staff through change.

Information

A positive effort must be made to inform staff, for example by team briefing meetings and newsletters, to counteract the effect of rumours and misunderstandings. Rumours can be particularly disturbing and staff may need frequent reassurance. Information should be exchanged and sharing encouraged, so that when 'mishaps' occur everyone is better able to cope.

Inertia among staff often appears to managers to be a problem, but this may be a result of confusion about changes that are being imposed from 'outside' or 'above' and staff being unsure about the purpose and direction of change. This reinforces the need for

managers to establish good lines of communication with their staff and to supply full and reliable information.

Support and loyalty

Support and loyalty should be encouraged in order to create a culture of readiness rather than one in which people do each other down.

Changes at local level can create or add to tensions between professional staff. For example, in some districts changes to community nursing services have inflamed disputes between GPs and nurses. It is imperative that managers support their staff and help them to establish good working relationships. Primary health care teams in particular would benefit from teambuilding to strengthen bonds between members. Stereotyping of GPs is a particular problem, although this has been overcome when GPs have been involved in multidisciplinary meetings.

Independence and self-worth

Independence and self-worth are also important strengths to be fostered in both professional staff and managers. In the past community health services tended to operate bureaucratically, allowing staff very little independence. Now they are being given more freedom, within certain bounds, for example through flexitime schemes.

Managers must recognise what is good in existing services and reward staff for the 90% of their work that is going well. Staff cooperation is crucial to the success of any change, so managers must make sure they take staff with them. One manager reported that incorporating staff views had been the key to ensuring enthusiasm for a move to locality management.

Decision making

Decision making must be located at the appropriate level, and should be linked to posts not people - managers need to be sure that decisions will continue to be made even if particular individuals leave.

Managers should find ways of monitoring staff workloads to ensure a reasonable level and distribution of work. In many places discharges from hospital were made without consultation on the assumption that nursing care would be provided in the community. In Croydon attempts have been made to stop this. Now a referral must be made and there is a waiting list for the evening district nursing service. General guidelines have been drawn up to help community nurses say no to taking on more than they can cope with. This is also a way of involving staff in managing resources and planning services.

Creativity

Staff should be encouraged to be creative and to use their initiative. One way is to ask neighbourhood staff to develop annual plans for their services, with a particular emphasis on local needs. The outcome may be as small as a local information booklet, but it will be what the staff thought mattered. Initiatives in Croydon include a health visitor session in a shop; a single parent support group; a local health exhibition; and a carers support group.

Leadership

Leadership is essential, but its style should be such that the leader enables people to take risks and acknowledges that the leader can make mistakes as well. Mistakes should be a base for learning in the future, not a source of shame. The aim is to provide a role model for staff.

The independence and professionalism of staff in community health services is a great strength, but managers may have difficulty getting staff to identify with corporate strategy. Creating an environment of trust and a shared vision is important, but this can be especially difficult at a time of uncertainty and in a climate where most change is led by the acute sector.

Principles into practice

These principles have been used to implement changes in community services in Croydon, including the introduction of neighbourhood nursing; more flexible working arrangements for health visitors and other staff; health promotion by district nurses and health visitors; induction programmes and personnel procedures. A team briefing mechanism is in operation and local debate and decision-making is encouraged. Managers are learning that decisions cannot be made in isolation and the amount of time spent in one-to-one and small group management meetings has increased. Short-term and long-term plans are made for care groups rather than around functional budgets, to encourage a service-based approach to decision-making not a 'who shouted loudest' approach. Opportunities are sought to give individuals projects that will help their own development. When any change is planned managers try to make sure all team members know what the aim is and how it will be achieved.

The group felt that the worst that could happen to community health services at this point was more structural change for the sake of change. The present organisation has problems, but with closer collaboration between agencies and careful monitoring of services it offers the best prospect for the future.

Community medicine: changing roles in changing circumstances?

This workshop examined the role of community medicine in primary care, especially the capacity of the specialty to act as a resource for planning primary care and community services. The discussion was introduced by ***Leila Lessof,*** *Director of Quality Assurance and District Medical Officer in Islington Health Authority, and* ***David St George,*** *Senior Registrar in Community Medicine, North East Thames Regional Health Authority. From the debate emerged a vision of the specialty's potential contribution to the development of community health services and an assessment of the changes that would be necessary to realise this potential.*

Community medicine has always played a central role in community health services and the provision of primary health care, although the nature of this role has changed over time. Prior to 1974, the medical officer of health (MOH) in the local authority was responsible for public health and community health services, and today's community provision has evolved on the foundations laid by MOHs. Community services were brought into the NHS in 1974, when medical officers of health were replaced by community physicians, some of whom continued to manage the clinical medical officers (CMOs) who provide child health and family planning services. Senior clinical medical officers (SCMOs), with community nurse managers, became and continue to be the backbone of operational management of community services, contributing to monitoring and planning in most districts. Other community physicians took on various aspects of health service management in the integrated NHS, including assessing health needs, planning, monitoring, developing information systems, evaluating services and acting as brokers between managers and professionals.

These changing roles, especially the growing identification with management, led to a crisis in the specialty following the introduction of general management in 1984. A committee of inquiry was set up under the chairmanship of Chief Medical Officer, Sir Donald Acheson, to identify the role of community physicians in the NHS under general management. Its recommendations, published in 1988, included changing the name of the specialty to public health medicine; appointing a director of public health in each health authority; and placing greater emphasis on 'applied epidemiology', ie. assessing health needs; developing policies to meet these needs; and monitoring and evaluating services in terms of their impact on the health of the population.[13] There is still debate within the specialty about these recommendations and uncertainty about how they will be put into practice.

Community medicine has therefore inherited a variety of roles, in response to changing circumstances in the NHS. However, the distinctive contribution of community medicine stems from its concern with the health of the populations or groups within a population; its tradition of investigating factors that may affect health, including the

organisation and delivery of health services; and its practical orientation towards finding ways of improving people's health and their health care. Community physicians in the NHS are uniquely placed to take an overview of health authority services and their relationship with services provided by GPs and local authorities.

A stronger role for community medicine

Community medicine departments could therefore be an important resource for those managing primary care and community health services, although not everyone in the specialty would agree that this is an appropriate use of the scarce community physician workforce. In some districts community physicians are making a substantial contribution, and an ideal picture of their input to the processes of policy development, planning, evaluation and monitoring of services is given below.

Policy development

Community physicians keep up to date with current thinking and research and can give advice and explanations about issues in health policy and medical practice. For example, the appropriate interval between screening tests, or what measures are most effective in preventing a certain condition. Their advice can be backed up by literature reviews, statistical information and analysis of service developments in other districts, to give managers a sound basis for formulating policy.

Assessing needs

Community medicine departments can analyse routine information and set up ad hoc studies, if these are necessary, to assess needs for a particular service. This role seems to be developing especially where community units are decentralising. 'Patch profiles', showing population structure and characteristics and patterns of morbidity, are becoming an important aid to locality management. There is great potential for work in the future using FPC population registers.

A task specified in the Acheson report for health authorities' new directors of public health is to produce an annual report on the health of the population. This is likely to highlight unmet or new needs for health care and will make recommendations for improvements to services.

Planning

The activities described above are the basis for proactive planning of community health services. Contributions from community physicians are therefore most useful if they tackle local priority concerns and fit into planning cycles rather than being discrete quasi-academic projects.

Monitoring, service reviews and audit

Community physicians can help managers work out their information requirements and establish appropriate information collection and analysis systems. In districts with locality management this seems to be the stage that follows compilation of 'patch profiles'. Establishing good monitoring systems will be essential for the development of locality services. Localities should eventually have inbuilt audit systems which can pick up variations in the provision of services, their uptake and quality, as well as giving some indication of effectiveness that can be fed back to staff.

Special reviews of services may require more detailed analysis of routine information and ad hoc studies may need to be designed, for example to provide information about variations in uptake of services or outcome for patients. Reviews may include services provided by GPs, or services provided jointly by GPs and community health services, to check whether duplication or gaps in services are a problem and to see if rationalisation is necessary. For example, in Haringey a member of the department of community medicine is examining new ways of providing primary care, such as clinics run jointly by GPs and CMOs, and various schemes for sharing the care of patients with certain chronic conditions, such as diabetes, between hospital, community services and GPs. This requires close collaboration with GPs and the first step is to find out what services they are currently providing and how they would like them to develop.

Departments of community medicine do not necessarily have to undertake all these tasks themselves - they can be a source of advice and help to others more appropriately placed to carry out surveys and reviews, for example nurse managers, community health councils, and quality circles.

Facilitation

There is potential for community physicians to facilitate the development of community health services by bringing staff together and helping them to agree values, priorities and objectives, and to set standards against which progress can be measured. The wheels of this process can be oiled by feeding in information about best practice or developments elsewhere. In a similar way, community physicians could also facilitate and support collaboration between community health services and FPCs, GPs and local authority services.

Realising the potential

In only a very few districts does community medicine currently play this full range of roles. Its contribution is limited for a variety of reasons. To realise its potential the following are required:

- *Sufficient community physicians in every district.* Many districts currently have only one community medicine post and there are many unfilled vacancies throughout the country. Community physicians and SCMOs often complain that they are

overloaded with routine work and have little time to expand their role and become involved with new initiatives.

- *Multidisciplinary teams in departments of community medicine.* The knowledge and skills of social scientists complement and enhance those of community physicians. Some departments already employ statisticians, sociologists, economists and anthropologists on research and development projects, but these non-medical staff tend to be on short-term contracts and in future will need to have clearer career paths.

- *Better training and development of the specialty.* Because of the changes in community medicine, not all community physicians have been trained for the role described above and might feel they do not have the skills needed to undertake particular tasks. Training to enable them to acquire new skills is therefore required, within a framework that presents an image of the specialty playing a full and varied role in health services development.

- *Raising the expectations of managers.* Not all managers know how they could use the skills of community physicians, especially those in districts where there have been few community medicine resources. Community physicians must therefore take the initiative and demonstrate the contribution they can make to the development of primary and community health services.

The strategic role of FPCs

A paper prepared by ***Linda Marks****, Health Policy Analyst at the King's Fund Institute, which explored how FPCs were developing their strategic role and gave examples of local initiatives, was the starting point for this workshop.* ***Mary Whitty****, General Manager of the Community Unit of Riverside Health Authority, opened the discussion by commenting on the variety of roles that GPs and FPCs were now expected to fulfil. Sceptics in the group questioned whether FPCs were yet getting to grips with strategies for primary care. An evolutionary approach to strengthening the strategic role of FPCs, building on the opportunities offered by developments in DHAs such as locality management, was preferred to more radical solutions which involved structural change.*

Developing the strategic role of FPCs

Five years ago, the strategic role of FPCs would have been a most unlikely topic for a workshop. Since 1985, when FPCs became independent authorities, they have moved from 'pay and rations' authorities to independent bodies with an increasingly well-defined strategic role. FPCs are now required to produce a profile and strategy statement every five years and an annual programme. They are implementing cervical cytology services, formulating plans for the breast cancer screening programme, collaborating with DHAs to reduce hospital waiting lists and developing policies for AIDS. In addition they work with DHAs on the range of shared services in primary care.

The 1987 white paper on primary health care, *Promoting better health*, reinforced the shift from adminstration to management in FPCs. Many of its proposals are concerned with the monitoring role of FPCs, for example, with regard to practice premises and dental surgeries and payment of the basic practice allowance. The 1989 white paper *Working for patients* goes considerably further in strengthening the FPC's monitoring role. FPCs are to monitor the expenditure of GPs who choose to work within practice budgets; promote better information links between DHAs and GPs and establish local medical audit advisory committees and small units to support and monitor medical audit procedures for general practices. FPCs will also set and monitor indicative drug budgets for each practice in consultation with the GPs concerned. The 1987 white paper also discussed improving the flow of information between FPCs and consumers, contractors and other authorities. Each of these activities has some strategic component. However, the proposals with the main strategic implications are as follows:

- setting targets for and monitoring uptake of preventive services, jointly with DHAs.
- influencing the distribution of doctors to reflect local needs.

- negotiating with GPs about employment of staff under the ancillary staff reimbursement scheme. GPs will be able to employ a wider range of staff and FPCs must decide on the number and type of staff involved and the proportion of their salary to be reimbursed.
- GPs are to be encouraged to submit annual reports to FPCs.
- assessing the quality of family practitioner services.
- assessing appropriateness of hospital referrals, with independent medical advice.

These tasks give FPCs a huge agenda and the extra duties involved will require additional resources and new skills. However, analysis of what FPCs are doing now shows that they are already carrying out an even wider range of tasks than envisaged in the 1987 white paper. But not all FPCs cover the whole range - strategic development is necessarily piecemeal. Some examples of the initiatives being taken by FPCs are described below.

Local initiatives

- *Developing coherent policies in collaboration with DHAs.* The possibilities for collaboration are enormous in shared services such as dentistry, child health, screening and health promotion. There is also scope for the joint development of policies in areas of care where boundaries between services are shifting and there is a danger of gaps in provision and duplication of services. For example, minor surgery by GPs, earlier discharge from hospital, and shared care of patients with chronic illness all require new relationships to be worked out between primary care and other services.

  FPCs have taken a variety of initiatives to help policy development. For example, Lancashire FPC started by carrying out a survey of GPs to check what they knew about services from voluntary organisations, the local authority and the health authority that might help their mentally handicapped patients. To encourage GPs to undertake minor surgery, Staffordshire FPC, jointly with the health authority, has more than 60 practitioners participating in a scheme in which sterile packs are provided free by the DHA. Calderdale FPC, among others, has made progress in developing policies for shared care between GPs and consultants.

- *Quality assessment in family practitioner services.* The development of practice profiles and performance indicators signals the beginning of FPCs auditing GPs' performance. Analysis of referral rates and prescribing patterns, in conjunction with independent medical advisors, means an even greater monitoring role for FPCs. Some, such as Nottingham FPC, are encouraging DHAs to provide GPs and FPCs with statistical information on use of pathology services and referral patterns, so that GPs can monitor their own performance. Two other routes to assessing the quality of family practitioner services are gathering consumer views, through a more

informal complaints procedure and patient surveys, and analysis of the information in the proposed annual practice reports compiled by GPs.

- *Incorporating wider philosophies of primary health care* . Few FPCs have yet begun to take an interest in the World Health Organisation's *Health for all* targets,[14] but some have looked beyond the purely medical aspects of primary health care. There is increasing discussion of reducing health inequalities and several FPCs have attempted to adopt equal opportunities policies. Health promotion in its wider and non-medical sense has been given priority in some FPCs, including Staffordshire.

Tools for strategic change

The scope for strategic action by FPCs is great, but the tools for achieving it are relatively underdeveloped. First and foremost, FPCs need good **information from their contractors** - without it any strategy is built on sand. They need to be aware of the current activities and future plans of contractors to enable services to be improved, collaboration and policy development to take place with DHAs, and monitoring to be carried out. Information is currently gathered from surveys, personal visits, data from item of service payments, the Prescription Pricing Authority and the Dental Practice Board. Surveys on specific aspects of GP care, for example care of homeless people, have also been carried out by FPCs. However, information may be difficult to turn into effective action without the cooperation of local professional committees.

Traditionally, **local representative committees** (LRCs) have safeguarded professional interests but have not had a planning or information-gathering role. A reassessment of the role of LRCs is necessary and FPCs must develop new forums in which strategies for primary care can be discussed and developed.

Establishing the **right strategic forums** is no easy task because an FPC may relate to up to seven DHAs and primary care cross-cuts most existing planning frameworks. The first is to create an FPC-wide strategic forum, so that the FPC can play a full role rather than attempting to attend numerous meetings in separate DHAs. The second is to set up forums on specific issues, for example minor surgery or cervical cytology, which may cover the whole FPC area or only part of it. The third is to develop local professional forums with a established channel to management decision-making groups.

Many FPCs have set up collaboration forums, which include members of the FPC and DHA and CHC representatives. To be successful these forums need clear routes to the decision-making levels of all the authorities involved. Similarly, many FPCs are developing the role of their planning sub-committees, and in some cases their membership has been expanded to include DHA representatives.

FPCs have tried different combinations of these methods for developing strategies and their choices depend on local interest, resources and circumstances. There is no blueprint for how FPCs should fulfil their strategic role.

Roles, relationships and real strategic planning?

FPCs are unlikely to fulfil their strategic role successfully unless GPs see it as legitimate for FPCs to act in this way. Expectations of GPs are growing too - they have four main roles, which are not necessarily complementary: treating illness; preventing illness; as a small business man; and as the care manager envisaged in the Griffiths report.

Balancing the various roles of the FPC can also be difficult. It has to act as both 'policeman', for example in the inspection of premises, and as 'best friend', for example in helping to find new premises. FPCs have a great deal of discretion about how they interpret their roles, and this raises important questions about the kind of staff they need, especially in the key post of administrator.

There are a great many potential conflicts between the aspirations of individual GPs and the need for FPCs and DHAs to plan services in a corporate way. GPs have a great deal of power over the services they provide, but little strategic responsibility. In FPCs the balance between power and responsibility is the opposite.

LMCs adopt different roles in relation to FPCs. Some are seen as the planning and monitoring arm of the FPC, and some as the 'GP voice' on all matters, although they may find difficulty representing their whole constituency of independent contractors. Relationships between FPCs and LMCs could change dramatically if family practitioner services are cash limited, as proposed in the 1987 white paper. FPCs will need explicit strategies and priorities to guide decisions about use of resources.

Some members of the group questioned whether FPCs were really getting to grips with strategies for the future development of primary care. Their current concerns seemed to be more about managing independent contractors and short-term operational planning than formulating policies and strategies. What they need - and most do not yet have - is an explicit framework, agreed with the DHAs, against which progress can be judged.

The creation of primary health care authorities could make the strategic role easier to fulfil, but more structural change was not thought to be desirable at this point. The preferred option is evolution, using the opportunities created by locality management in community health services, to build strategy at the local level.

Turning Griffiths into practical reality

The workshop was introduced by ***Tessa Jowell****, Director of the Birmingham City Council Special Action Project, who described the project and its achievements and* ***David Hunter****, Health Policy Analyst at the King's Fund Institute, who considered some implications of implementing the Griffiths report on community care in a 'worse case' scenario. The Special Action Project has shown the importance of involving service users in community care developments, but its success in translating ideas into practice was considered exceptional by the workshop participants. Others are taking smaller steps in similar directions, although everywhere progress is being hindered by the government's delay in responding to Griffiths. Managers are particularly concerned about the new responsibilities they might have for controlling and monitoring the work of providers they do not employ.*

Birmingham City Council Special Action Project

The project is a joint venture between Birmingham City Council and the Policy Studies Institute to develop innovative ways of providing community care. Its aims are to:

- identify the means by which people with special needs can have improved access to the full range of specialist and integrated services available in the city
- develop methods of involving users and their carers
- make the best use of resources.

A series of 'project principles' were devised and taken to all the key council committees for approval, to build ownership of the project and its aims. The challenge for the project was to close the gap between rhetoric about community care, and what is available in practice. Current services were assessed using a set of test questions, for example: Do the services encourage participation? Is informed choice offered? Is there independent advocacy?

A formal structure has been established to maintain the project after its initial phase comes to an end in 1990. The project also has an informal structure with input from service users and carers, voluntary organisations, trade unions, CHCs and health authorities. The project's strategy is to raise the profile of service users, to give them an opportunity to make their voices heard, and to see if this influences how services are delivered.

Carers

The most significant work of the project has been with carers, who do the bulk of the work in community care and whose support networks needed to be strengthened. Open

meetings were set up around the city, in consultation with local carers' groups and with input from the King's Fund Carers Unit. These meetings generated information about carers' experiences and the difficulties they faced. A list of practical changes was produced, which would improve services but cost little. The project persuaded senior council officers to consult carers directly as one step towards building a more user-sensitive culture.

Much of the work arising from the open meetings involved improving information for carers and the project focussed on getting information to generic points of access such as neighbourhood offices. This helped users to get directly to the correct point of referral rather than going through social services to gain access to services.

The needs of mentally ill people

Birmingham is served by two large psychiatric hospitals, one of which is to close. An agenda for action is being built around the known community care needs of users as they define them. It gives priority to relationships, in this case recreating shattered social networks, rather than buildings or services.

Day services

The project's test questions were used to review what people with disabilities did during the day. As a result services are being improved by combining a 'think big' approach to strategy with an 'act small' approach to implementation. Thinking big includes devising a new structure for the delivery of daytime occupation, developing employment opportunities, adult education and leisure and recreation facilities. Acting small means incorporating advocacy, user involvement, staff training and needs-led plans into implementation of the strategy.

Quality assurance

As in other proposed areas of work, the project's approach to quality assurance is to involve users, but it is important to distinguish different ways of involving users and to be clear about why they are being involved. The empowerment of users is one reason for getting them involved. Methods of doing this will include using them as planning advisers, or seeking feedback and suggestions. Feedback from users will then have to be translated into action. The project identified the following areas: the need to provide better information for users; the importance of adopting a proactive approach, asking about needs before anything else; and the need to underpin the interests of service users in relation to voluntary organisations and the private sector.

Conditions for success

From the experience of the Birmingham project, the following conditions for success can be identified: political commitment, senior and chief officers' commitment, user

consultation, staff training and development, advocacy in different forms, the application of quality assurance measures and systematic monitoring.

The project is acting as a catalyst for change and a number of factors contribute to its success in that role, including project staff staying overnight in residential accommodation to gain a feel for the service; creating opportunities for feedback; challenging traditional bureaucracy; being innovative about community care; flexibility (using the community care development fund) and backing from senior chief officers and elected members.

The project now faces problems but is looking ahead to the future when local authorities may be managers rather than providers of services. The imperative for user involvement is one message that has emerged unequivocally from the project's work so far.

Implications of the Griffiths report

The group's discussion of the possible outcomes of the Griffiths report was set against a background of continuing delay by the Government in responding to the report; evidence of increasing 'planning blight' in relation to community care; and raids on priority services' budgets by acute services. A survey of views on the Griffiths' proposals, carried out by the King's Fund Institute, showed that they have considerable support from social services departments but weaker support from health authorities. There is concern among community health services about where they belong in the Griffiths' scheme, and much distrust of local authorities among health authorities. These feelings are likely to intensify if the delay continues.

Four possible consequences of the Griffiths' proposals were highlighted in a 'worse case' scenario, the purpose of which was to show that Griffiths was a double-edged weapon. If this prediction proves accurate, the result will be impoverished services for vulnerable groups.

Changing relationships

The Griffiths' proposals entail new relationships between central government and local agencies, such as social services, FPCs, health authorities, housing departments, voluntary organisations and the private sector. There will also be new relationships between these agencies.

The new Minister of State for Community Care proposed by Griffiths would be required to relate to 108 authorities providing and planning services for four care groups. This would prove too much to manage and could lead to a form of 'blame diffusion', with the authorities being blamed for what did not happen and what went wrong. In addition, it would be difficult to monitor joint plans effectively, with the result that poor plans would slip through or plans would not be produced at all. Social

services would be overstretched, particularly with the increasing numbers of potential carers. A growing concern with child care services would drive out the needs of priority groups. Social services departments would fail to provide good quality care and would look for ways of offloading or 'cost-shunting' difficult cases on to other agencies, chiefly health authorities. Furthermore, because the boundary between health and non-health needs was not clear, any attempt to enforce a boundary could rigidify joint working and joint planning which require a flexible approach.

The mixed economy of welfare

The 'contract culture', with a separation between purchasing and providing services, is the cornerstone of Griffiths' vision of the future and it will require effective regulation and monitoring. Overstretched and ill-equipped local authorities will do it badly or not at all. A second-rate public service could be the result of this change in culture.

If public services come to occupy a residual role, there will be the attendant dangers of stigma and low staff morale. With no agreed service levels or standards for quality of provision, users will be at the mercy of the marketplace. The position of social services will be circumscribed through a restrictive panoply of specific grants, charges for services, and the requirement to give all possible encouragement to the private sector. The loss of social security board and lodging payments could cut off an important source of funds for innovative schemes. The upshot of all this is that the proposals could leave local authorities worse off in terms of total resources for community care.

Care management

Confusion reigns over the meaning of care (or case) management. In particular, there is a potential conflict if a care manager is expected to be both a resource manager and an advocate for a client. Also, it is not clear who the care manager would be, whether the post would be in health or social services, and what powers the care manager would have in relation to services from other authorities. It could be a case of responsibility without power. A care manager would have limited authority over a provider managed by another agency. Finally, care managers would be expected to 'shop around' for the 'best buy' but this could result in a search for the cheapest services if insufficient attention is given to standards and quality.

Pluralism

Stimulating a plurality of service providers and service responses in a mixed economy has much to commend it in a situation where there is no single right answer or one best way. But greater diversity could be disastrous unless performance and service quality are policed and regulated sensitively. There are dangers in over-regulation of a restrictive, coercive nature, since it could lead to stultifying the very innovation and entrepreneurial spirit which a pluralistic approach is intended to release. Appropriate skills training will be essential if such an outcome is to be avoided. In this way

innovation may prosper and opportunities for learning can be encouraged so that new ways of providing care may transform mainstream services rather than creating isolated models of excellence.

Looking ahead

The group's discussion focussed on the problems and opportunities of strategic management; the value of care management; regulation and standard setting; and the extent and limits of involving service users.

The structure of organisations was considered vital to the success of strategic management. At present there are tribal barriers, different pay scales and conditions of service which would need to be addressed before strategic management could work. The excellent example of the Birmingham City Council project, working successfully at strategic and operational levels, was thought by the group to be an unusual one.

If the Griffiths' proposals are implemented, controlling and monitoring the work of contractors will be a central concern for managers. Standards should be built into a well-specified contract and an inspectorate and advocacy system established. The mixed economy of care may make it more difficult for users to be involved in service management, but they could help to draft contract specifications. There must be ways for clients to let others know if there are problems with services provided by contractors. In Cambridgeshire a 'service deficiency system' is working well - it allows users to express their views and to point out problems.

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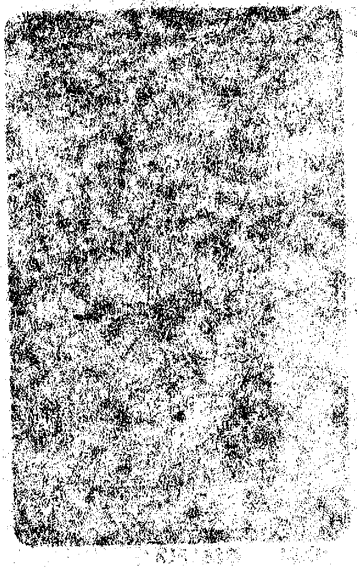

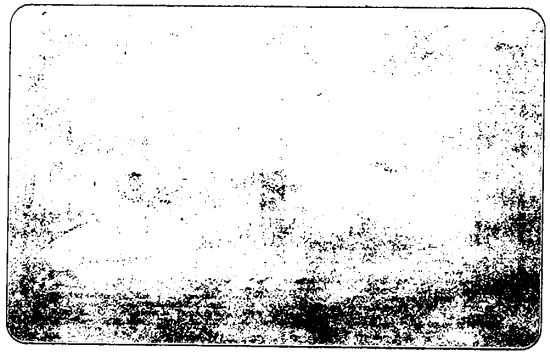

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