Working paper for managers: 5

LOCALITY MANAGEMENT

FROM PROPOSALS TO PRACTICE IN LEWISHAM & NORTH SOUTHWARK

Dave Morgan

Lewisham & North Southwark Health Authority

King's Fund Centre for Health Services Development.

HMP:HAB (Mor, 1or

PRIMARY HEALTH CARE GROUP

126 ALBERT STREET
LONDON NW1 7NF

ACCESSION NO.	CLASS MARK
31096	HMP:HAB
DATE OF RECEIPT	PRICE
15 Sept 1989	£3-50

Newcastle University. Before working on the
m and North Southwark he was employed by Camden Social
ly working in the Priority Care Unit, Lewisham and North

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

This series of working papers is designes to make material from work in progress readily available to a wider audience.

PUBLICATIONS

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

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

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

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

The management response to childhood accidents
Constantinides P.
ISBN 0 900889 98 5 £3.50
A guide for managers to the effective use of NHS information and resources to prevent accident injuries in childhood.

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

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

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

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

Counter sales at King's Fund Centre.

SEE REAR COVER FOR FURTHER PUBLICATIONS

Working paper for managers: 5

LOCALITY MANAGEMENT

FROM PROPOSALS TO PRACTICE IN LEWISHAM & NORTH SOUTHWARK

Dave Morgan

Lewisham & North Southwark Health Authority

King's Fund Centre for Health Services Development.

KFC No.89/59
Price £3.50

First published in 1989

© Copyright the King's Fund Centre 1989.

All rights reserved. No part of this book may be reproduced or utilized in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage and retrieval system, without permission in writing from the Publisher.

ISBN 0 903060 35 3

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

CONTENTS

Introduction			1
1 Lewisham and North Southwark			3
2 Original proposals, philosophy and purpose			6
Why decentralise?			7
Aims and objectives			8
Working parties			8
Defining patches			10
Priority care unit			10
3 Consultation process			13
4 Revised proposals			17
Defining patches			17
Dual professional/managerial responsibility			19
5 Patches in operation			22
Objectives for patch managers			22
Training			24
Management Board			25
Initial impact			25
6 Financial considerations			28
7 Future developments			31
8 Conclusions			35
Management			35
General practitioners			37
Boundaries			37
Training			38
Costs			38
Evaluation			38
Appendices	A	Map	40
	B	Priority care unit - a framework for patch management	41
	C	Patch Manager job description	56
	D	Project Worker job description	58
	E	Glossary of abbreviations	61

Introduction

In 1985 the Department of Health and Social Security (DHSS) agreed to fund three development workers to work in three differing health authorities with the following aims:-

> To explore the possibilities for improving primary health care in the inner city by developing smaller scale (patch or locality) management and planning of services, in which providers of statutory and voluntary services and service users are encouraged to work more closely together to make services more effective.
>
> To establish three local experiments with different approaches to patch working and to document these.

The three districts selected for demonstration projects were Islington, Riverside, and Lewisham & North Southwark. The projects were coordinated by the London Programme of the King's Fund Centre. Each project worker was employed on a fixed two-year contract. The three districts did not follow similar decentralisation models, the involvement of the project workers varied, and they each assumed different roles within the districts. Moreover, the three districts moved towards the implementation of localised structures at very different paces. Unfortunately, the project worker appointed in Lewisham & North Southwark left before she was able to complete her task and submit her report. After some discussion between all the relevant parties as to how best to proceed, a new project worker was appointed for a six-month period with a brief to research and document the progress towards decentralisation in Lewisham & North Southwark (L&NS), and to assist in drawing up criteria for the evaluation of the new patch structures. This report is the result of the first part of that brief.

The material for the report was gleaned from two main sources. Firstly, from detailed study of the working documents, reports, minutes etc. used by L&NS during the period when decentralisation was being planned and implemented, March 1986 to April 1988, and the work started by the initial King's Fund project worker. Secondly, through interviews and discussions with those people who were involved and affected by the decentralisation proposals. This included L&NS staff, both management and field staff, some of whom no longer work for the district, general practitioners, and members of the health authority. Further assistance, both personal support and useful background material, was received from members of the King's Fund Primary Health Care Group (London Programme).

Grateful thanks are due to all who cooperated in the preparation of this report, and especially to those who allowed their files to be ruthlessly examined.

In examining, after the event, any management and service change as large as that

undertaken by L&NS it is all too easy to quibble and find fault, and to get carried away by wisdom in hindsight. This was certainly not the intention, and it is to be hoped that it has not happened. The intention was to draft a report that would provide from L&NS a clear documentation of the measures and practices adopted, and to serve as a useful case study for other health authorities, and for the locality managers in them.

1. Lewisham and North Southwark District Health Authority

Statistics

Lewisham and North Southwark (L&NS) was created in 1982 from a merger of the old Lewisham and Guy's (T) Health Districts. It covers the London Borough of Lewisham (LBL) and the northern wards of the London Borough of Southwark (LBS), Cathedral, Browning, Abbey, Rotherhithe, Newington, Chaucer, Riverside, Bricklayers, Dockyard and about two thirds of Faraday. It covers an area of 4531 hectares with a population of 312,000 at the 1981 census.

Acute services are provided primarily at Guy's and Lewisham hospitals, with additional facilities at Grove Park and Hither Green. There are seventeen clinics, nine health centres incorporating nineteen general practices, and seventy two general practices based in their own premises.

In common with other inner city areas, the overall population has declined in recent years, most markedly in 5-15 age band, but the birth rate is increasing and it is forecast that the proportion of the population in this age group will increase correspondingly. Single parent families account for 3.6% of the total population. Although the actual number of people over 65 has decreased, the proportion of the population in this age group has increased, especially in the over 75 age group. Single pensioners accounted for 16.2% of households.

13.9% of the population were born outside the United Kingdom, and comprise over 50% of the population in some areas, particularly the more deprived and overcrowded parts of the District.

Lewisham and North Southwark ranks 16th amongst all District Health Authorities on the Jarman Scoring Method of social deprivation, with considerable variations within the District. Several wards in North Southwark have very high Jarman scores whilst several in Lewisham have very low scores. In 5.5% of households there is more than one occupant per room, and 5.8% of households do not have exclusive use of a toilet and/or bath.

In 1985 there was an estimated 2,500 'homeless and rootless' people in the vicinity of the District, with particular problems of alcohol and other drug dependency and tuberculosis.

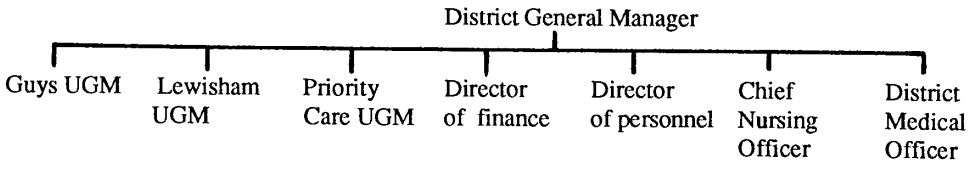
In the south of the District, 64% of households own a car, and this figure falls to only 29% at the northern end. Public transport runs radially to and from London Bridge and Waterloo, and lateral travel across the District is difficult.

These poor socio-economic conditions contribute to high rates of illness and death. In 1983 the infant mortality rate for the District was 11.0 per thousand births, compared to 9.4 for the South East Thames Regional Health Authority (SETRHA) and 10.1 for England and Wales. There are approximately 4,000 deaths per year in the District, the principal causes being coronary heart disease, stroke, lung cancer, other cancers, chronic obstructive airways disease, pneumonia and accidents. Coronary heart disease accounts for a quarter of all deaths. There are about 75 deaths per year from alcohol related causes, and it is estimated that there are at least 550 preventable deaths per year. The life expectancy at birth of males is 65.5 years.

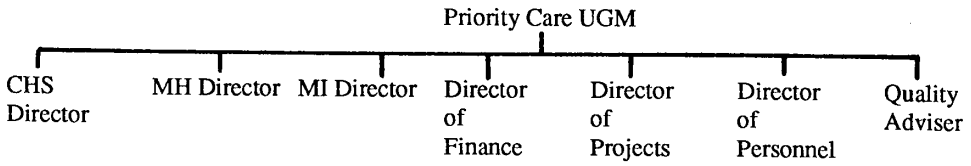
Levels of morbidity from mental illness are higher than the SETRHA average, and incidence of mental handicap is higher than would be expected on the basis of accepted norms.

Structure

The District is split into three units, Guy's Acute, Lewisham Acute and Priority Care, each headed by a Unit General Manager (UGM) who is a member of the District Management Board (DMB) and reports to the District General Manager (DGM):-



Within the Priority Care Unit (PCU) there are three executives, Mental Handicap (MH), Mental Illness (MI) and Community Health Services (CHS), each headed by a Director, and with a Chief Executive where the Director is a part time appointment. Together with the central support services, they comprise the PCU Management Board:—



For 1988/89 the District has a gross revenue budget of £129.67 million, apportioned as follows:-

UNIT	BUDGET (£000's)
Guy's Acute	50126
Lewisham Acute	32062
Priority Care	30800
District HQ	11666
Reserves	5021
Total	129675

Within Priority Care, the 1988/89 budget is divided:-

EXECUTIVE	BUDGET (£000's)
Mental Illness	10455
Mental Handicap	4617
Community	10952
Therapy	3842
PCU Central	934
Total	30800

This report is concerned with service and organisational developments within the Priority Care Unit.

2. Original proposals, philosophy and purpose

The process of decentralising the Community Health Services (CHS) in Lewisham and North Southwark Health Authority (L&NS) has been both lengthy and complex. Documents referring to possible modes of decentralisation were written as long ago as August 1983, and yet a decentralised patch structure did not become operational until April 1988. However, it would be an error to assume that serious proposals for decentralisation have been discussed and blocked for five years, rather it is the case that a number of different and differing proposals have come and gone, largely coinciding with the employment tenure of those people making the proposals.

Indeed, there is no evidence to suggest that work done in earlier exercises was used in any way when later proposals were formulated. Accordingly, it is not intended to devote much time to descriptions of earlier work, save to mention its existence.

The real commencement of decentralisation work began with the establishment of the Decentralisation Steering Group (DSG), and the appointment of a decentralisation co-ordinator. The impetus for a thorough investigation into the possibilities for localised management came directly from the District General Manager (DGM), and the decentralisation co-ordinator was a senior appointment reporting directly to the DGM.

It is interesting to note that the correct title of the DSG became obscured as time went on, and that it was generally called the Directors' Steering Group, and was seen as a body with a wide remit and very considerable powers. This body first met on March 17 1986 and comprised, inter alia, the District General Manager, the Priority Care Executives, the Director of Finance, and representatives of the Community Health Council and the London Boroughs of Southwark and Lewisham. Its terms of reference were:-

> The Steering Group will advise the District General Manager and the Health Authority on the most appropriate arrangements to adopt in order to decentralise Priority Care services.
>
> The Steering Group will advise on:-
>
> (i) Management Arrangements;
>
> (ii) Information and Computer Systems;
>
> (iii) Budgetary Systems.

This development work shall be completed by 31.12.1987.

From this it can be seen that the aim of the DSG was to decentralise all aspects of Priority Care services within a common timescale. Such an aim was undoubtedly very ambitious, involving as it did an attempt to treat in a similar manner a number of clearly dissimilar services.

Why decentralise?

The first meeting of the DSG also considered a paper entitled, most appositely, 'Why Decentralise?' This document addressed, firstly, two themes common to all health authorities, namely the run down of long stay institutional facilities and the consequent expansion of community services, and the changes in management style and structure brought about by the Griffiths report. In doing so it identified the need both to strengthen and devolve the management of the new community services. The argument was very straightforward, that diversified services cannot be effectively managed by a centralised structure. However, the physical presence of managers in a number of locations may make for a localised structure, but of itself does not make a decentralised one, since real decentralisation must involve the decentralisation of power and resource management. This crucial point was both accepted and understood.

From the acceptance of the necessity of devolving power evolved what was called the 'philosophy' of decentralisation. Two possible models were identified, and these were termed 'accountability' and 'organisational'. The former model was deemed to be inappropriate in that it was *"open to manipulation at local level by unrepresentative groups"* and *"would necessitate radical changes in management structures to respond to the needs of accountability"*. Thus the latter model was considered to be more appropriate, and its primary purpose was cited as being:-

> "The desire to maximise organisational output. The idea is that decentralising services allows local managers and service providers greater flexibility to respond to local demands, and in doing so a more efficient and effective service is provided. One outcome of this approach may be greater accountability, but it is not the primary goal."

This approach puts particular emphasis on management issues. It is important to realise that decentralisation and general management are not one and the same thing. It is perfectly possible to have one without the other, although the approach taken in L&NS was to deal with both issues concurrently. Whilst it clearly was the wish of the decentralisation co-ordinator to institute the principles of general management as a priority, and whilst patches were seen as a useful method of doing so, the failure to differentiate between the two objectives inevitably meant that the two became seen as one, which led to a degree of confusion when the details were being considered.

Aims and objectives

Having agreed the 'philosophy', the DSG was then able to identify the more specific purposes of the decentralisation exercise. These were:-

1) All priority care services, except acute and rehabilitative hospital care, should be provided in people's local neighbourhood in a familiar community environment;

2) These services should be planned and managed at this local level and involve those concerned with patient care;

3) All development monies should be used within the context of decentralisation;

4) Consumer and local staff input should provide the basis for examining the quality and quantity of services provided;

5) To use this decentralised service to achieve a more desirable distribution of primary and community services across the District;

6) To collaborate at local levels with Local Authorities, GPs, and other agencies to ensure efficient patterns of health provision.

To what extent any or all of these objectives were achieved will be discussed later.

This first meeting also identified potential problem areas which decentralisation might encounter, some of which were indeed to bedevil the whole process. These were quality assurance, monitoring, small and specialised service areas, the treatment of rare conditions, and the conflict between managerial and professional accountability.

Working parties

The intention was to break the decentralisation work down into four sections, each of which would be dealt with by separate working parties, with the DSG retaining overall control and supervision of the whole project. It was agreed that the DSG would meet regularly on a bi-monthly basis to carry out this supervision, but in fact it only met on four further occasions between March 1986 and September 1987. Yet this eighteen months period was, as it turned out, the crucial time when the relevant choices were being made and decisions being taken.

At its second meeting on 8th July 1986 the DSG received the first report from the sub group which had been set up to examine management issues relating to decentralisation.

Before dealing with the detail, one point is most relevant. Whilst the report still addresses the decentralisation of all PCU services, it recommends that the three executives

(see chapter one) should remain in existence. It has been mentioned above that to deal with all parts of PCU in a common manner would have been very ambitious. To do so whilst retaining the day to day functional management under three different management bodies would have been quite impossible. Whether this was recognised at the time, or whether it was hoped that by retaining the executives that the process of decentralisation would have been facilitated through greater co-operation is impossible to say for certain, though it is likely to have been a compromise between the UGM and the decentralisation co-ordinator who saw things in different lights. It is also very likely that the authors of the first document did not wish to put into print quite so quickly the fact that a major component of the overall decentralisation proposals had fallen at the first hurdle.

Instead of removing the executives it was proposed that each patch should have an advisory team comprised of three team leaders, one from each executive, and a representative of the GPs, of local authority social services departments and of the nursing staff. The CHS team leader would in all patches be the chair.

The executives were to retain their existing membership and undertake the following functions:-

1) The Executives will develop the district-wide philosophy and objectives for their services which, in turn, will be developed into plans and priorities. The three Executive plans will then form the basic Priority Care Unit strategy.

2) The Executives will continue to manage services both within and outside the patch. The patch managers will manage staff based in the patch and be responsible to the Director of each Executive.

3) The Executives will monitor the standards of service provided by staff within the patch, and the professional standards of the staff themselves. The Executives will provide the professional head of each service.

4) The Executives will manage the process of closing long-stay institutions.

It was also accepted that certain district managed and specialised services did not lend themselves to decentralisation, and this led to a proposed tripartite classification of services:-

a) services based and managed within the patch;

b) services based in the patch but managed by the executives or other managers;

c) services based and managed outside the patch.

The problem then was to reach agreement on which service fell into which category, and what should be the relationship between each of the service categories and the support services.

Defining patches

In addition, of course, it was necessary to define the patches themselves. Since one of the primary stated objectives of the decentralistion programme was to make services more responsive to local needs, it was clearly necessary to construct patches that were capable of both recognising and responding to these needs.

Three possible approaches were identified for defining patches, these three being based on neighbourhood/community, caseloads or pragmatism. Whichever of the approaches was to be adopted, it was recommended that the newly created patches would have boundaries that were coterminous for all three executives, and also be coterminous with local authority boundaries. At the time, the London Borough of Lewisham was undertaking a comprehensive survey of the Borough to identify local 'communities' for the purpose of their own decentralisation programme, which would have involved the re-drawing of their housing and social services area boundaries, and thus there was an ideal opportunity to achieve coterminosity. Whilst no such thorough review was being undertaken by the London Borough of Southwark, discussions on decentralisation and the re-drawing of boundaries were taking place, and both Boroughs were in attendance at the DSG. The historical evidence of three public bodies being able to achieve coterminous internal boundaries was not good, and it was recognised that Lewisham and North Southwark might have no alternative but to define their own boundaries if the decentralisation timetable was to be adhered to, and hope to achieve coterminosity at a later date.

In addition to defining boundaries the other key issues to be settled prior to implementation of patches were management arrangements, patch profiles, staff profiles, financial systems and information systems. The timetable was to complete these tasks and implement patches by 1st April 1988.

Priority care unit

As has been described above, the Priority Care Unit (PCU) was not only a relatively new creation, but it was composed of a number of different services which had had no history whatsoever of working together. Their structures and methods were in no way similar, they served almost wholly separate client groups, and below the levels of senior management the staff within the three PCU executives rarely even knew who each other were.

More importantly, the three executives had already reached very different degrees of decentralised organisation. Within Community, (CHS), the nursing staff operated from seven nursing areas, within Mental Handicap (MH) there were three areas, whereas Mental Illness (MI) operated an essentially central structure, albeit one utilising consultant psychiatrist catchment areas.

Mental illness

Within the PCU, the most concerted initial opposition came from the consultant psychiatrists and the MI Executive. The confusion and overlap between decentralisation

and general management has already been mentioned, however this overlap was not a problem for MI since, at the outset, they were vehemently opposed to both. For the MI executive the problem was quite stark. General management demands that the managers are in control of all aspects of resource management, yet the power of the consultants made it evident that this was not the case within MI. Moreover, the contractual position of consultant psychiatrists meant that the Authority was not able to insist on any management changes, so effectively a power of veto existed. This is not to imply a regressive or obstructive position on the part of the consultants, merely to recognise the different circumstances that applied.

The MI executive itself was equally worried by what it saw as proposals to abolish the three executives within the PCU, as this might adversely affect certain service areas. There was a strongly held belief that if specific client groups do not have specific budgets and staff allocated to them, then these client groups will suffer. The then Director of MI has clearly expressed her belief in the ring-fencing of budgets, and cites, as an example, the view that the failure of the Authority to deal adequately with the needs of elderly people is inevitable given that there is no specifically identified provision for the elderly, and is a direct consequence of this lack of specific provision.

The combination of the total opposition of the consultants and the almost total opposition of the MI executive was sufficient to ensure that MI was not included in the detailed discussions on patch implementation. Although the consultation document "A Framework for Patch Management" still included proposals for the decentralisation of the whole of the PCU, MI had already been effectively excluded by the time it was issued. It is impossible to determine exactly when this decision was taken, or by whom. Certainly the decision was not taken by the DSG, and it seems most likely that it was simply presented by MI as a fait accompli.

Mental handicap

Mental handicap had for some time operated through three community teams, one in Southwark and two in Lewisham, and was moving towards a much more community orientated strategy with the closure of long-stay institutions. As with MI there was great concern over the proposal to abolish the three executives, the training and appointment of patch managers, and most specifically the speed of the changes that were being proposed. Rather than the outright opposition expressed by MI, the details were heavily queried and work undertaken in such a manner as to make the decentralisation timetable impossible.

Community health services

Within CHS there was a somewhat more receptive environment. The CHS executive members expressed support for the concept of general management, and also saw the patch proposals as a means of bringing together the various parts of CHS. Since nursing staff comprised by far the greatest part of CHS, and since they were already devolved into nursing officer areas, it seemed to make perfect sense to bring all services under a common management structure and for this structure to be decentralised into a number of largely

self sufficient patches, probably with CHS staff playing a lead role, the precise number to be decided later.

Within the authority as a whole, sufficient queries were raised as to effect a diminution of the scale and practices of the decentralisation proposals.

The DSG was informed that the King's Fund had agreed to participate in the patch proposals by funding an administrative worker to assist Lewisham and North Southwark as part of its London decentralisation project. A job description is attached as appendix D.

The next stage was to develop this original philosophy and purpose into practical arrangements, and to consult widely on its possible consequences.

3. Consultation process

At its second meeting on 8th July 1986, the DSG considered a report on the consultation procedures. Four groups were identified with whom it was considered necessary to enter into consultation, namely:

1) staff and their representatives;

2) local authorities;

3) community health councils;

4) the public.

In the introduction to this report it was stated that its primary purpose was *"to form an agreed management framework for pursuing decentralisation to community patches. The report will focus on broad decisions rather than detail, in order that a wide discussion process can be undertaken with the staff and managers that (sic) will be involved"*. In other words, any consultation that took place would be solely about 'how' and not at all about 'whether'. A further paper to the third meeting of the DSG on 2nd September 1986 developed this approach. The 'consultation' process was now termed a 'discussion' process and its purpose was *"..... to inform Priority Care Unit staff of the proposals to move to patch management, and to receive staff views as to the suitability of these proposals in relation to their services"*.

Consultation document

In September 1986 the UGM issued a paper entitled 'A Framework for Patch Management' (Appendix B). Over 800 copies of it were sent to interested parties, and over 50 meetings were held throughout the District to explain its contents to staff, GPs and others. In addition, a short briefing sheet was sent to all staff. In response, 51 written replies were received. Clearly this was a thorough exercise which was taken very seriously by management, and since many of the replies reflect the views of groups of people rather than just individuals, it is equally clear that a lot of the people involved also took it seriously. The information exercise can be adjudged to have been a success.

Recent discussions with those staff who took part in the consultation process reveal a number of points. Firstly, they all understood that they were not being consulted over whether the decentralisation/general management patch should be followed. It was accepted that this decision had already been taken, much though many would have liked to have strongly advised against doing anything of the sort. Secondly, they did expect to be listened to and have their views taken seriously when it came to discussion of the details. In general, field staff feel that their comments were largely ignored. Thirdly, those who

were successful in getting the changes that they wanted incorporated in the revised proposals did so through their membership of the CHS executive or other official fora, and not through the consultation/information exercise.

The responses

Following receipt of the replies, in April 1987 a summary document entitled 'Responses to a Framework for Patch Management' was issued. The replies indicated a degree of concern about the proposals as they applied to individual service areas, but also showed considerable support for the principles and philosophy underlying the decentralisation proposals. The replies were sufficiently encouraging to enable the PCU to feel confident about the course that was being followed.

Family practitioner committee (FPC)

The FPC was kept fully informed of all proposed developments but does not appear to have sought to play an involved part. They expressed no opposition to the concept of patches, but were concerned to ensure that a flexible approach was adopted. In particular, they were worried that rigid boundaries might restrict patients freedom of choice, and believed that this problem could be avoided if the patches were based primarily on existing and established GP catchment areas. In addition, they were concerned lest patches should undermine the role of general practice.

Local medical committee (LMC)

The views of the LMC were very similar to those of the FPC. The committee firmly believed that services should be anchored in the practices, with boundaries and CHS services geared to them. They were pleased that GPs might become more involved in the decision-making process, and that the possibility existed for a GP to become a part-time patch manager.

Following the formal consultation period, the DGM invited all GPs in the district to a meeting to discuss the patch proposals in greater detail. Here the greatest worry was that patches might threaten existing GP nurse attachments, but the DGM was able to deny that this would happen.

Accepting the difficulty of anybody being able to speak for all GPs, the DGM said that it was hoped to deal with this problem by the appointment of a GP facilitator with DHSS funding to canvass the views of all GPs.

Local authorities

The replies from the Local Authorities were, at the same time, both supportive and non-committal. Generally speaking, one public body will always tread very carefully when commenting on the operating practices of another. So both Lewisham and Southwark welcomed the intentions to improve primary health services for local people, and the wish

for the health authority to work more closely with the local authorities. Short of a decision publicly to espouse sin, one could hardly expect either council to oppose these two aims.

Community Health Council

The Community Health Council's response to "A Framework for Patch Management" was not enthusiastic. They were particularly concerned that the decision to retain the three executives would lead to a continuation of the situation whereby people defined as mentally ill or mentally handicapped would continue to experience difficulties in obtaining basic medical or nursing services. This concern had been alluded to by some staff within Lewisham and North Southwark but was only expressed clearly by the CHC. As the original proposals at the DSG recognised this problem and attempted to resolve it, it is difficult to see how the CHC's charge can simply be written off. As an alternative, they proposed giving CHS control and responsibility for all community services whilst the other two executives retained responsibility for professional guidance but management of only the acute wards. Whilst this had more in common with the first proposals, to have considered it in the spring of 1987 would have taken the entire decentralisation exercise back to square one.

In addition, the CHC did not believe that the extension of general management to the lowest possible level would produce any improvement in the quality of the services provided. They firmly believed that it was essential for managers on the ground to be professionally qualified and to retain their own casework responsibilities, as is the case in local authority social services departments. Without this, they felt that coterminosity of boundaries, if achieved, would be almost irrelevant since the managers from the two authorities would not have equal standing.

They concluded:

> *.....we believe that a re-examination of services of this sort should have started with a consideration of client needs, moved on to an evaluation of professional practices and only then come on to consider organisational issues. We fear that by starting at the wrong end the District's paper may have wasted an important opportunity.*

Such a view was not wholly at variance with a number of GPs who also believed that any re-organisation ought to start with the clients and work upwards, and they were not impressed with imposed management structures that were insensitive to varying workloads. However, where they differed from the CHC was in wishing to see GPs as the start point for any new structure, with GPs being the lynch pin of primary health care teams which would form the basis for all services.

Although the public was invited to participate in the consultation exercise, and advertisements were placed, it has not been possible to ascertain if there was any public response.

Post consultation

Whilst discussions on decentralisation details continued at PCU and CHS executive level for the next year, for the majority of staff there was to be no more consultation. Moreover, the flow of information relied on individual line managers disseminating what they themselves knew rather than any formalised process. As a result, a lot of people felt confused and in the dark, knowing little about what was to happen to themselves and their part of the service until just before the changes actually occurred. A feeling that everything was being decided 'up there' by 'them' became prevalent.

To a large extent this was true, and it would be surprising were it not so in a hierarchical organisation. Moreover, maintaining a regular flow of accurate progress reports would have been very difficult in the highly charged and fluid state of affairs that prevailed at the time, but it is precisely at times like these, when major changes are afoot, that up to date information dissemination is most important.

This applies as a tenet of good management everywhere, but applies all the more so when staff are spread over many locations, working part-time and working shift patterns. In such circumstances, it is unrealistic to expect informal information channels to be effective. As more staff are decentralised, and no matter how much power is decentralised to the patches the centre will continue to be perceived as the power base, the need for the centre to impart information on a regular and formalised basis will grow. The alternative is chinese whispers or staff being left in ignorance, or both.

4. Revised proposals

In April 1987 a revised strategy document was produced which was to form the basis of the eventual decentralised patch structure. This followed the consultation/information exercise undertaken during September/ November 1986. The most crucial variation from the original DSG proposals was an acceptance of the impossibility of all of Priority Care following a common timetable and operating under a common structure. Instead, it was proposed that CHS would lead the development work and achieve operational patches by 1st April 1988. Under this timetable, Mental Handicap, Mental Illness and the District Therapy Services would review their position in the light of CHS progress after April 1989.

Defining patches

'A framework for Patch Management' listed three possible ways of defining a patch. During the consultation/information exercise it became clear that most GPs were very distrustful of the entire decentralisation plan, and saw as its only saving grace the possibility that patches might be constructed around GP caseloads. The reverse of this coin was that the nursing staff considered the worst possible outcome would be to gear the system to the workings of GPs, and accordingly they favoured a neighbourhood approach. The adminstrative staff responsible for co-ordinating the patch plans favoured the pragmatic approach as the only one that would fit in with the timetable.

For managerial reasons, and to achieve the most effective spans of control, CHS had decided to implement the decentralised structure in ten patches, three in Southwark and seven in Lewisham, since it was not adjudged sensible to have any patch that crossed Borough boundaries. This would enable patches to have populations of between twenty five and thirty five thousand, smaller than the existing nursing officer areas of between thirty and fifty thousand. Although these patches would be larger than those recommended in the Cumberlege report, it was very much hoped that the Authority would be able to adopt the principles of neighbourhood nursing. Whilst there was one subsequent suggestion of seven or five patches, the proposal for ten was never seriously challenged.

Lewisham Council had already undertaken a lot of detailed work on neighbourhoods. This work looked at 'historic' communities, perceived localities, shopping centres, work patterns, natural boundaries (roads, railway lines etc.) and public transport routes, and had identified nineteen neighbourhoods. Considerable time was spent trying to marry together the needs of CHS with this neighbourhood study, and to make the seven Lewisham patches aggregations of the nineteen neighbourhoods. The additional cited needs and determining factors were:

distribution of GP practices and their workloads;

management costs of implementing patch management; current working practices, using existing decentralised services;

levels of deprivation as per Jarman scores and Department of the Environment's Index of Deprivation;

the nature of services within mental illness;

coterminosity as far as possible with social services boundaries; recommendations of the Cumberlege report.

Of course, one of the prime CHS needs was to have a major health centre or clinic in each patch, since it would have been foolish to agree a patch boundary and not have the primary health care infrastructure to service it. Accordingly, CHS worked from the startpoint of their existing establishments and drew the patch boundaries as close to the neighbourhoods as was possible. This produced some anomalies and a great deal of debate. At the North Southwark end of the district the three patch centres effectively chose themselves, and the patch boundaries followed electoral ward boundaries.

This resulted in the following patches [see map appendix A]:—

PATCH	HEALTH CENTRE/CLINIC	*POPULATION
Aylesbury	Aylesbury HC	26,000
Bermondsey	Bermondsey HC	35,000
Surrey Docks/St. Olaves	Surrey Docks HC	23,000
Deptford	Waldron HC	21,000
Forest Hill	Jenner HC	38,000
Sydenham	Sydenham Green HC	35,000
South Lewisham	Downham HC	37,000
Lee/Grove Park	Lee HC	40,000
Central Lewisham	Central Clinic	28,000
Honor Oak/New Cross	Honor Oak HC **	29,000

* The above figures give the district a total population of 312,000. Because they are based on 1981 census figures they are bound to be at variance with the current actual populations, but it is not thought that the relative sizes of the ten patches have changed to any marked extent.

** In the first nine patches the health centre/clinic would serve as the patch's administrative base, whereas the last patch would be based at CHS headquarters at New Cross.

The boundaries shown in appendix A were by no means the first and only proposals. A good deal of discussion took place both within and without the CHS Executive, with GPs and field staff in an attempt to refine them and iron out as many anomalies as possible. The population spread was greater than had been intended, but bearing in mind the very

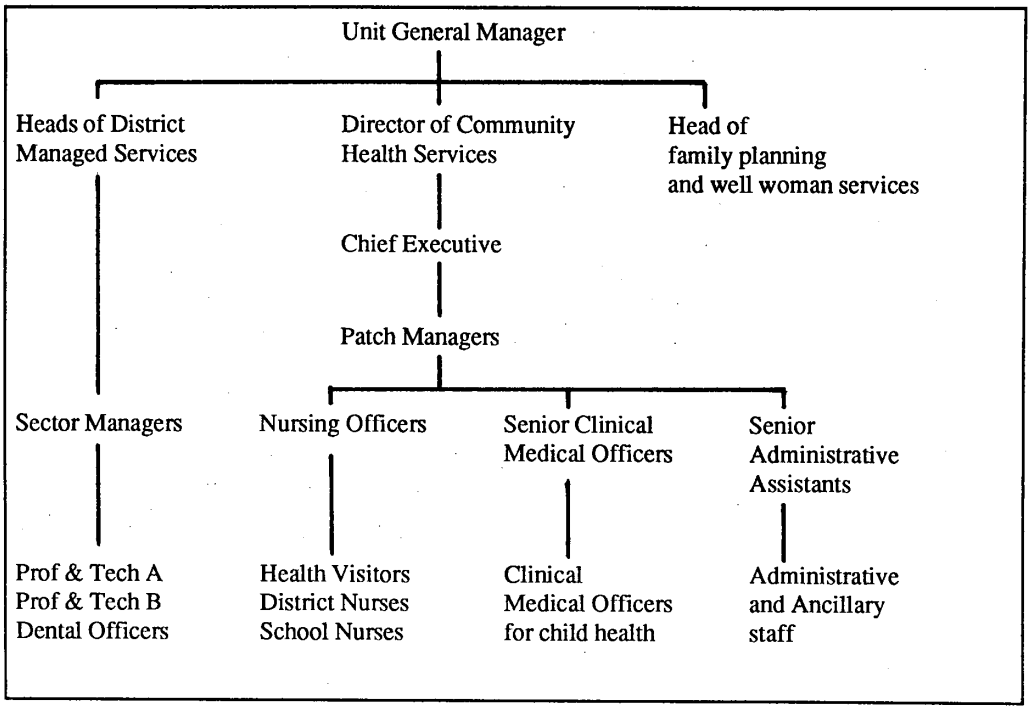
differing levels of social deprivation and need across the district this was not considered to be a real problem. Indeed, since part of the underlying philosophy of the decentralisation exercise was to enable CHS to meet better the health needs of the district's population, it would have beenvery odd if the executive had simply followed the model of the Congress of Berlin and drawn neat, straight lines across the district to achieve a nearly equal population spread.

Dual professional managerial responsibility

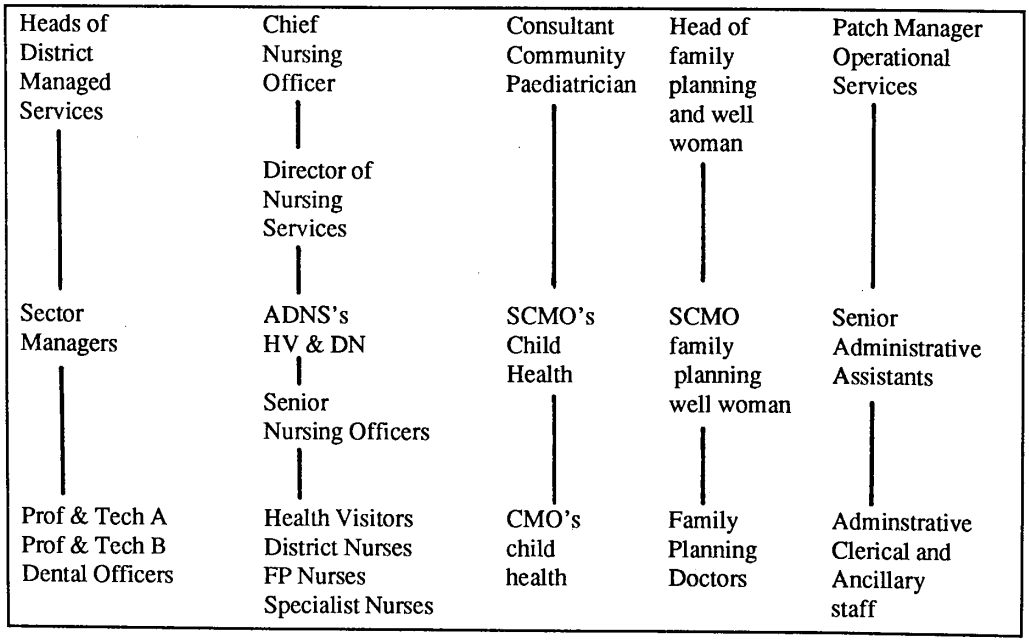
Although the March 1986 proposals recognised the need to ensure that the best professional standards were maintained, it was not specific on the organisational mode necessary to achieve this. The clear intention was that all staff working in patches would be fully accountable to and managed by the patch manager, who in turn was accountable to the CHS Director. This being so, how was it possible to ensure that the professional standards of, primarily, the district nursing and health visiting staff were maintained, and problems of a professional nature dealt with? Some districts that have decentralised have sought to solve this problem by only appointing as locality managers people from a nursing background. In Lewisham and North Southwark a number of patches militated against this, and in addition it was the district's policy, as part of their wish to extend the principles of general management, to appoint patch managers from as wide a background as possible. Thus whilst some might have nursing experience, others, most assuredly, would not. All patch managers would be supported by two nursing officers, district nursing and health visiting, but the nursing staff and senior nurse managers had made it clear that they would find the new structure quite unacceptable unless two Assistant Directors of Nursing Services (ADNS's) were retained. The proposed solution was to retain the posts but not the functional responsibilities. Specific posts were established of patch manager with additional responsibility for health visiting or district nursing issues. This particular solution was then extended and additional dual responsibility posts were established to cover school and specialist nursing, child health services and operational and support services. In doing so, CHS was able to guarantee a position in the new structure for existing senior staff by having them 'slotted—in' to these newly established posts.

Two parallel structures were thus proposed, one managerial and one professional:-

CHS patch management structure



CHS professional management structure



During the summer and autumn of 1987 these proposals were subjected to seemingly interminable, and very circular, debate and minor alteration, but actual progress towards implementation was slight. It must be borne in mind that by July 1987 it was clear that CHS was heading for a massive overspend on its 1987/88 Business Programme expenditure, and the senior management staff had to spend a large part of their time seeking to rectify this. Not only did the work on the projected overspend threaten to imperil the April 1988 implementation date, it also created an unfortunate atmosphere in which to introduce a radical new structure. Patch Management would inevitably be seen as no more than a plank of financial retrenchment.

Approval was of course still needed from the DHA before action could be taken, and a report seeking this approval was presented in November 1987. Whilst in style and appearance it differed markedly from the internal document of April that year, its content and proposals were almost unchanged.

It was no longer proposed to establish patch advisory teams with officers from the three executives, the difficulties experienced by Mental Handicap and Mental Illness in progressing their decentralisation plans had made this impossible. One of the aims of the initial proposals had been to increase consumer involvement and understanding of local health services by having common structures and common points of access. The extent to which the three executives had gone along different roads meant that this aim was not achievable. The document stated that:-

> *It is important that as our services in the community grow and become more complex, we should ensure that they work more closely with the local community and that they are better co-ordinated amongst themselves. To achieve this is necessarily a longer term aim, but community care will ultimately be ineffective unless this aim is achieved. Our initial target, however, is to decentralise the services to provide a firm basis from which community care can effectively operate.*

Initially there had been opposition amongst some authority members, from those who felt that the failure to achieve co-ordinated community services nullified the entire exercise, and from GPs who did not believe that any improvements in patient care would follow. A lot of detailed briefings and discussions took place with the authority members to answer the questions that they raised and to satisfy any concerns that they might have. This ensured that when the decentralisation plans were presented to the authority approval was given, both to the general proposals and timetable, and to the administrative and staffing measures necessary to achieve them.

5. Patches in operation

The patches became operational on April 1st 1988.

Objectives for patch managers

To assist the new patch managers to operate efficiently in their new posts within this new structure, clear management objectives were set centrally. These covered both community wide and patch specific objectives:-

(A) General objectives

1) To work more closely with GPs in Lewisham and North Southwark to enable them to achieve their optimum capacity for caring for their District patients and to ensure that the duplication of services is minimised.

Patch manager to involve GP patch representative in patch team discussions by May 1988

Patch manager to meet with every GP in patch by 1.6.1988.

Patch manager to establish a Primary Health Care Team in each patch by 31.3.1989.

Patch manager to develop a CMO attachment to a GP practice within the patch (31.3.1989).

2) To implement the first year plans for a full call/recall system for cervical cytology screening through the development of the system in four patches.

Central patch to be first patch. Patch steering group to be set up by 1.4.1988
Remaining three to be identified by management board to come on stream 1.7.1988; 1.10.1988; 1.1.1989
Patch manager and GP patch representative to identify participating GP's four weeks before operational date.
Patch manager and GP patch representative to estimate demand for additional clinics four weeks after operational date.
Patch manager and GP patch representative to achieve 40% uptake of called patients.

3) To implement and monitor specific policies relating to service provision for the elderly.

Patch managers to ensure that in line with the recommendations of 'Ageing Well' that their health visiting officers identify those clients aged 65 or over in conjunction with local GPs with a view to identifying those at risk.
Patch managers to discuss level of priority with patch teams and report to management board.
Patch teams to discuss desirability of setting up Well Pensioner clinic.

Patch managers to set up mechanisms to allow discussion with other service agencies involved in community care for older people to discuss implications of extending the health visiting service to this age group.

North Southwark patch managers to participate in a pilot project of community care assistants for one year.

4) To introduce the Integrated Personnel System for staffing and manpower.

To identify accommodation within each patch base for an IPS terminal.

To ensure that those inputting and accessing data have attended an appropriate training programme.

To participate in the distribution of data collection forms.

5) To implement decentralised services through the development of patches and monitor effectiveness.

Patch managers to participate in management board by April 1988.

Patch managers to meet objectives set by dates indicated.

Patch managers to contribute to initial evaluation report.

6) To develop services for children suffering physical and sexual abuse.

Patch managers to be aware of named community doctors who can carry out physical examinations.

7) To provide appropriate services to AIDS patients and to provide appropriate prevention testing services.

Patch managers to ensure distribution and comprehension of CHS AIDS policy by May 1988 to all staff to promote safer staff working practices.

8) To identify specific quality targets for service provision.

Patch managers to examine their local patch services in the light of the quality indicators identified by CHS Heads of Service.

Patch managers to establish at least one Quality Circle in each patch by March 1989.

9) To implement across the District, the Authority's agreed health promotion policies (No Smoking, Sensible Alcohol, Healthy Eating).

Patch managers to identify designated smoking areas for staff in all Health Centres and Clinics in consultation with local users.

Patch managers to ensure that the no smoking policy is adhered to at all meetings, clinical areas, reception desks, waiting areas.

Patch managers to ensure an adequate supply of appropriate literature from Health Education for staff and patients.

Patch manager to ensure staff awareness of Sensible Alcohol Policy and its recommendations.

(B) Specific objectives

1) Bermondsey

To develop a new health centre on site/within existing framework of Bermondsey Health Centre — to start June 1988. Services to be temporarily re-located.

To plan for practice premises on Bricklayers Development to have CHS staff attached - 1989/90.

2) Surrey Docks

Plan a 10 bedded Respite Care Home for St. Olave's site to produce short term residential and day care for elderly physically and mentally frail people.

Plan a replacement physiotherapy department for St. Olave's site with accommodation for community physiotherapists and outpatients department - to open during 1990.

To ensure CHS services in Surrey Docks match local population needs.

3) Waldron

Develop 24 bedded Nursing Home at Deptford Wharf. Residents to be transferred from long-stay ward at Hither Green Hospital - AIP by April 1988.

4) Central

To establish Lewisham Child Development Centre in former chest clinic and to enable current disparate services for children with special needs to be provided in one central location. Work to start April 1988.

5) South Lewisham

To develop Downham as a Health Centre with GP suites.

The purpose of these objectives was not simply to provide a useful framework within which the new patch managers should operate. They served as a clear example of Lewisham and North Southwark's commitment to extending downwards the principles of general management, in this case by the establishment of clear management objectives which would be monitored throughout the year and revised annually as part of the preparation of the business programme.

Training for patch managers

As further assistance for patch managers, a development programme was formulated, split into two parts. The aims of the first part were:-

to provide patch managers with the information and knowledge they will require to meet the immediate demands of their job;

to ensure a common degree of understanding of the planning tools available to them;

to prepare those who have not previously managed multi-disciplinary teams with sufficient information to enable them to undertake this role.

This first part was a three day course attended by all patch managers, co-ordinated and led by the Chief Executive.

The second part of the programme was longer term, spread over six months and geared to the individual developmental needs of the patch managers. This latter part was organised in conjunction with the North East Surrey College of Technology.

These courses appear to have worked extremely well and the patch managers have expressed appreciation for them, but also for the way in which they fostered mutual learning and enabled the development of a peer group support network.

Management board

As part of the management re-organisation arising from decentralisation, it had been agreed by the DHA that the Community Executive should be disbanded, and a new CHS Management Board be established. The membership of this board was:-

Director of CHS
Chief Executive
Director of Nursing Services
The ten Patch Managers
GP representative
Specialist in Community Medicine
Consultant Community Paediatrician
SCMO/Senior Nurse Family Planning/Well Woman
Representative(s) of District Managed Services Developmental Planning Officer
Unit Accountant
Unit Director of Personnel

This rather large body of twenty two people was to meet on a monthly basis. It was recognised that the Board could not deal with all issues in but a few hours per month, and so it was also decided to establish a 'core group' of the CHS Director, the Chief Executive, and the DNS which would meet on a weekly basis, and for other meetings between the Chief Executive and the ten patch managers to deal with those CHS matters specifically and directly related to patches to be considered. As both the CHS Director and the Director of Nursing Services have now left the Authority, the 'core group' no longer meets, and as part of the continuing assessment and re-evaluation that follows a major reorganisation, both the role and the composition of the CHS Management Board will inevitably be under review.

Initial impact

The first effect of patch management was that staff had physically moved, not only those staff now working in the new patches, but also all the consequential office moves of staff throughout Priority Care now based at the old CHS headquarters. The relocation of managers and administrative staff to community sites made it clear that a new system was in operation. This simple movement of people gives decentralisation an advantage over other management and operational changes in that it is apparent from day one, internally at least, that, after the years of talking, something has actually happened. Reference has been made to the concerns felt by some staff about the new arrangements, but easily off-setting this was the enthusiasm of many others. As the details became clearer a lot of apprehensions were assuaged and the support for patch management grew. There was also a remarkable determination by nearly all staff, whatever their reservations about patches might have been, to make them work regardless. Patches thus began in a distinctly up-beat rather than a bathetic environment.

For all staff in patches there was a need to familiarise themselves with each other, with

the patch, and with the changes in jobs and working practices where relevant. Not suprisingly, this was effected with varying degrees of smoothness, but, despite a few hiccoughs, without any significant problems. Of course, for the majority of patched staff, the district nurses and health visitors, there had been a change in the reporting lines but no change in their actual work.

All the patch managers stressed the importance of learning the details of their patches before they could be in a position to operate effectively or make any changes. This need to learn was heightened by a general feeling about the inadequacy of the patch profiles with which they had been provided. Similarly, the patch administrators had much to learn about new areas like estate management and property maintenance before they could offer any advice on possible alternative administrative or organisational arrangements.

General practitioners

The second group of people to be involved were the General Practitioners. GPs fell into four differing, though not wholly exclusive groups. Those who knew about the changes and supported them, those who opposed them, those who knew little but were interested, and those who neither knew nor cared. This last group was very small, but posed a certain problem for patch managers in fulfilling their objective of meeting all GPs by 1st June 1988. Despite the efforts of CHS, the local Medical Committee and the GP representative in the preceeding year, the overall level of appreciation of the new structure among GPs was not felt to be high, a factor which emphasises the need to establish closer working relationships. Nevertheless, sufficient interest existed in the establishment of Primary Health Care Teams (PHCT) for patch managers to be confident of identifying a suitable practice with which to set up such a team in each patch. There continue to be differences of opinion, primarily between GPs and nurses about the role and structure of PHCTs which will hinder all patches in actually starting a PHCT.

There can be no doubt that contacts between CHS and the local GPs have increased considerably. This increased liaison is not uniform, and given the independent contractual position of GPs never will be. One patch has invited all GPs to attend a meeting to discuss proposed alterations and improvements to the local health centre and twelve attended. Another has begun a series of regular meetings, the first of which covered the patch's cytology screening programme. In North Southwark, all three patch managers hold monthly clinical update sessions with local GPs and consultants from Guy's Hospital to cover the services provided and to increase co-operation between CHS, the GPs and the acute unit.

It might be considered unfortunate that it needed a major management re-organisation to achieve this dialogue, and it is too early to be able to report on changes in services that have resulted, nevertheless this development is an improvement that must be welcomed.

Consumers

It has been noted that the consultation exercise about patches appears not to have touched members of the local community, despite a wish to listen to their points of view. Most patch managers recognise the need for community participation, but this is an area where there is very little past practice within health authorities to guide them. Accordingly they do not expect that there will be any developments in this field for at least the first year. Bearing in mind the early decision of the DSG to follow an 'organisational' as opposed to 'accountability' model for change, this is perhaps not surprising, but the patch managers will have difficulty in identifying the health needs of their localities without establishing some form of community participation.

Patch information

As well as patches learning in detail about themselves this information has enabled CHS and PCU to learn more about itself, most notably in the first instance about its physical self. Health centres and clinics had tended to be considered as buildings 'out there' and suffered as a consequence, particularly in comparison with the acute units. As mentioned below, they had also suffered from the banking of minor block allocations. Having staff on the ground who are responsible for the buildings can only lead to an improvement in their upkeep and appearance, which will be to the benefit of staff and client alike.

Additional funding will always be tight, and patches are now looking to localised small scale fundraising initiatives, not to supplement core services, but to provide, for example, client refreshment facilities paid for by car boot sales in conjunction with the CHS League of Friends. There is much to be learned from the experience of authorities which decentralised before Lewisham and North Southwark and this is being facilitated by patch managers attending the London Locality Managers Forum organised by the King's Fund, but progress has started.

It has been noted that patches commenced operation in an optimistic manner. Along with this optimism went a feeling of uncertainty. It was not expected that organisational change would bring about rapid changes in service delivery, and of course this has not proved to be the case. The first few months were handled with considerable caution as people attempted to find their feet and keep well clear of other peoples toes. However, the foundations have been laid on which services can be developed, improved and made more relevant.

6. Financial considerations

Two statements in the original decentralisation proposals provided the financial guidelines for the project. Firstly, that the management costs should not increase as a result of the new structures, and, secondly, that all development monies should be used for the furtherance of decentralisation/general management. For a whole number of reasons it is extremely difficult to say whether either of these guidelines was adhered to.

At first glance it would appear that a new structure which created ten new patch manager posts, plus increased administrative and clerical support posts, must result in increased management overheads. Whilst it is true that the majority of these posts were recruited internally, some involved increased costs as a result of promotion, and some were indeed external appointments.

However, this self evident truth of increased management costs is belied by the CHS business programme which shows administration costs for 88/89 reduced by 0.7% against the 87/88 estimates:-

	£'000
87/88	1486
88/89	1475
Reduction	11

Unfortunately, the bald figures in the business programme do not reflect the true position either. The main reason for this is that the situation wherein some patch managers have dual responsibility means that parts of their salaries can be charged to other lines, or in the case of two patch managers who remain heads of district therapy services, it means that CHS effectively gets two patch managers free. Since it is very unlikely that dual responsibility could be undertaken by a new appointee should any of the existing post holders leave, it is to be hoped, for financial reasons, that they do not.

In fact, only five of the ten patch managers are charged to the CHS administration line, at an estimated additional cost of £45,000 per year.

Patch	Dual Role?	Payment Source
Aylesbury	No	CHS/admin
South Lewisham	No	CHS/admin
Central	No	CHS/admin
Honor Oak	Admin/support issues	CHS/admin
Sydenham	Part time SCMO	CHS/admin & newcomen
Bermondsey	Health visiting	CHS/nursing
Surrey Docks	School nursing	CHS/nursing
Deptford	District nursing	CHS/nursing
Forest Hill	Chiropody	District services
Lee	Speech therapy	District services

If one assumes an average salary for a patch manager, ignoring on costs, of £15,000, then the patch managers ought to cost CHS/administration lines £150,000. In fact, because of judicious appointments, the reported costs of management in the first year will be only £67,500. Assuming that people leave and are replaced by full time managers, then CHS will have to pay an additional £30,000, and show in its management overheads an additional £75,000. These figures will be £37,500 and £82,500 if the Newcomen monies do not continue.

Four additional nursing officer posts were created for the post-decentralisation structure. Of these, one was paid for by transferring resources from slippage in the Primary Care Resource Scheme in Bermondsey, and the other three were paid for by vacancies elsewhere in the nursing complement; the net effect being no increased financial cost. As the new posts of patch administrators and patch secretaries were filled either by re-deployees, or by new staff paid for by monies released through a general restructuring of the community administration, here again there was no increased financial cost.

Thus, on paper, the net staffing cost to the Health Authority was £45,000 pa, of which CHS was only responsible for finding £5,000 in each of the first two years. The 1988/89 Business Programme states that the DMB have made available £40,000 pa for two years for the CHS decentralisation programme, which will cover nearly all the additional costs outlined above.

The capital costs of the decentralisation programme are also not entirely straightforward. This is because the new patch bases were all in existing clinics or health centres which were subject to a minor block allocation programme. Therefore works carried out for conversion to patch bases and works as part of backlog maintenance sometimes overlapped.

For some years Priority Care had been banking with the Region £1 million pa of its minor block allocation to create a contingency reserve for acute unit redevelopment, and a number of CHS premises had suffered a degree of run down as a consequence. It was agreed that £200,000 of this fund could be spent on a joint programme of providing the administrative accommodation necessary for decentralisation, essential repairs and making

the premises more 'user-friendly'. By dint of careful choice of patch bases, re-planning of internal staff usage of the centres and the removal of unused dental facilities, very little new office space was required and only £18,500 needed to be spent on new partitioning and re-decoration. This very limited work in new offices unfortunately created an incorrect impression that only facilities for administrative, and not field, staff were being improved. The remainder was spent on maintenance, primarily roofing, and considerable up grading of one very run down health centre.

Two, apparently unused, pram parks were lost in the conversion work, but there was no other loss of client or direct treatment facilities.

Thus in both revenue and capital terms the implementation costs of decentralisation were very low, but the manner in which they were kept so low has of itself created a number of problems which might, at some time, come to the surface and cause a degree of financial difficulty.

7. Future developments

Following the implementation of patches, a number of work areas still need to be tackled. These fall into three categories.

1. Minor issues

The first can be described as those points which have yet to be fully settled, but which are no more than teething troubles. In this category are points like the precise compilation of the street index, which must await a walking tour of the patch boundaries so that the exact point at which a boundary crosses a street can be settled. The problems here are no more than are to be found in any management structure, be it newly changed or long term crystalised.

2. Further decentralisation

The second category is the further discussion of those services not currently included within the patch system. This includes both services which are wholly under the auspices of CHS, like the family planning/well woman service, child health administration, statistics and information, twilight and night nursing, and also the district managed services. Whilst it is in the CHS Business Programme to review the position of the former during 1988/89, the latter needs to be dealt with at Unit level and is a longer term item.

3. Dual responsibility

The third category covers the operation of the current patch system, and contains those issues referred to earlier which were either compromised or not tackled. The first is clearly dual responsibility. Dual responsibility served two useful, even vital, functions. Firstly, it enabled CHS to retain the two ADNSs, which all nursing staff argued were essential, and for whom there was no alternative place in the new structure. Not only was there no obvious place for them, but their retention would have negated an inherent principle of the decentralised structure, i.e. that patch managers were managerially responsible for all staff working in the patch. Secondly, it enabled CHS to mitigate the costs of decentralisation by cross charging some patch managers. However, at some point one or more of the patch managers with dual responsibility will surely leave, and what happens then? Whilst it is of course possible that a new appointment could carry out both aspects of the post, this is considered most unlikely. So one of two things could happen. Either two people would have to be appointed at considerable additional costs, or a patch manager would be appointed without additional responsibility and the professional overview role would disappear.

Since it is not within the power of CHS to say that there will not be a head of a District Service, should one of the dual district service heads/patch managers leave then two

replacements would be necessary. If,though, it were one of the ADNS/patch managers then it seems likely that the ADNS function will go, leaving the remaining dual responsibility holder in a very curious position, and leaving the nursing organisation within CHS with an unbalanced hierarchical structure.

There remains an equally important unresolved issue about dual responsibility; does it work?

Again, it is necessary to draw a distinction between the district service heads and the ADNSs. The former retain managerial responsibility for their service and the question is; can one person do both jobs? The latter have a professional, non managerial, function, and the question is whether the function is necessary, and is it being carried out? Alternatively, if the function is being carried out too enthusiastically, how does it affect the specific patch responsibilities of the dual post holder? and how does it affect the working relationships in the other patches?

First thoughts

When interviewed in April and May 1988, just as they were starting their new jobs, most patch managers, not surprisingly, did not know the answers to these questions. The district service heads all believed that their new jobs were tenable, otherwise they would not have applied, but were not entirely sure how it would work out. Whilst other patch managers did not all share this optimism, none was terribly concerned since the area of dual responsibility did not directly impinge on their work. Nor was there any expressed disquiet concerning the patch managers who held responsibility for operational and support issues, school nursing or the part time SCMO.

With regard to nursing staff, there exists far greater uncertainty. Nurses form by far the majority of a patch manager's staff complement, and in general were the most opposed to patch management. All patch managers were insistent that if they were not the nurses' line manager de facto as well as de jure then they could not do their job. Whilst they generally accepted the need for certain professional issues to be settled by an appropriately qualified person, they saw these issues as being very limited, and expected that staff would see them as the line manager and have little or no need to take matters to the ADNSs. One stated that as the ADNSs would be busy with their own patches and have little time to be available for nursing matters in other patches, then in the course of time their dual roles would decline, possibly to the point of extinction. This seems most unlikely.

Having fought to retain the posts and the functions, it is far more likely that nurses will continue to make great use of the ADNSs. In the first three months of patch management, these two members of staff were still spending almost as much time in their respective professional fields as they had done before, and as they picked up the reins of being a patch manager it was at the expense of their own free time and not of district wide nursing issues.

Cross-patch operations

As the new patches did not correspond to any of the previous nursing officer areas, and as individual case loads could not possibly be re-drawn from scratch, there was a lot of cross patch working by both health visitors and district nurses. In addition, some GP attached staff found themselves with a base in one patch, their attachment in a second, and even some of their patients in a third. Many GPs had their lists covering a number of patches. In the first instance all this causes is a degree of administrative confusion and overlap. Staff were allocated to the patches centrally, and in the first year patch managers were responsible for the staffing budget of the number of people they had, not in any way were they responsible for agreeing the numbers themselves.

As patches develop more comprehensive plans for meeting the health needs of their own localities and populations, the staffing complement of each patch must begin to vary. Not only in terms of absolute numbers, but also with regard to the relative numbers of each staff group. In addition, some patches may require specific staff to undertake community development work or other specialised functions which do not fit into any current Lewisham and North Southwark practices. Since such staff will have to be found from the existing overall staffing complement, negotiations will have to take place with the relevant professional head responsible for authority wide standards, and it is unclear whose decision is final.

There may well also be reluctance to having patch staff working in other patches, unless the cross patch element is self balancing. Whilst all patch managers wish to operate in a constructive and mutually responsible manner, the possibility of damaging interpatch rivalry exists.

Staff recruitment

Of greater concern is the way in which recruitment trends might adversely affect some patches. Traditionally, it has been easier to recruit staff, both nursing and clerical, to work in the central and southern, rather than the northern, parts of the district. There are a number of reasons for this; from the undoubtedly greater deprivation and increased social problems and consequential occupational stress of North Lewisham and North Southwark, to the difficulties encountered by staff travelling in highly restricted parking areas where parking tickets are a hazard of the trade, the costs of which have to be borne by the individual staff. On top of these problems are the greater problems of recruiting nurses in London, and of the NHS's inability to compete with the private sector secretarial salaries available in the City. With a district wide organisation it had been possible to compensate, in part at least, for these problems by arranging cover and internal staff transfers. If this does not prove to be possible in a decentralised structure then the risks for staffing in the northern patches are potentially very serious.

Mentioned above was the need to tidy up the edges of the patch boundaries, this being the minor logistical problem. Over and above this is the likelihood of more fundamental anomalies arising which would necessitate significant re-drawing of the boundaries. Most

staff, both those in patches and those at the centre, recognise that changes will be required, and most have assumed that it will be possible to make such changes, there is far less certainty about how. Just as the existing boundaries did not please everyone, it is futile to assume that any alterations would be universally approved of either. Change for change's sake is usually of little benefit, so minor alterations may not be considered worthwhile. On the other hand, there will be a reluctance to undertake major alterations soon after the introduction of a new management structure. Boundary difficulties may well remain unresolved.

The final point is that all the experience of local government and health authorities who have undertaken major decentralisation is that greater access to facilities and services create of itself greater demand for them. In the short term, more complaints are received and it is accepted that this is largely because there is now someone local to complain to. So whilst this increased disatisfaction does not necessarily mean that the service is becoming worse, it does highlight shortcomings that were previously unarticulated. It remains to be seen whether Lewisham and North Southwark will have the ability or the resources to meet this demand.

8. Conclusion

Management philosophy

The context within which the decentralisation programme operated was agreed at the first meeting of the Decentralisation Steering Group, on 17 March 1986, and needs to be re-stated. It was:-

> The management task facing the Priority Care Unit (PCU) over the strategic period will be heavily influenced by two factors:
>
> (i) The district management philosophy.
>
> (ii) The scale of the service changes required.
>
> The management philosophy that has developed within the acute units places management and planning decisions about services in the hands of service providers, and has created a budgetary and information system that supports these structures.
>
> The purpose of introducing these decentralised systems to the acute units was to provide greater official accountability, improve efficiency, improve service planning and involve clinicians in decisions about their services. These broad management goals are applicable to the Priority Care Unit, which has yet to evolve a similar decentralised management structure. The role of this project is to provide the structure within which these changes in management style can occur.
>
> The service issues facing the Priority Care Unit can be summarised as follows:
>
> (i)The development of community based services to replace long stay institutional care.
>
> (ii) The development of new acute hospital facilities for psychiatric and geriatric services.
>
> (iii)Working with GPs and Local Authorities to develop new methods of community care, in order to reduce the acute hospitalisation rate for District residents.

It was also accepted that the only managerial model that was capable of bringing about this desired re-structuring was Griffiths style general management. As was stated in

chapter 3 , decentralisation and general management are not the same thing, but in L&NS they went hand in hand and were indeed inseparable. The desire to introduce the principles of general management to community services was both the parent and the child of decentralisation.

Thus the original aim was to achieve a decentralised organisation, under general management and responsible for all community services, and to have this in place and operational by April 1988. Whilst the start date was achieved, the extent of the services covered by the revised management arrangements was smaller and more limited than that first envisaged. Only Community Health Services (CHS) within the PCU followed the path laid out by the DSG, and not all of its services were suitable for inclusion. If one considers that decentralisation finished in April 1988, then the exercise has achieved limited success. However, it is much more realistic to see the 1988 start date as the completion of only the first stage of decentralisation, with other parts of CHS, and the Mental Illness (MI) and Mental Handicap (MH) executives to follow.

General management

It did not prove possible to introduce a unified general management structure across the whole of PCU, primarily because the three component parts contained such a diversity of existing structures and services that common treatment was not practicable, but also because MH and MI did not feel satisfied that the proposals fully recognised the needs of their services. However, within CHS the principles and practice of general management were adopted. Both the job description and the management objectives for patch managers make it clear that day to day responsibility for staff, budgets, premises and service delivery will rest firmly with the patch managers. With regard to quality indicators and professional guidance, the patch managers have a duty to liaise with and consult the heads of service, and to reach agreement with them on levels and quality of service provision.

The matter of professional responsibility has been contentious throughout the decentralisation process. Whilst it is unlikely that the agreed solution of a number of dual responsibility holders is to everybody's satisfaction, the arrangements appear to be working without difficulty or disruption. However, because this structure relies on the particular skills of a number of existing post holders, a caveat needs to be entered regarding longer term arrangements.

Considerable reference has been made to the functioning of the dual responsibility system. Whilst nobody could tell in April 1988 exactly how it would work, six months of operation have cast little additional light. There has been what can best be described as a 'honeymoon period'. Only when the patch managers assume full responsibility for all staffing and non-staffing budgets in April 1989 will it be possible to fully test the system.

Staff recruitment and retention is a problem for all DHAs especially those in and around London, and if the general management style does not satisfy the aspirations of field staff, then this dissatisfaction might manifest itself in falling staff numbers, with personnel going

either to other districts or leaving the NHS altogether.

General practitioners

The DSG recognised the crucial importance of bringing closer together the services of GPs and the health authority, not only to make existing services more efficient and accessible, but also because of the increase in community based services that must follow the run down of the long stay institutions. To achieve this, CHS had to produce systems that could facilitate this greater co-operation, but it also had to retain the confidence of the GPs and win their support for a decentralised structure.

As has been mentioned previously, it is difficult to comment authoritatively on the views of GPs, since there are almost as many views as there are GPs, and few mechanisms exist to enable these views to be presented in a collected or consensus manner.

It is clear the GP fears that all existing practices relating to attached nursing staff would be changed have proved to be quite unfounded. It is also clear that the revised structures have made it much simpler for GPs to get in touch with the person who is responsible for CHS services in their area. In some cases of course, this responsible individual turns out to be not one person, but two or three people. Whilst this can cause specific and localised areas of overlap, it does not mean that the system as a whole is not effective.

What it does highlight is the continuing need for flexibility in the provision of attached nursing staff to practices that cover more than one patch. Whilst one view of flexibility is that the health authority should tailor its services wholly to the wishes of GPs, in general it means recognising the problems faced by them. If the GPs consider that health service structures are too cumbersome and bureaucratic then their reaction might be to ask the FPC to emply its own practice nurses directly. Whilst at present this would not seem to be an attractive option for many nurses, or indeed a favoured solution for many GPs, the DHA cannot afford to disregard the possibility.

Boundaries

Whilst a lot of time was spent in devising the most appropriate boundaries, in fact they are of less importance than might be thought. This is because patches will stand or fall according to how effectively they are run, and not because of the merits or otherwise of the cartography. The patch managers all considered that their job was to provide the best possible services within their patch, and that this would be the case whatever the details of the patch boundaries turned out to be.

Each patch fulfilled the requirement of having within it a major CHS location that could serve as the patch base, but this resulted in a greater population spread than was desired. However, the varying service needs of each patch and the consequent variations in staff within each patch has meant that management spans of control approximate well to those recommended by Cumberlege.

Whilst the boundaries will be subject to review after April 1989, the belief that it is the services provided rather than their geographical confines that is most important makes it unlikely that revisions will be made.

Training

When the DSG proposed that community based services should be run under the umbrella of general management, it was not only assumed but hoped that the patch managers would come from a wide variety of different backgrounds and professions. Although this was not an approach adopted by some other districts, who preferred to recruit locality managers from within the nursing profession, it best fitted the L&NS management philosophy. Whilst this approach brought together a diversity of experience, it created the need for comprehensive training to deal with those aspects of the post which patch managers were not wholly familiar. This training was done in-house and with North East Surrey College of Technology.

In addition, training was given to the patch administrators to enable them to deal with new work areas, such as property and estate management.

The first stage of training was short and intensive, and was designed to 'jump start' the patch managers into their new jobs. The second part is much more lengthy and will develop as does the nature of the job, and will be geared to individual needs. An integral part of this training is the establishment of semi-formal peer group support networks, and will apply both to patch managers and administrators, enabling them to meet together and discuss mutual problems, similar to the existing meetings of nursing officers.

Costs

As detailed in chapter 7, an assessment of the costs of decentralisation is not straightforward. The PCU was operating within the very clear constraint that management costs of the revised structure should not exceed that which previously existed. This was achieved by a thorough re-organisation of the central CHS administration to make it relevant to the needs of the decentralised service and avoid duplication, and by transferring staff from the centre to the patches. The complications arise from the way in which a number of staff are cross-charged to other parts of the PCU budget. This creates the potential for increased CHS administrative costs in the future. Whether these costs do increase depends on how recruitment is handled when any of the current dual responsibility post holders leave.

Evaluation and review

It is not sufficient to implement a new organisational structure that has as its aim the improvement of services, and then merely to assume that the aims have been achieved. A thorough review and evaluation is necessary. It has been agreed that CHS will "develop a plan for the evaluation of decentralisation to patches in terms of costs, impact of delivery of community services and key performance indicators". This plan is to be in place by

March 1989 for the evaluation to take place during the latter half of 1989/90, i.e eighteen months after the introduction of patch management. This evaluation will look at the objectives that were set, both management and service objectives, the organisational methods used during the implementation, and the results that have been achieved.

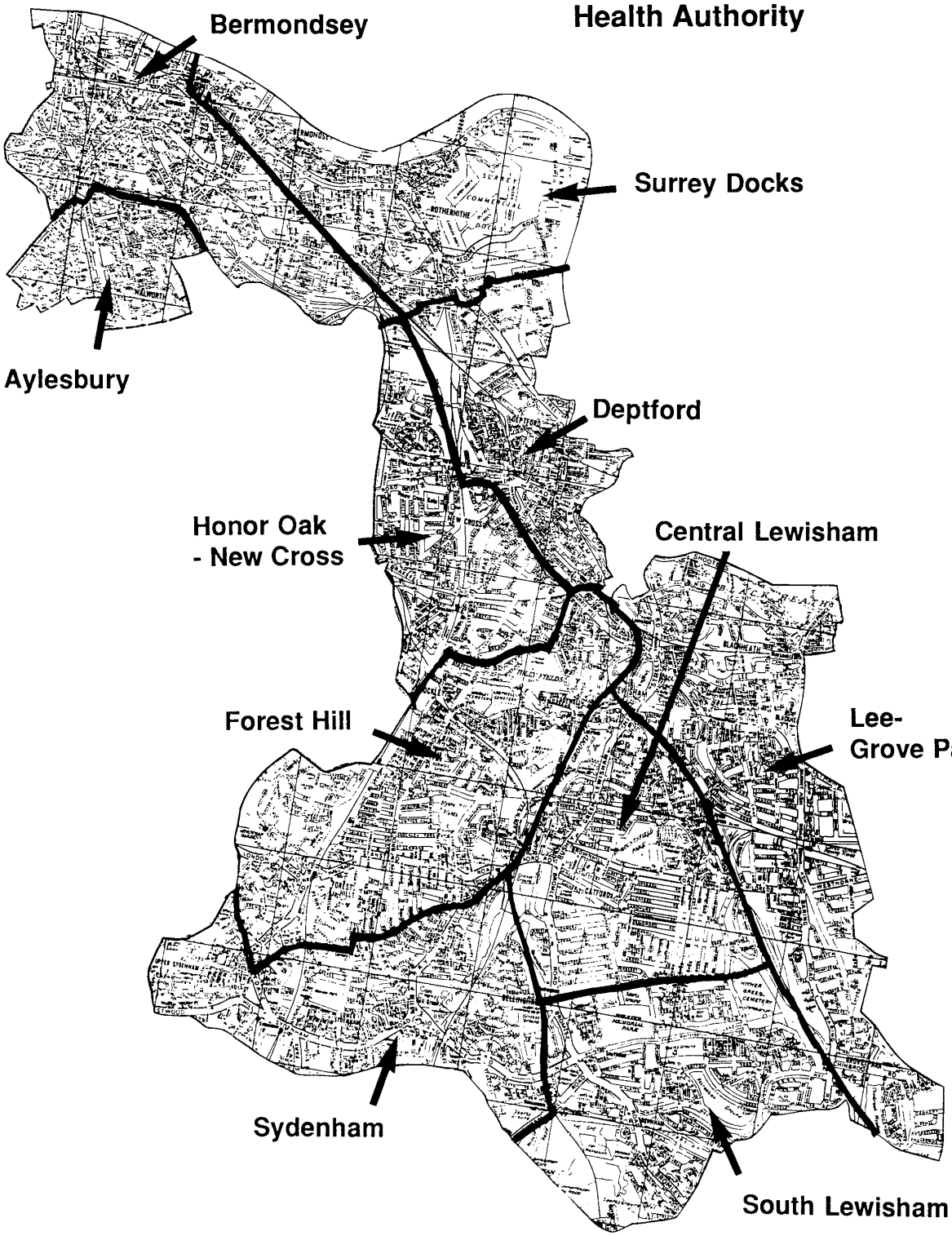
In doing so, CHS will have to review those services which have not yet been decentralised, such as child health, statistics and information, family planning/well woman and the twilight and night nursing service. These services were not included in the first stage of decentralisation because their sizes and structures did not lend themselves to being devolved into ten patches. With the pressure to implement patches by April 1988 it was not possible to devise alternative decentralised models, but this now needs to be done, and has in fact already started.

Which decentralised model will be followed by Mental Illness and Mental Handicap has yet to be finalised. This report has not addressed developments within these two executives beyond the stage where it was decided not to include them in the scheme for decentralisation by April 1988. This does not mean that all work stopped at that point, merely that it was not possible to report its outcome. Development work has continued towards localised management, although a common structure may result, it is unlikely that it will be a unified one for some years to come.

The objective for the Priority Care Unit remains that "all services, except acute and rehabilitative hospital care, should be provided in peoples local neighbourhood in a familiar environment,.... and that they should be planned and managed at this local level".

Appendix A

Lewisham and North Southwark Health Authority



Appendix B

Lewisham and North Southwark Health Authority
Priority Care Unit

A framework for patch management
Introduction

In January of this year, the District General Manager (DGM) and the Unit General Manager of Priority Care Services (UGM) set up a Steering Group to examine the possibility of moving to a patch management system. The Steering Group contains senior managers from the Priority Care Unit and other senior officers from the District. The Group is chaired by the DGM. The proposals outlined in this paper have been drawn together by the Steering Group and are issued for discussion to all staff working in the Priority Care Unit, the local authorities, and other interested parties, for example GPs.

The primary purpose of this report is to form an agreed management framework for pursuing decentralisation to community patches. The report will focus on broad decisions rather than detail, in order that a wide discussion process can be undertaken with the staff and managers that will be involved. There will be a series of meetings held to discuss the content of this paper. Specific detail in relation to individual patches will be formulated after the discussion period.

The discussion period will last for eight to ten weeks to allow the maximum opportunity for feedback and comment.

Further copies of this document and comments on the proposals for management arrangements, and patch boundaries should be addressed to:

Celia Pyke-Lees
Unit General Manager
Priority Care Unit
Mary Sheridan House
St. Thomas' Street London SE1 9RT
Telephone: 01 - 378 7431 x 2915

(All comments should be sent to the address above by Friday, 28th November 1986.)
September 1986

Setting the scene.

The Priority Care Unit faces a challenging future. The services provided by the Unit will both expand and change over the next ten years. The District Strategy has outlined how services will develop, and the Mental Illness, Mental Handicap and Community Executives are developing new services to meet the requirements of the plan.

The broad outline of the strategy agreed by the Authority is shown below:

(i) Community Services.

A key aim is the development of services that provide a preferable alternative to the acute sector and facilitate a reduction in the medical and surgical hospitalisation rate. Services should, where possible, be developed within the primary health care team and relate to giving people the choice of staying out of hospital and effecting easy transfer both to and from hospital.

A second strand of the strategy relates to the provision of services for the elderly which is the key care group in the District Strategy. The integration of hospital and community services is required and the creation of new long-stay facilities in the community is essential.

A total of £2.9m revenue has been set aside for these service developments.

(ii) Mental Handicap Services.

The primary objective of this service is to support handicapped people in their own homes or in alternative community based accommodation. The closure of long-stay institutions is a priority, particularly Darenth Park Hospital.

The Authority has identified £2.2m extra revenue to meet these tasks.

(iii) Mental Illness Services.

The key objectives relate to the development of new acute hospital facilities and new community based long-stay residential and day facilities.

The closure of Cane Hill and Bexley Hospitals is a priority.

This Executive provides services to adult, child and elderly mentally ill people. Any new proposals will need to be flexible enough to maintain the identity of each of the three strands of service. The Authority is providing £6.9m development monies for this care group.

Current management structures within the Priority Care Unit have evolved to meet the requirements of hospital based services or have remained based on the local authority models for delivering generic community services. The scale of change now facing the Priority Care Unit has forced the Unit to reconsider how services are delivered.

The closure of long-stay mental illness and mental handicap hospitals, and the placing of hundreds of people in the community for continuing care, will have a profound effect on the way services are delivered. It is inconceivable that current management models will be effective for the day to day management of these dispersed facilities. Indeed, the Mental Handicap Executive has already moved to locally based services provided by teams based

within the community.

For generic community services provided by the Community Executive, the change has been equally dramatic. The closure of acute hospital beds, and the increase in demand for support services has placed great burdens on the locally based staff. Further, the effect of bringing long-stay mentally ill or mentally handicapped people into the community has placed an extra burden on these staff. The co-ordination of the various services in the Priority Care Unit is essential for effective service delivery.

This realisation that in order to fully develop our service plans, a change is required in the management style of the Priority Care Unit, forms the basis for the proposals to move to a patch management system.

The second theme that has emerged from consultation on the District Strategy, is the different health needs of different communities within the District. During this consultation, one of the main criticisms by District residents was the lack of Health Authority response to perceived local health needs. It is clear that the District cannot be viewed as a single entity, and that the Authority must develop different strategies for different areas within the District.

Some services already try to meet this need. The district nurses and health visitors have developed management models that concentrate on specific catchment areas or groups of patients, and have consciously evolved a structure that facilitates links with the decentralised local authority services. Further, the community nursing staff have developed strong local links with the people they serve, this is particularly true for the health visiting service.

Finally, it is the aim of the DGM and the UGM to introduce the general management principle of maximum delegation of the management function to service providers and locally based managers. In many parts of the Priority Care Unit this delegation of responsibility already occurs. It is the wish of the UGM that this process is co-ordinated within an agreed and understood management framework. These three issues:-

(i) the scale of change facing the Priority Care Unit,

(ii) responding more effectively to local health needs,

(iii) the general management philosophy,

are the reasons why patch management is being examined. They also form the basis for identifying the objective we are seeking to achieve. This objective is to: identify more effectively the health needs of people within the defined area, and to meet them in a more co-ordinated and efficient manner than at present.

In seeking to achieve this broad objective, the following are the specific aims that patch management should meet:

(i) Priority care services provided in the community (i.e non—hospital services) should be planned and managed at local levels. Each team should be based in the areas to which they provide services, and have a single manager responsible for that team. Specialist community based priority care services should be provided by teams covering wider areas as appropriate. Service provided to patches by other teams should be set at an agreed service and financial level.

(ii) Consumer and local staff input should provide the basis for examining the quality and quantity of services provided.

(iii) The decentralised service should be used to achieve a more sensitive distribution of primary and community services across the District. This distribution should depend on an evaluation of local needs and priorities.

(iv) Patch managers and their teams should collaborate with local authorities, GPs, and other agencies to ensure efficient patterns of health service provision at a local level, which conform to statutory requirements where these are set.

Summary

The Priority Care Unit will change greatly over the next ten years. In order to manage both the change in services, and to more effectively meet local needs, it is proposed to set up a patch management system. The broad outline of this system will be similar to the present, with the creation of a new locally based manager responsible for the day to day management of the teams providing care.

It is envisaged that all community based staff will relate to patches.

Factors Influencing Direction

Any change to the management of services will cause some disruption and anxiety. Whilst it is inevitable that change will occur, the UGM is determined to build upon the strengths of the present system, and to evolve into patch management. In attempting to ensure that this evolutionary approach is adopted, discussions with managers have been undertaken to ensure that the strengths of the current management system are defined, in order that they act as the framework for future changes.

The areas raised by managers as matters of concern are discussed below. When possible they have been included as part of the proposals.

The role of specialist staff

In many areas of service, specialist teams have developed to handle specific problems. The skills contained within these teams are not provided elsewhere in the District and it is therefore important to retain them. However, there is often only one team for the District and therefore they cannot be broken into smaller groups. It is clear that some services will have to be based and managed outside patches. Where services are provided outside a patch, the services will be delivered by the specialist staff at an agreed level to all of the patches.

Patients with special needs

It has been argued in the past, that patients with rare conditions tend to be disadvantaged by decentralised delivery systems. These rare cases appear so infrequently in small areas that patient needs are often overlooked. There must be clearly defined pathways for patients

to follow from each patch to the specialist care needed.

The role of the GP

One of the key issues facing the decentralised system is the relationship between the District managed health services and the independant general practitioner. It is clear that the independent nature of the GP will be preserved. Therefore, methods of increasing joint working between the GP and health service staff must be found. Any new system developed must not threaten the good working relationships between some GPs and health service staff that currently exist, but it must provide the flexibility for future developments. It is envisaged that at patch level, the locally based teams and the GPs will form service agreements to increase the quality and efficiency of services. Where possible these service agreements should allow for the increased development of primary health care teams. If GPs do not wish to form part of these discussions then the status quo will continue.

As the District Strategy has been refined, a key concern has been the need to maximise resources not only within the District, but also between the District and other agencies. In order to meet the increasing demands placed upon it, the Priority Care Unit will need to develop stronger links with GPs , local authorities, and voluntary organisations. Only by strengthening these links will it be possible to reduce the acute medical and surgical hospitalisation rate. In the past, developing these links has proved to be particularly difficult because of the split between two local authorities, the size of the district, and the independent working methods of GPs. The success that the Community Executive has had in working with other agencies has occured when resources have been concentrated on specific areas or specific GP practices. The Care at Home project has provided the opportunity to examine ways of keeping people out of hospital. The structure evolving is a decentralised multi-disciplinary team based around a GP practice. By concentrating at this local level, the particular problems associated in the past with multi-disciplinary team approaches have been successfully overcome, and many different agencies and professionals have input into the programme. The benefits of the interaction between different health professionals have been commented upon by all the people involved in the project.

Relationship with local authority services

For many priority care staff, the key relationship is not with the GP but with local authority social services, housing departments, housing associations and the voluntary sector. It is essential that any new delivery system is able to strengthen these links.

Many managers have stated that the links with social services are so important that they would wish to retain or create coterminous boundaries between health and social services as a first priority.

The future of the Executives

There has been much discussion with the Directors of the Executives in relation to the future role of these. It has been agreed that, in order to maintain the drive to develop services

for underprivileged groups and to maintain a coherent overview of each service the Executives should be retained. In order to retain this development drive the Executive Directors will continue to have a managerial role.

The Heads of Professions

The health service is made up of different groups of professionals. There has always been a degree of professional sensitivity between and within these groups. These professional sensitivities, particularly in relation to the professional advice and managerial roles, will form a major constraint on the decentralised system. However, the concentration on front line staff based in the community within local areas, will allow local solutions to be evolved by those staff. Greater emphasis on locality rather than team may provide the basis of overcoming some of these problems. It is expected that professional and line accountability will form the basis of a dual accountability system for managers within the patch.

Most staff will be managed within a patch team. However, some staff will be based in the patch but will not be part of the team; chiropody and physiotherapy may be such services – these staff will continue to be managed by the head of service.

The key role for the professional head of each service will be the setting of standards and the creation of a structure that allows professional advice and support to be maintained and strengthened.

Accountability

Whilst there are clear lines of accountability between the Executive Directors and the UGM, new lines of accountability must be forged between locally based staff and the patch managers, and between the patch managers and the Executives. This accountability will form the basis of a clearly defined monitoring system. Following the general management principle, it is envisaged that patch managers will come from a variety of backgrounds.

Support systems

The final constraint relates to support systems. The newly decentralised system will require new budgetary, information and service monitoring systems to be developed. These support systems and the staff running them will need to coordinate their activities to enable the smooth transfer to patch management. The role and function of finance, personnel and central administration departments will be reviewed prior to implementing patches.

Development work for management budgeting and information systems has been started.

Training

A major commitment by the Priority Care Unit will be to training. Patch managers and team members will require training to ensure that the new systems are understood and can be run by the locally based staff. A training programme will be developed prior to the

implementation programme for patch managers and post implementation for patch team members.

The training of nurses and other care staff in the community will become increasingly important. Any proposal will be able to support the continued training of direct care staff.

Service agreements

It is the intention of the UGM to introduce service agreements as a method of defining levels of service to be delivered to the public. Those service agreements will be between teams within the patch and where possible will be formed between GPs and local teams, and social services and local teams. The creation and use of service agreements will allow patch managers and teams the opportunity to closely control and monitor resources and services.

Summary

It is intended to build upon the strengths of the current staff and managers in the community. In order to evolve a new management structure that builds on the strengths of the current system, the following factors have been identified as major factors that will influence the direction of patch management:

i) Specialist staff
ii) Patients with special needs
iii) The role of the GP
iv) Links with local authorities
v) The future of the Executives
vi) The heads of professions
vii) Accountability
viii) Support systems
ix) Training
x) Service agreements

Patch management

The broad objective for the decentralised system is the desire to identify more appropriately and meet the health needs of people within a defined geographical area. This broad objective will be met by achieving the aims described earlier in the paper, which relate to the decentralisation of priority care services to the patch.

Each of the three Executives working within the Priority Care Unit have teams based within the community. The Community Executive provide primary and acute services based on nursing officer areas. The Mental Illness Executive has divided the District into consultant catchment areas. The Mental Handicap Executive provide services from community based teams. None of these teams are based within coterminous boundaries. It is inevitable that such a system cannot provide a comprehensive and unified service to the public, because teams are not based on common areas and therefore find it difficult to discuss common problems.

In principle then, all teams working in the community should have common boundaries, in order to improve communication and to provide a unified service to the public. Some teams may cover more than one patch but they will relate to common boundaries.

It is proposed that each Executive will have a team within each patch, i.e each patch will have three teams. Each patch based team will have an identified manager responsible for the financial control and day to day management of the team. This patch manager will be responsible to the Executives. It is expected that the majority of patch managers will come from within the present teams.

The management of hospital facilities within the Priority Care Unit will need to reflect the change occuring in the community. It is envisaged that acute services in the priority care sector will relate directly to individual or groups of patches. Managers of long stay facilities will have the opportunity of planning the transfer of clients out of hospital to designated patches.

The aim of decentralisation is to provide these teams with the managerial skills and facilities to take on greater responsibility and accountability for service delivery, quality of care and management functions.

It is envisaged that each of the three teams within the patch will interlock to provide a comprehensive local service. If possible the patch teams will be coterminous with social services and housing departments and will mesh with those services also to provide linked services to the public.

There will be services outside the control of these three teams that will be required to provide a comprehensive service, for example some therapy services, community midwifery and support services. These facilities will be provided by the managers in charge of these external services. It is, however, envisaged that the vast majority of all priority care staff will be based in and managed on a patch basis.

The management process

At a patch level, each of the three teams will have a manager. The role of the manager is to act as the co-ordinator of the team and to provide the input into the patch advisory team.

The manager will not manage staff in relation to the professional tasks undertaken, these will remain the responsibility of the professional head of each service. He/she will, however, be responsible for the overall budget for that team and for the performance of that team in relation to the objectives set by the Executives. It is envisaged that the managers will come from within the team.

At patch level:

i) Each Mental Handicap, Mental Illness and Community manager, with other team members will evaluate their own services within the patch, and draw up service objectives within the philosophy and objectives set by the Executives. Each service within the patch will then be in a position to develop a patch based service plan;

ii) Each patch based team will be required to develop quality action groups, to facilitate the implementation of quality assurance;

iii) Each patch will develop an advisory team chaired by the manager of the Community team. The role of this team is to take the local service plans and priorities developed by each service based team, and create a patch strategy, prioritising the service plans into a single patch plan.

The patch advisory team will be different for each patch, but will contain a minimum of the following members:

a) Community Patch Manager (Chair)
b) Mental Illness Patch Manager
c) Mental Handicap Patch Manager
d) GP representative(s)
e) Social Services and Housing Representative(s)
f) Nursing Representative(s)

With the development of an agreed plan and priorities, the patch will bid for development funds via the Business Programme.

The key role for the patch managers will be the local negotiation of service agreements both between patch teams and between health service resources and GPs, social services and the voluntary sector. These local negotiations will offer the opportunity to tailor local services to the local needs of the patch.

At Executive level:

The Executives will continue with their present membership. The Executives will provide

five functions:

i) The Executives will develop the District-wide philosophy and objectives for their services which, in turn, will be developed into plans and priorities. The three Executive plans will then form the basic Priority Care Unit Strategy.

ii) The Executive Directors will continue to manage services both within and outside the patch. The patch managers will manage the staff based in the patch on behalf of the Executives, and be responsible to the Director.

iii) The Executives will monitor the standards of service provided by staff within the patch, and the professional standards of the staff themselves. The Executive will provide the professional head of each service.

iv) The Executives will manage the process of closing the long-stay institutions.

v) The Executives in conjunction with the Priority Care Unit officers will set the framework for quality assurance at patch level. This will provide for each patch a defined standard of service to be delivered.

At Priority Care Unit level:

At the Priority Care Unit level the UGM will oversee the development of the Business Programme. The UGM will ensure that the Programme will provide:

i) The financial reconciliation which will be within the sum of development money agreed by the Authority for the year in question.

ii) That the plans developed by the patch advisory teams meet the general requirements of the Directors and the Executives. The UGM will be required to reconcile differing views between the patches and the Executives if these occur.

iii) Once the patch plans and development programmes are agreed, each Executive will be required to reach a formal agreement with the patch manager on the quantity of services to be provided within and the total budget for that service. These agreements will form the patch budget, the Mental Illness, Mental Handicap and Community Team budgets and the Executive Directors' budgets.

iv) The Priority Care Unit will develop the overall framework for quality assurance and provide the input to the programme to advise and monitor its successful implementation. In particular the development of defined standards will be monitored at this level, and reported to the DMB and the Authority.

This broad management process has been developed for discussion within the constraints laid down by the 'Griffiths Report' HC(84)13. These proposals are issued for comment by staff working within Priority Care Unit.

Summary

It is proposed that teams based in the community will be organised into coterminous patches. Each patch will have three teams, and each team will have a designated manager.

Patch managers will be responsible for the day to day management of services, and will form the core of the patch advisory team.

Executives will monitor implementation and create standards. Each Executive will contain the professional heads of service.

The UGM will reconcile financial and resource issues, and resolve differing service views

with the aid of central support staff.

Defining the patch

We have defined a broad management structure based around the patch team and the Executives. This section defines the type of area that would form the preferred patch.

Each patch must be able to support a level of staffing that allows flexibility for managers to cover sickness, absence and annual leave. Further, the Authority must be convinced that the new system offers adequate financial control mechanisms, and that the monitoring procedure can be properly exercised. Finally a major constraint will be the management cost of any change, which must be kept to a minimum.

Involving GPs in the patch process is one of the key aims for patch management. GPs will continue to draw patients from both within a patch and from other patches. This freedom of choice must be maintained. Currently, GPs with patients outside the local nursing catchment areas have their patients seen on an internal arrangement by the community nurses. Such a system will need to be supported and developed to allow for cross patch referrals. However, for most GPs the patch will contain the majority of the list.

For many people, the key service links are with social services. It is proposed to work jointly with local authorities to define common areas for patches.

A final constraint is the wish that any changes that are proposed keep service disruption to a minimum, for both service providers and for the public.

Defining the basis for a patch

A considerable amount of work has been undertaken by many people in attempting to define suitable patches for management. The process has been characterised by two approaches. The 'top down' approach which defines patches in relation to management pragmatism, and the 'bottom up' approach which defines patches in relation to service caseload.

Whilst these two approaches are important they are not the only method to approaching this problem. There are, in fact, three options for defining the basis of a patch:

i) The neighbourhood approach

In the Cumberlege Report on Neighbourhood Nursing, the idea of providing services to defined neighbourhoods is developed. The concept of neighbourhood, however, has been loosely defined and there are few parameters that have been agreed that define neighbourhoods. It is proposed that each Cumberlege neighbourhood should have 10-25,000 people within it.

The local authorities have been examining similar issues in relation to decentralising their own services. The London Borough of Lewisham has endeavoured to develop neighbourhood profiles in order to be more responsive in creating their own decentralisation areas. The general approach adopted by Lewisham has been to develop neighbourhoods on the basis of housing, shops, and community facilities, having regard for the natural boundaries, such as rivers, roads and railway lines, that exist in the borough. The London Borough of Southwark have not yet developed this approach.

ii) The caseload approach

The vast majority of non-hospital services provided by the three Executives in the Priority Care Unit are provided by staff working in existing patches. These patches have developed over time to facilitate good patient care. It may be possible, by examining all the patches currently used, to find a common boundary. It has been agreed that all community based staff should work within the same patch boundaries.

In the Community, Mental Illness and Mental Handicap Executives, the main patches that exist are described in Appendix 1.

As has been described earlier, the key link for many service providers is with the local authority social services. The links between community nursing, mental handicap and social services areas demonstrate this. Nursing officer areas in the old Lewisham Health Authority were designed to link with social services.

One other possible service patch has been explored. GP lists could provide a suitable basis for developing patches. This method is difficult to quantify because not all GPs have age/sex registers that provide accessible data to define patches. It has not been possible to pursue this method for these reasons.

The major drawback of developing patches based on caseloads is that these may not reflect local health needs. Many people in the District are not registered with GPs or known to other agencies, but have real health needs. The possibility of perpetuating these imbalances is a major constraint against using the caseload approach.

iii)Pragmatic approach

There are many boundaries that are already in use. The local authorities are divided into electoral wards, social services areas and many others. Pragmatically, it would be possible to adopt these areas, or aggregates of them to provide the basis of a patch.

Alternatively, a pragmatic approach could be to use one current service defined patch and 'fit' other patches into it.

The most appropriate patch

In seeking to define a series of patches, the Health Authority is seeking to achieve three items:

i) Coterminosity

In order to develop local networks of service providers it is essential that each service patch is coterminous. Where possible the patch should be coterminous with social service and housing areas. The opportunities for jointly planning health, social services and housing developments must be grasped in order to develop a comprehensive and integrated network of care.

ii) Localities

Each patch must be able to be identified by local people in order that local plans can be formulated in partnership with the public.

iii) Links

Within each patch links should be developed with other service providers, notably GPs, voluntary organisations and social services and housing. Linkages between Southwark Borough and the Authority would be much easier to develop if the Health Authority's boundary also formed some internal boundary to co-ordinate the formal care staff and to better support informal carers.

The current patches described in Appendix 1 do not meet all these aims. There is some coterminosity between health services and social services areas in Lewisham, but these areas are often too large for patches. Current services are however fairly well linked to social services, and these links must be strengthened.

The majority of current patches do not reflect neighbourhoods or localities as they have been developed for other purposes. Because current patches lack coterminosity and location, teams find it difficult to build links.

The pragmatic approach to using groups of wards fits well into the patch approach, as current social service areas are based upon wards. However, as has been described above, not all the current health service boundaries mesh with social service areas.

The neighbourhood approach most nearly fits with that approach recommended by the Cumberlege Report but shows little relation to current social services or health service areas.

Both Local Authorities are examining the opportunity of decentralising to local areas. The London Borough of Lewisham have defined 20 neighbourhoods to decentralise services to.

Given that the current patches do not meet the objectives set, and in the light of the health authority's desire to develop a network of care both within the NHS services, and between the NHS and other formal and informal carers, the following options for patches are available. The options are shown in priority order, and form the basis for discussion with NHS staff and with the local authorities.

Option 1

Joint areas are agreed between the health authority and the local authorities that allow health, housing and social services to work within jointly defined and agreed boundaries. Services would be decentralised to these coterminous areas.

Option 2

Joint areas are agreed between health and local authorities that allow health and social services to work within jointly defined and agreed boundaries.

Option 3

If the health and local authorities cannot agree on a set of common boundaries or if the timetables for implementation are incompatible, the health authority will define its own boundaries, and reorganise services correspondingly.

The preferred option will be discussed with the local authorities during the discussion period.

Summary

Given the desire for coterminous patches both within the NHS and between the NHS and other agencies, the preferred patch would be one that was jointly agreed with the local authorities. Ideally, the patch would contain both NHS, social services and housing officers within common boundaries.

Appendix 1 - main patches in use in the community

Community Executive Patches

Staff Group	Type of area
District nurses	Nurses are based in health centres and attached to practices. However, they work to approximate areas based around health centres. They correspond to local authority wards and, in part, to social services areas. Each patch has a nursing officer and a number of district nurses and support staff.
Health visitors	Health visitors are based in health centres and clinics; some are attached to practices. Each clinic has a defined catchment area that acts as the catchment for the health. visitor. A number of these areas are amalgamated to form a Nursing Officer Area
School nurses	School nurses are based in health centres and clinics. They work within similar areas to the Health Visitor Nursing Officer Areas. *The Health Visitor/School Nurse areas are not generally the same.
Specialist nursing services	There are a number of specialist services that cover a wider area than the nursing officer catchments. These include services for homeless and rootless people, geriatric liaison teams, and the pain relief/McMillan teams.
Mental Illness Executive	
Consultant AMI	Each consultant has a catchment area for which he/she is responsible.
Consultant EMI	Each consultant has a catchment area for which he/she is responsible. There is little

	correspondence to the AMI areas.
Consultant child psychiatrists	There are notional areas of responsibility for consultants. However, for this group of consultants strict catchments are not applied. These areas do not correspond to AMI or EMI areas.
Mental Handicap Executive	
Mental Handicap teams	Each team has a catchment area of responsibility relating to two social services areas.
Therapy services	
Therapy services	The therapy services that are not hospital based tend to be attached to multi-disciplinary teams, eg. mental handicap teams, and thus follow those areas. However, for some therapy services, a District-wide service is provided, eg. chiropody, although these services tend to be based in health centres or clinics.

For the majority of teams working in the community, there are no common boundaries. Each of the patches above does not relate to any of the other patch boundaries.

Appendix C

Lewisham And North Southwark Health Authority
Community Health Services Executive

New Title: Patch Manager
Location: Patch Base
Responsibility To: Director - Community Health Services
Responsible For: Nursing, Medical, Administrative and Clerical Staff working in the Patch.
Liaises With: Local GPs, Heads of District Managed Services, Officers of the Local Authority responsible for Housing, Social Services and Education, ILEA, staff providing services for people with a Mental Handicap and the Mentally Ill, Voluntary Organisations.

Job Summary: The Patch Manager is directly accountable to the Director of Community Health Services for the effective and efficient management of resources within the patch; for ensuring the highest possible standards of patient care; giving leadership to all staff working within the patch; for ensuring that the objectives established for the patch are met within the framework of the CHS Management Board's plans and policies and within the required timescales.

Principal Duties and Responsibilities

Managerial Leadership

1) To delegate responsibility including budgetary management to the point where effective action can be taken and ensure the effectiveness of that delegation.

2) To ensure that professional advice is fully considered when establishing priorities.

3) To ensure that the patch complies with appropriate legal and statutory requirements.

4) To ensure the active involvement of all Community Staff and General Practitioners in securing the most effective use and management of resources.

5) To ensure that appropriate action is taken concerning issues which cross patch boundaries either within the CHS Management Board or directly with other services outside the Management Board.

Policy Formulation

1) To review the provision of services in consultation with appropriate users/service providers to ensure that they reflect the needs of the local community and are consumer sensitive, developing plans to achieve change as necessary.

2) To be responsible for new developments within the patch.

3) To participate in any specific capital developments in the health premises within the patch.

Use of Resources

1) To control the resources for the provision of services within the patch, delegating the responsibility for budgetary control to the nearest point of consumption.

2) To participate in budget setting discussions to ensure that financial allocations relate to the objectives and agreed responsibility for the services.

3) To ensure all financial responsibilities are exercised in accordance with the Health Authority's standing financial instructions and audit requirements.

Management of Staff

1) To ensure the effective implementation of the Authority's Personnel and Industrial Relations Policies and Procedures within the patch in conjunction with the CHS Management Board, Unit and District Officers.

2) To promote good industrial relations, employment practices and communications in conjunction with the Director of Community Health Services and Personnel Manager.

3) To be responsible for all aspects of Health and Safety, Fire Precautions and Security and to ensure that proper policies and procedures are produced and implemented.

4) To identify and meet training needs of staff managed in conjunction with the Director and Personnel Manager.

Service Quality

1) To work with professional staff and managers within the patch to set and monitor standards of service provision.

2) To develop means of taking account of consumer views in determining the quality, effectiveness and appropriateness of service delivery.

3) To take appropriate action with professional advice in response to instances where service quality is found to be below acceptable standards.

Premises

1) To ensure that premises are used effectively and efficiently.

2) To carry out a review regularly of the costs of any premises for which rental payments are made.

3) To work with the Director of Projects in setting patch priorities for maintenance work.

NB The Community Health Services Executive is undergoing an exciting redevelopment and the post holder will play a key role in this programme. This job description is, therefore, a reflection of the current situation and may alter in detail or emphasis in the light of the developing needs of the Executive.

Lewisham And North Southwark Health Authority
Priority Care Unit
Project Worker- Decentralisation Of Community Services

Job Description

1) Background

This is a new, two year, full time post funded by the DHSS within the Priority Care Unit of Lewisham and North Southwark Health Authority. The project worker will help the Unit's senior managers develop and implement a programme for decentralising community services within the district. Two similar posts are being established in other London districts and this initiative is being co-ordinated by the King's Fund. As well as helping the three districts make further progress with their plans for decentralisation, the Fund and the DHSS hope to learn from the projects more about how small scale management and planning of primary care services can be introduced and the benefits and difficulties it may bring.

A paper outlining the Lewisham and North Southwark decentralisation programme is attached.

2) The Post

The project worker will be accountable to the Decentralisation Programme Development Officer through him to the Priority Care Unit General Manager. The worker will be expected to report regularly to the Project Steering Group.

For the first two or three months, the project worker will work closely alongside the Development Officer and the Unit General Manager to become familiar with the District, the Priority Care Unit, the services it provides, its management structure, and plans for the decentralisation programme. During this time a specific and realistic work schedule will be devised for the worker that takes account of the requirements of the decentralisation programme and the skills and interests of the worker.

It is envisaged that the majority of the worker's two years will be spent on activities concerned with facilitating implementation of the decentralised management system and making refinements and improvements to it. Implementation is seen as a dynamic, two way process between operational and policy making levels in the Authority. One of the worker's main tasks will be to provide senior managers and policy makers with detailed feedback from the operational level about progress with implementation and with achieving the objectives of the programme. The worker would not be expected to do this in general terms or across the whole district. She/he will be expected to investigate specific issues or problems or perhaps to look in detail at one locality in the district.

One particular issue which requires further explanation is how, as part of the decentralisation initiative, providers of health services and local authority staff could be

encouraged and helped to work together more closely to make patient care more effective. This is expected to become part of the worker's specific brief.

Detailed work of this kind will require the worker to undertake tasks such as:

seeking and receiving views about the new system and its impact on individuals from health authority staff, GPs, local authority staff and others providing care in the community; users of services or their representatives from voluntary or community groups;

observing the functioning of service locally;

discussing problems with senior managers and making recommendations about how they might be resolved;

reporting findings to the development officer.

The worker will also be expected to keep a systematic record of his/her activities and prepare progress reports and other papers as necessary.

Towards the end of the project, the worker with the development officer, will review progress and write a detailed report describing the work that has been carried out. This will include an assessment of its impact and value to the district.

During the two years there will be regular meetings of the workers from all three DHSS funded decentralisation projects in London. These meetings will provide 'mutual support' and an opportunity to exchange ideas and views. They will be co-ordinated by the King's Fund. The Fund also has a brief to help with evaluation of the work and practical assistance will be provided.

The worker will be based at District Headquarters, secretarial help will be provided.

3) Qualities and Experience required

We are seeking someone who will take an enterprising approach to the opportunities provided by this new post. Willingness to work as part of a team and a commitment to improving NHS community health services are expected.

The project worker must have a thorough knowledge of NHS community services and must understand how these are organised and delivered at local level. This will be demonstrated by having worked recently in the NHS, local authority or related organisation.

The successful applicant is likely to have:

first hand experience of introducing, or monitoring the introduction of, changes in large organisation or in an agency providing services;

a strong interest in Health Service organisation and management;

enthusiasm for innovation and change.

The skills necessary for this post are:

confidence, tact and sensitivity to work with a wide range of people;

good communication skills, especially the ability to write clearly and concisely;

good organisational skills and the ability to carry work through to completion and on schedule;

good analytical skills, especially in collating information from a wide range of sources and distilling from it the important messages.

Personal knowledge of the area covered by Lewisham and North Southwark Health Authority would be an advantage but is not essential.

This is not a research post. The Project Worker will have no opportunity to carry out major detailed studies.

4) Terms and Conditions of Service

The appointment will be with Lewisham and North Southwark Health Authority for a period of two years.

The salary for the post is NHS A&C Scale 9, currently £9,137 to £11,222 plus £1,133 London Weighting per annum.

Annual leave is 20 days per annum, plus 2 statutory leave days.

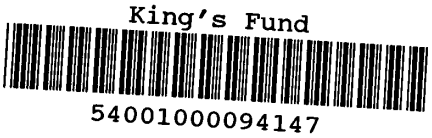
Hours of work will normally be 9am to 5pm, Monday to Friday, but some flexibility would be expected in this post. The work will involve travel within Lewisham and North Southwark and occassional travel to meetings elsewhere.

Travelling expenses incurred in the course of the job will be reimbursed.

Appendix D

Glossary of abbreviations

ADNS	Assistant Director of Nursing Services
CHC	Community Health Council
CHS	Community Health Services
CMO	Clinical Medical Officer
DGM	District General Manager
DN	District Nurse
DNS	Director of Nursing Services
DSG	Decentralisation Steering Group
FPC	Family Practitioner Committee
FP/WW	Family Planning/ Well Woman
GP	General Practitioner
HV	Health Visitor
L&NS	Lewisham and North Southwark District Health Authority
LBL	London Borough of Lewisham
LBS	London Borough of Southwark
LMC	Local Medical Committee
MH	Mental Handicap
MI	Mental Illness
PCU	Priority Care Unit
SCMO	Senior Clinical Medical Officer
SETRHA	South East Thames Regional Health Authority
UGM	Unit General Manager



PRIMARY HEALTH CARE GROUP PUBLICATIONS

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

Telephone Access to GPs. Project paper 53.
Allsop J and May A.
£4.50
A study of the problems of telephoning doctors in London which examines availability of GPs, variety of answering services and use of telephone in practices. Widespread recommendations.

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

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

Coordinating change in child health services. Working paper for managers: 1
Winn K.E
KFC 88/5 £2.00
How Newham Community Unit set about decentralising the administration of its clinics and health centres and the benefits that resulted.

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

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

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

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

Community development in health: addressing the confusions
Somerville G.
KFC 85/141 £3.00
Addresses the major issues in community development in health, describes initiatives and analyses what can be learned for planning primary care.

Improving health care for travellers
Cornwell J.
KFC 84/124 £1.50
Describes three initiatives to improve health care for travelling families.

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

Above titles available only as counter sales at King's Fund Centre, 126 Albert Street, London, NW1 7NF. Tel 01-267 6111.

If you have difficulty obtaining any of the above titles, please contact Primary Health Care Group direct.

Price £3.50
ISBN 0 903060 35 3