Pimlico Patch Committee

An Experiment in Locality Planning

Helen Dunford and Jane Hughes

RIVERSIDE
HEALTH
AUTHORITY

PRIMARY HEALTH
CARE GROUP
KING'S FUND CENTRE
FOR HEALTH SERVICES
DEVELOPMENT
KFC 88/40

Pimlico Patch Committee

An Experiment in Locality Planning

Helen Dunford and Jane Hughes

Autumn 1988

PRIMARY HEALTH CARE GROUP
KING'S FUND CENTRE
FOR HEALTH SERVICES DEVELOPMENT
126 Albert Street, London NW1 7NF
Tel: 01 267 6111
KFC 88/40

CONTENTS

1 Introduction

In the early 1980s, ideas about organising services on a 'patch' basis — serving a relatively small geographical area or neighbourhood — began to be discussed in the NHS. The ideas came directly from publicity about decentralisation of local authority services, which emphasised the benefits brought by 'going local'. Their appeal was obvious to managers of community health services: organising on a small scale appeared to offer a way of overcoming the continuing difficulties of co-ordinating and integrating the care provided by a variety of professionals and of matching services more closely to the needs of the population.

The introduction of general management to health authorities in 1984 gave a further boost to the popularity of the locality approach. The brief for new unit general managers included clarifying management structures and accountability and finding ways of getting 'closer to the consumer'. Basing the organisation of community services on clearly defined geographical areas looked a promising way of achieving these and other aims. However, at that time there were few practical examples of 'patch' approaches on which managers could draw. Exeter Health Authority had established a system of locality planning with a strong 'consumerist' emphasis and this was widely known.(1,2) Other districts had set up less well-known, smaller-scale projects in which health, social services and sometimes voluntary sector staff worked together to meet the needs of a neighbourhood, often in a particularly deprived area.(3,4,5,6) These examples offered some lessons for managers, but no ready-made models that could be transferred complete to other settings.

It was against this background in 1986 that the King's Fund, with financial support from the Department of Health and Social Security, established three experimental projects in inner London to explore the possibilities for improving primary health care by developing small-scale (patch or locality) management and planning of services.

One of these projects was located in Riverside Health Authority. Funds were provided to employ a project worker for two years to help managers develop and implement plans for a patch approach in the hope that other districts would learn and benefit from the experience.

This report describes how the Riverside project was set up and documents in detail one particular initiative — the Pimlico Patch Committee — an experiment in which statutory and voluntary service providers and service users were brought together and given a say in planning for their locality.

The patch committee has much in common with the 'health care associations' recommended in the Cumberlege report as a way of enabling local people to contribute to health care planning for their neighbourhoods. (7) Although not directly or immediately linked to the development of neighbourhood nursing teams in Riverside Health Authority, the Pimlico experiment tested in practice

some of the ideas promoted by the Community Nursing Review Team. The lessons from the experiment will therefore be of particular interest to managers in districts which now have neighbourhood nursing teams and are considering building a system of 'grassroots' input into planning and policy-making.

The Pimlico experiment was reviewed after six months to assess the patch committee's achievements and the obstacles it had encountered. The findings of the review are summarised here, the lessons drawn out and recommendations made for future developments.

This report is divided into chapters which follow the development of the patch committee chronologically, documenting the decisions that were made at each stage. The early days of the Riverside project are described in Chapter 2, which also gives background information about the health authority and its population. The aims, membership and terms of reference of the patch committee and what it did during the first six months are discussed in Chapter 3. Chapter 4 describes how the experiment was reviewed and gives the project worker's assessment of the first six months. The project steering group's views are presented in Chapter 5 as lessons from the experiment, from which are drawn recommendations for future developments. Chapter 6 describes briefly how the experiment has progressed since the review and how some of the lessons identified by the steering group have been put into practice.

2 The development project in Riverside Health Authority

Riverside Health Authority (population 287,000) was created in 1985 by amalgamating Victoria and Hammersmith and Fulham health authorities.(8) Initially, for the purpose of managing its community health services, the district remained divided into two units — Riverside East (Victoria) and Riverside West (Hammersmith and Fulham) — until the two units were merged, as planned, in April 1988. In the period leading up to the restructuring, the two unit managers were keen to explore options for smaller scale management and planning of community services, and particularly to find out more about the implications of 'patch planning' for those at the sharp end of delivering and receiving care. They therefore welcomed the offer of a project worker for two years to help them with this task.

The project worker's brief

In early 1986, Riverside's two community unit general managers and the project coordinator from the King's Fund met to draw up detailed plans for the project and a job description for the worker. These were based on the Fund's experience of development work and tailored to the particular circumstances and views of managers in Riverside. The thinking behind the project worker post was that the processes of service development could be helped by someone who was not tied by the responsibilities of a job in the hierarchy of the community unit and who could move freely between its operational and policy-making levels. The worker would be able to build up a complete picture of how the unit worked, from a detailed knowledge of what was happening 'on the ground' to an understanding of how decisions were made by senior managers. The worker would not operate independently, but would be a facilitator who helped mainstream staff achieve their aims for changing and improving the services they provided. This would involve identifying obstacles to progress and intervening to overcome them, thus speeding the development process.

In line with these ideas it was agreed that the worker's brief would be to help managers in both community units develop a programme for decentralising management and planning of services. However, because Riverside faced the prospect of organisational change to bring together the two units, no commitment could be made at the outset to implementing a district-wide locality management

structure as some other districts were doing at this time. It was proposed, therefore, that the worker should try an experimental, 'bottom up' approach: testing ideas at field level on a small scale, to learn more about the advantages that patch planning might bring and to inform decision-makers about management arrangements for the new unit. The initial focus chosen for this work was South Westminster, and the worker was asked to help managers find practical answers to the following questions:—

- how to get field staff to take an active part in planning and monitoring the services they provide?
- how to involve and respond to community groups and their representatives?
- what are the appropriate management and planning structures for a patch system?
- what staff development and training are needed to support implementation of the new system?

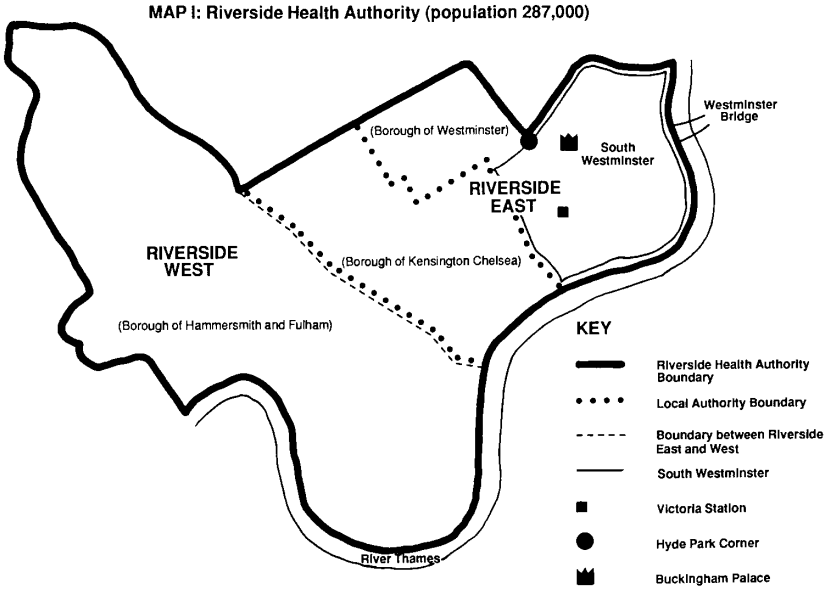
The project worker was accountable to the Unit General Manager responsible for community services in the South Westminster area. A project steering group was established to provide a forum for developing ideas and plans; helping the worker set a realistic agenda; giving support and monitoring progress; and to ensure that the lessons from the project were fed into planning and policy making in the unit and the authority as a whole. Membership of the group included Unit General Manager for Community Services (Riverside East), Unit General Manager for Community Services (Riverside West), Associate Unit General Manager (Riverside East) Assistant Unit General Manager (Riverside West), Assistant Director of Nursing Services (Riverside East), Planning Officer, Director of Nursing Services (Riverside West), Project Worker, and representatives from the King's Fund, the Community Health Council, the Social Services Department, and the Department of Community Medicine. The project steering group was chaired by the Unit General Manager (Riverside East).

The project worker's job description can be found in appendix 1.

The groundwork

The project worker began work at the end of June 1986. The first three months were spent familiarising herself with Riverside East Community Unit and the health authority as a whole. She collected information about the population served by the Unit, with particular attention to South Westminster, and made maps showing the boundaries of the different organisations operating in Riverside East. She interviewed fieldworkers, managers, GPs and community groups to build up a picture of working methods and communication networks. Some of this information is shown in the box on page 5.

MAP I: Riverside Health Authority (population 287,000)

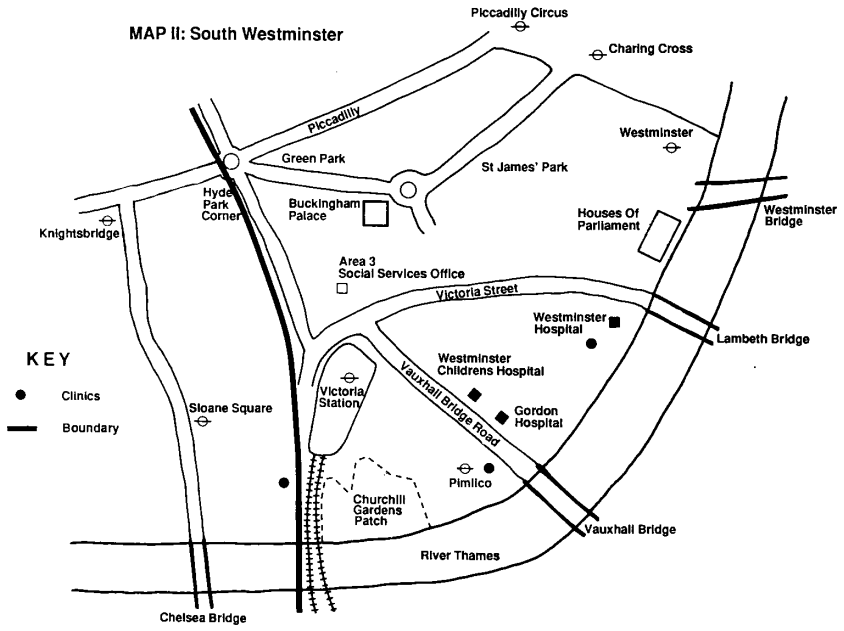


Riverside Health Authority stretches from South Westminster in the east to Hammersmith and Fulham in the west. The south side is bounded by the River Thames and the north by Notting Hill Gate and White City. (See Map 1)

South Westminster has some of the best known landmarks of Central London — Buckingham Palace, Victoria Station, St James' Park, The Houses of Parliament, Whitehall and Hyde Park Corner — and covers the districts of Belgravia, Millbank, Pimlico, St James' and Victoria. The population of South Westminster is approximately 36,000. Despite including areas such as Belgravia, much of South Westminster had high levels of social deprivation. Ten per cent of the total population are elderly people living alone and there are large numbers of homeless families and single people living in temporary accommodation in hostels and hotels. Fifty per cent of accommodation is in the privately rented sector, although there are four council estates in the south of the area. There is a 'hidden' but substantial proportion of ethnic minority groups (Spanish, Portuguese, Latin American, North American, North African, Eritrean and Bengali) many of whom may not have been included in the 1981 census. (9)

Health service provision in South Westminster includes Westminster Children's Hospital, Westminster Hospital, the Gordon Hospital (psychiatric) and three clinics. (See Map II) For the area as a whole, health service boundaries are the same as those of Westminster Social Services Area Three, whose office is located near Victoria Station. Local GPs are organised into six group practices and ten single handed practices, all but two of which are based on the western side of the Vauxhall Bridge Road. This major road runs through South Westminster from north west to south east and is a serious barrier to pedestrians. It reduces access to GPs for people living to the east and this is reflected in their higher use of hospital casualty services.

The results of this work were presented to an early meeting of the project steering group. As a result of discussions with managers, fieldworkers and others about locality planning, the project worker floated the idea of committees of grassroots workers from health, social services, housing and voluntary organisations and community representatives who would use their local knowledge and experience to take a new look at services in the area where they lived or worked. The steering group supported this notion, but it was clear that the whole of South Westminster, with its 36,000 population and complex pattern of services, would be too large an area for one committee of this sort. Equally, it was too ambitious to attempt to set up more than one committee initially. The worker was therefore asked to do more groundwork to select an appropriate patch within South Westminster for the experiment, to spell out in more detail the role of the 'patch committee' and to define its membership.



Selecting a patch

Throughout the following month the project worker collected further information in order to select a patch. There were many possible ways of dividing South Westminster into smaller localities — by following natural boundaries, such as main roads, rivers and railways, or patterns of housing and shops; according to boundaries imposed for health or local authority staff or GPs' catchment areas; by electoral wards or census enumeration districts; and based on local people's definitions of 'natural' communities. The project worker gathered extensive information about boundaries of wards, enumeration districts and postal districts; location of schools, GPs, clinics and social services offices; fieldworker boundaries; and the areas recognised by voluntary agencies; and put all this on to maps. She also obtained relevant statistics about population sizes and structures (from the Census) and about health service provision. She continued to discuss the idea of locality planning with people living and working in South Westminster and with those undertaking similar projects in other districts.

This exercise did not yield any obvious solutions to the choice of a patch. None of the fieldworkers' boundaries or GP catchment areas were the same. However, despite different working patterns, it was established that liaison between agencies and services in the area was good and referral systems well-established. There was no question of redrawing boundaries purely for the purposes of the project.

One of the clearest features to emerge from the mapping exercise was that the four social services teams comprising 'Area 3' operated patches that were well recognised by other staff. Since coterminosity with social services was considered an important factor, it was decided to base the experiment on the Churchill Gardens social services patch in Pimlico. (See Map II) The patch had clearly-defined boundaries which also matched those observed by health service staff, housing and Age Concern fieldworkers. With a population of 8140 this also seemed a manageable size for a patch committee.

Once this decision had been approved by the project steering group in September 1986, activity focused on setting up the patch committee.

3 The patch committee experiment

Following informal, individual meetings with managers and staff from the statutory and voluntary organisations in South Westminster, the project worker circulated a discussion paper describing the health authority's interest in locality planning. She followed this up by further meetings to discuss the aims of working on a patch basis and the role of the project.

As a result of these discussions, the project worker developed clearer ideas about how the patch committee should operate and who should be involved. From the outset there had been a commitment to trying a 'bottom up' approach to planning services, centred on those who delivered care directly and those who received it. The idea was that people with first-hand experience of local services would be best placed to say whether needs were being met and to offer suggestions for improvements. These ideas were reflected in the aims set for the patch committee and the decision that its core membership should be fieldworkers from statutory and voluntary agencies and local residents.

Aims

The following aims for the patch committee were drawn up by the project worker and agreed by the steering group:

1 Check the state of knowledge about each other's roles and skills.

2 Build up a comprehensive picture of services and resources available within the patch.

3 Identify examples of good collaboration and referral:
— do these occur despite rather than because of the current system?
— are the factors contributing to good practice identifiable and reproduceable elsewhere?

4 Identify major health-related problems in the patch in order of priority.

5 Identify gaps in the provision of health services.

6 Look at ways in which existing resources can be tailored to meet the needs of the local community.

7 Look at ways of involving the local community in health service planning.

8 Develop communication networks between the operational and the management and planning level of the health service.

Membership

In October 1986, senior managers from the health authority, local authority and voluntary organisations were invited to a meeting chaired by the Community Unit General Manager to discuss the project and the proposal to set up a patch committee in Churchill Gardens. Their support for this plan was obtained and they nominated staff working in the patch whom they thought would be willing to become members of the committee. The project worker subsequently met the staff who had been nominated to talk about plans for the patch committee and what membership would entail.

It was decided to limit professional representation to one member from each profession working in the area. This would keep the committee reasonably small and minimise demands on busy professionals' time. The intention was that professional staff should represent their colleagues' views and feed back to them information from the meetings. They were also asked to invite clients and local people to the meetings.

It was easy to identify the main professional groups who should be on the patch committee, and often the choice of representative was obvious since only one or two staff covered the Churchill Gardens patch. Most were already based nearby in South Westminster. Health visitors and district nurses had offices at Ebury Bridge and Bessborough Street clinics, social workers and occupational therapists were based at the Area 3 Social Services office near Victoria Station, the housing department had a local office on the Churchill Gardens Estate and the community psychiatric nurses were based at the Gordon Hospital. The Education Welfare Department was based outside the area but one officer dealt with schools in the patch.

General practitioner representation was a more difficult question. The 23 GPs in South Westminster are concentrated in a small area on the western side of Vauxhall Bridge Road and their caseloads are not limited to particular zones. People living in the Churchill Gardens patch might be registered with any one of these practices, so there was no obvious focus for GP involvement with the experiment. Many of the voluntary organisations contacted by the project worker were based outside the area. It was decided to invite only groups with a local base in South Westminster to sit on the committee. These were Caring for the Carers, Bengali Cultural Association, Migrants Resource Centre, Age Concern, Family Workshop and the Churchill Gardens Estate Tenants' Association.

The question of how to get local 'consumer' involvement with the patch committee was a difficult one. There was concern that if the meetings were advertised to the public, the size of the committee would become unmanageable. It was agreed that a number of local people should be invited to join the committee, in the same way as the professionals had been nominated and invited. The project worker therefore asked professionals and community organisations to nominate people they felt would make a useful contribution to the committee. The project worker sent out invitations and explanations about the initiative. It

was recognised that this 'word of mouth approach had both benefits and limitations. The benefits were that lay members were likely to have recent experience of health services in the locality, either as patients or carers and would be able to speak from first-hand experience. The limitations were that they would probably not be representative of the local community and its views. It was discovered at this stage that the local priest was interested in the experiment and he too was invited to join the committee.

Those invited to the patch committee initially were therefore:

District nurse
Health visitor
GP
Community psychiatric nurse
Social worker
Occupational therapist
Education welfare officer
Nursing officer
Priest
Representatives of voluntary organisations
Tenants association
Local people

After several meetings of the committee the community physiotherapist working with the health authority's team for elderly people and the worker with homeless and rootless people became interested and began to attend meetings.

Terms of reference

The project worker and the steering group drew up terms of reference for the patch committee. These provided the framework in which the committee was to operate and established important practical details. Meetings would take place once a month and the committee would be serviced by the project worker. The steering group also specified that the experiment should be reviewed after six months, at which point the future of the patch committee would be decided. The full terms of reference can be found at Appendix II.

Preparing the committee

It was decided that the first two meetings of the patch committee should be introductory sessions to explain its role and function and to begin to establish a group identity.

In November the project worker convened a meeting of training officers from the local authority and the health service to develop ideas for these sessions. It was agreed that members would need time to discuss the aims of the committee and

the roles of its members; they would also need an introduction to the organisation of services in Riverside Health Authority and an explanation of how the patch committee related to existing management and planning arrangements. Time would be set aside for members to describe their jobs and say how they come into contact with health services.

The project worker prepared information packs for all members containing a map of Churchill Gardens, a paper about the patch committee and a copy of 'On Stream', Riverside Health Authority's in-house journal. These were sent out with an invitation to attend the first meeting of the patch committee in December 1986.

A paper by the project worker summarised for the steering group how the work had progressed over the 4 months since she took up post. (See appendix III) It identifies 'milestones' in the development of ideas and plans up to the first meetings of the committee.

The first two meetings

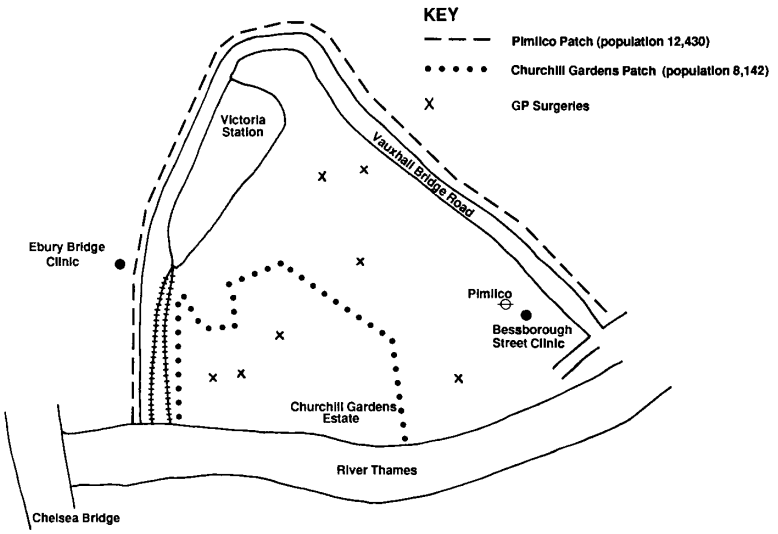
The introductory meetings of the patch committee were held on 19th December 1986 and 20th January 1987.

The first meeting attracted a range of professionals, except a GP, and representatives from voluntary organisations, but no local people, although a number had been invited by the project worker. There was a long discussion about how to increase attendance and members decided to take responsibility for issuing *personal* invitations. A personal approach from someone known and trusted seemed to work and six local people came to the next meeting. The health visitor and district nurse approached a local GP, who also came to the January meeting.

A total of 17 people came to the second session. Discussion focussed on the boundaries of the patch and the health needs of its population. The boundaries of Churchill Gardens were considered artificial and unsatisfactory because they cut across what was recognised locally as the neighbourhood of Pimlico. It was agreed therefore to extend the patch to cover this larger area of 12,430 population. (See Map III) The committee also brainstormed a list of 23 categories of health needs in Pimlico. From this list, agreement was reached on three groups whose needs were to be given priority in the patch committee's deliberations: elderly people, homeless families and black and ethnic minority groups.

At the two introductory sessions concerns were voiced by members about where the patch committee fitted into health authority structures and whether its views would be taken seriously by managers and planners.

MAP III: The Pimlico Patch



The patch committee underway — February to July 1986

At its February meeting the patch committee decided to focus first on the needs of the elderly population, since there was already a pressure group for homeless families in the area and discussion of the needs of the black and ethnic minority people could be part of the more general debates. A report from the Homeless Families Group became a regular agenda item at patch committee meetings.

From March to June the committee met monthly at Churchill Gardens Youth Club or a local church hall. The meetings lasted approximately two hours and began with the project worker reporting back the Unit General Manager's and steering group's replies to issues raised by the committee. Minutes were taken and an agenda agreed for the next meeting.

Membership fluctuated since work commitments, illness, holidays, etc., meant that no-one was able to attend every month. A core group, including the health visitor, district nurse, education welfare officer, social worker, occupational therapist, two local residents, health education officer, the Homeless and Rootless Project Worker and representatives from Caring for the Carers and the Migrants Resource Centre attended on a regular basis. Other members, for example, the general practitioner, and representatives from the Bengali Cultural Association and Age Concern attended occasionally.

The committee produced a map of resources available in the area. The aim was

to use it for reference and as a starting point for the discussion of gaps in the provision of health services. Information provided by committee members was collated by the project worker and the map was discussed at each meeting. It took 3 months to complete and proved a useful way of pooling local knowledge. However, it was felt that the map should have covered a wider area in order to show health service facilities available to Pimlico residents which were outside the patch.

Issues that were raised regularly at meetings included service provision in the locality and questions about the role and approach of the patch committee.

Concern about local services focussed on

- lack of respite care facilities. A respite care ward at St Mary Abbots Hospital had been 'temporarily' closed and the committee tried to find out about plans to reopen it.

- poor access to GP services. Members of the committee felt some groups in the population needed better information about how to register with a GP. There was also concern that no local GPs spoke relevant minority languages or fully understood the religious and cultural needs of the Bengali community in particular. These questions were taken up with the Family Practitioner Committee.

- day care for elderly mentally ill people. The committee had heard that a day centre was to be built in the patch, but no one seemed to know exactly what the plans were or what stage they had reached. There were many rumours and members of the committee were anxious to have a say in the type of facilities they felt would be most useful to elderly mentally ill people living locally.

Discussions about how the patch committee should operate focussed on

- the direction recommendations should take. Since there were no precedents, members needed reassurance from the Unit General Manager about how recommendations should be presented; how they would be directed to the appropriate planning group; whether managers would feel obliged to respond; and the lines of communication between the committee and managers with executive responsibility.

- consumer involvement. The committee was predominantly made up of professional members. Various ideas for increasing involvement with local people were aired. This led to a stall at the Pimlico Festival in June being taken by the health visitor, the project worker and one of the lay members to advertise the committee's work and to seek local opinion about services. People who lived in the patch were asked to fill in a questionnaire about health services in the area. Other proposals to increase consumer involvement included visiting local clubs and groups and holding alternate afternoon and evening meetings.

The July meeting, the committee's fifth after its two introductory sessions, was dominated by discussion of the review of the patch committee and the project worker's unexpected pregnancy. The review was written into the committee's terms of reference, but members were concerned that six months was too short a time to show any significant impact. They feared that this, combined with the withdrawal of the project worker in September, would mean that the committee would be shelved by Riverside.

Happily this was not the case. At its September meeting the steering group agreed that the Pimlico experiment had confirmed that the idea of a patch committee or similar forum was feasible and worth pursuing. It had been over-ambitious in such a short time to expect a full-scale grassroots planning process to emerge, but there were important lessons from the pilot scheme that could be built on in the future. Plans were made to continue to support the Pimlico Patch Committee for a further six months.

4 Reviewing the experiment

Once the patch committee was underway, the project steering group began to discuss how to evaluate the experiment. This presented particular problems because there is no commonly accepted method for assessing projects like this. Some members of the steering group initially argued that the only useful methods were those that included measuring outcomes — changes in services or in the health of the population — that could be attributed to actions taken by the patch committee. It was agreed eventually that this approach was inappropriate. After six months it would be too soon and too ambitious to expect to find changes as a result of the setting up the patch committee. Also, rigorous evaluation of this sort was far beyond the means of the steering group. The project worker and the steering group would have to undertake the review within their own resources.

The most appropriate and feasible course of action was therefore to review the *process* of establishing the patch committee and to compare what had been achieved with what had been intended. Assessing the patch committee's performance in relation to its terms of reference and aims would be a central part of this exercise. The project worker would be the main resource for gathering material for the review from as many people as possible who had taken part in the experiment or who had been in a position to observe the patch committee's progress. Her own reflections on the processes involved would also be important data. The role for the project steering group would be to draw out the lessons from the experiment and to make recommendations for building these into future developments in Riverside. Accordingly, the project worker began to plan how she would gather material for the review and drew up a framework for a three-stage process.

The first stage was to describe in detail how the patch committee was set up, why decisions were taken, who came to meetings and what was discussed. This information was gathered from the project worker's own field notes, minutes of meetings and papers prepared for the steering group. It formed the basis for the account of the patch committee given in the previous chapter.

The second stage was to design a way of assessing how far the patch committee had been able to meet its aims. To help clarify what information was needed, the project worker looked in turn at each of the eight aims set for the committee and how she could measure whether they had been met. (See appendix IV) This formed the basis for the checklist that was used to guide the project worker's interviews with patch committee members and others in May and June 1987. (See appendix V) As part of this stage, the project worker was asked to reflect on the process of setting up and working with the patch committee for six months

and to give her impressions of its achievements and difficulties that had been encountered.

The third stage in the review process was to submit the material gathered by the project worker to the project steering group for discussion. The steering group would assess what had been achieved in relation to the aims of the project as a whole and draw out lessons and recommendations from the experiment.

This framework was accepted by the project steering group in May 1987. The project worker arranged to interview patch committee members and relevant others in June. A report of her findings was written in July and a special meeting of the steering group to discuss it arranged for early September. The remainder of this chapter gives a summary of the project worker's assessments and the following chapter includes the lessons identified by the steering group and its recommendations.

The project worker's assessment

To review the progress of the patch committee during its first six months the project worker interviewed as many as possible of those who had attended meetings and others who were in a position to observe what had happened, such as members of the steering group.

She used the material gathered from these interviews to assess how successfully each of the committee's aims had been achieved. Once this had been done she wrote her own personal reflections on some aspects of setting up the committee, under the headings of membership, preparation, timing and support. The two sections that follow are taken from the report written by the project worker for the steering group.

> ***'It is a unique meeting where professional carers and their clients can confront one another as equals.'***
>
> ***'I am impressed that the health service is trying to consult with local people. It isn't easy to look at yourself with others who have an axe to grind.'***
>
> ***'The NHS thinks it has all the answers. In theory they are committed to local consultation but in practice they are not ready to take on board consumer recommendations.'***
>
> ***'What worries me is whether what is talked about is going to get back to where it matters.'***
>
> ***'It's a good idea but it needs more time, more development and more support.'***

Did the patch committee achieve its aims?

At the time of the evaluation, the patch committee had been meeting for only five months, excluding the two introductory sessions. Although it was still in the process of evolving, the committee achieved most of its aims in this time. It successfully established a forum where health, local authority and community group representatives could discuss local services. It was sufficiently informal to allow everyone to make a useful contribution and the committee was able to identify health priorities in the patch and begin to think about how these might be tackled.

The original idea that the patch committee would increase liaison between professional staff in the area was considered misplaced because in Pimlico collaboration was said to be already good. However, the project worker observed that professional members used the meetings to exchange information informally. It may be that there were low expectations about how far liaison might be improved.

The issues which the patch committee took longer to get to grips with were greater involvement of health service users and making practical recommendations for change.

Each of the aims set for the patch committee is discussed below. The material is from observations and notes of meetings kept by the project worker and from her interviews with committee members.

1 Check the state of knowledge about each other's roles and skills.

Part of the second introductory session was spent exchanging information about the different roles of members of the committee. In general it was felt that professionals already understood each other's roles and had found the experience more useful as a way of learning about the structure of the health service, the role of the unit general manager, and decision making processes in the health authority and family practitioner services.

Local people found that working with the committee over time was a more effective way of learning about what the professionals did rather than the concentrated information that was presented at the introductory session.

2 Build up a comprehensive picture of services and resources available within the patch.

Members of the patch committee used their contact at meetings to exchange information informally. The time before meetings began and after they ended offered opportunities for members to catch up with changes that were happening in the patch, or to talk about clients or concerns they had in common. It was

impossible to document precisely the nature and value of the transactions that took place outside the formal part of the committee meetings. The project worker, however, suspected that the information gained from informal discussions was an important bonus for those who attended the meetings.

As part of the formal process of pooling knowledge, the committee produced a large map which showed facilities and resources available within the patch. Building up the map was time-consuming, but it was an activity to which all members could contribute and gave a basis for beginning discussion about gaps in provision of services. Most of the members and the senior nurse managers who were interviewed said that the map was useful but needed to be expanded to show resources located outside the patch but which were available to Pimlico residents.

When the map was complete it was considered more useful for lay people than professionals and it was suggested that it should be developed for use in clinics and other public places.

3 Identify examples of good collaboration and referral.

Some of the professional members of the committee had already established links through the liaison forums organised by Area 3 social services. Topic-based meetings were held regularly to which a broad range of professionals were invited. However these were considered by those in the NHS as being more for managers than field staff, who saw themselves as 'not having time' to attend regularly. Professionals all said that liaison and referral systems in the patch were good, and they did not see improving these as a reason for joining the committee. The connections they hoped to make were between the operational and planning levels in the statutory authorities.

Lay members saw the patch committee as a way of meeting health and local authority professionals informally and would have liked more GPs to be present.

> ***'Meeting people should not be a reason for joining the patch committee as there are lots of liaison forums at which we all meet already.'***

> ***'At field level we already speak to one another, it's the people higher up the ladder we need to begin talking to.'***

4 Identify major health-related problems in the patch in order of priority.

The committee whittled its original list of 23 problems down to three groups of people whose health needs were considered to be top priority: elderly people, homeless families and ethnic minority groups. There was unanimous agreement about this decision.

Twenty per cent of the population of the patch are over the age of 60 and the district nurse estimated that 95% of her caseload were elderly people. Homeless families living in bed and breakfast hotels form a large proportion of the health

visitor's caseload and have long been recognised in Pimlico as a group who have difficulty gaining access to health services. According to available Census data, 8% of the patch population were born in New Commonwealth countries, Pakistan or the rest of the world. A report by the Migrants Resource Centre, 'Out of the Shadows', argues that these statistics do not accurately reflect the true numbers of Spanish, Portuguese, Latin American, North African, Bengali and Eritrean people in Pimlico, 40% of whom are believed to have been omitted from the 1981 census. (9)

The only concern about the decision to concentrate on the needs of the elderly was that it ignored the needs of the 17% of all households in the patch with dependant children. The health visitor felt that the committee got 'bogged down' by discussion of elderly people and ignored the considerable problems faced by families with young children.

5 *Identify gaps in the provision of services.*

Once priorities were agreed the patch committee had no difficulty in identifying gaps in the provision of services. For elderly people there was a need for more respite care and for more information about services. Other major gaps in services were

— hospital discharge procedures:

'Patients are sent into the community without anyone knowing. We really need a proper 24 hour community nursing service and the ambulance service could be a lot better.'

— general practitioner services:

'It takes three days to book an appointment, which you have to take half a day's leave to attend. Access for wheelchairs and prams is inadequate. Receptionists are often unhelpful and aggressive and patients are not given any information about primary health care nurses, facilities or resources available either within or outside the practice.'

— poor access and communication:

'Homeless families can't register with a G.P. and so don't have access to anything.'

'Because of their lack of access to primary health care services people from ethnic minority communities often end up in hospital because preventable problems develop into crises.'

'People in the health service don't look after it and we are not given sufficient information about how to use the service. I rang the hospital to try to give back some aluminium crutches and the staff nurse told me to put them on a skip.'

6 *Look at ways in which existing resources can be tailored to meet the needs of the local community.*

At the time of the review, the committee had not reached the stage of doing this. However, members felt that there was a pressing need to draw up a list of recommendations for action in the near future. This, it was hoped, would form the basis for discussions with managers.

'We need to practice negotiating with managers'.

The review helped the committee to formulate its ideas more clearly and crystallise its plans for future action. Members recognised that they needed to learn how to present and support any recommendations they made, and that to do this they must start a dialogue with managers and the project steering group.

7 *Look at ways of involving the local community in health service planning.*

Of the voluntary groups invited to patch committee meetings, four (Caring for the Carers, the Bengali Cultural Association, the Migrants Resource Centre and Age Concern) sent representatives, although they did not all attend regularly. The Family Workshop did not send a representative because of organisational changes and was deterred by the decision to focus on the needs of elderly people. Members of the tenants' association found afternoon meetings difficult because of work commitments.

There was general agreement among members that more participation by users of health services should be encouraged but the consumers who did attend felt uncomfortable at times.

'There should be more young patients, chronically disabled and young mothers.'

'I felt that the meetings were professionally top heavy.'

'There was an unintentional cliqueness because so many of the professionals knew one another well.'

All the local people who attended meetings were registered with a GP, two were disabled, one was undergoing psychiatric treatment and one had nursed several relatives through longterm illnesses. Their contributions to discussions were invaluable because they had direct experience of local services and made their views known unhindered by the need to observe agency boundaries or professional sensitivities.

The committee was aware that although most members' found the meetings easy to contribute to, they excluded people who did not feel comfortable at small meetings and those who had to work during the day.

8 *Develop communication networks between the operational and planning and management levels of the health service.*

Recommendations and requests from the patch committee reached managers and planners by two routes. Minutes were distributed to steering group members for discussion at their meetings and regular reports were made by the project worker directly to the unit general manager.

In the first six months, the patch committee used these channels mainly to seek information from managers rather than to make recommendations. For example, the unit general manager was asked to clarify when the respite care ward would reopen; steering group members used their contacts to discover what stage the plans for the psychiatric day centre were at; and discussion was opened with the FPC about GPs and ethnic minority groups.

The patch committee recognised that by this arrangement they were 'leap-frogging' several layers of the hierarchy and that this access to senior management could be cut off at any time. This affected the committee's credibility in the eyes of its members. Asked whether they thought it had made any headway in making managers and planners more aware of the problems of Pimlico they were reticent.

> ***'We need to develop a better dialogue. I don't think the committee is being used to its full potential.'***
>
> ***'I think we need more feedback from the health service.'***
>
> ***'It's beginning to look like tokenism.'***
>
> ***'We haven't got anywhere with Moreton Street*** *(the proposed day centre for elderly mentally ill people)* ***even though we've been asking about it for five months.'***
>
> ***'Since it's a health authority initiative one assumes that managers will take it seriously but they don't seem to know what to do with it now they've set it up.'***
>
> ***'What has it achieved? It's never been mentioned at Adult Supervisory Board meetings.'*** *(Senior manager and planner who was not on the steering group).*

The project worker's reflections on setting up the committee

Membership

The committee relies heavily on the interest and goodwill of local people who attend meetings on a voluntary basis. The challenge is to maintain this interest, making the meetings accessible with a minimum of formality and paperwork. The committee has also set itself the task of looking at different ways of 'building in the consumer view'. It began by holding the stall at the Pimlico Festival in the Summer of 1987 and took a decision to experiment with evening meetings on specific issues. Although there was a policy of leaving meetings open to anyone who wanted to attend, there was a feeling that the fluctuation in membership which this caused was distracting. A third of the members interviewed suggested that the patch committee should have developed a small core group organising general meetings to discuss specific issues and look at different ways of consulting residents.

Securing the interest of local GPs proved difficult. As independent practitioners in contract with the FPC they may have different priorities from the other professionals on the committee. The uneven distribution of practices in the inner city means that their catchment areas can never match patches precisely, and this raises anxieties about access to community nursing and other services. This has not been eased by suspicion among GPs about the Cumberlege Report.

Community groups, health service and local authority staff welcomed the opportunity to influence local services by feeding into the planning process. They saw themselves as representing their patch and the clients for whom they were responsible rather than their other colleagues or professional group. Report back to colleagues was mostly carried out on an informal basis.

Preparation

For the first two or three months the group struggled to establish a working identity. It was, predictably, the members who had had the most experience of meetings, for example the social worker and the education welfare officer, who were the most vocal. Health service staff played a less prominent role. They had been given no more information or preparation than any other member on the committee. In retrospect, since this was a health service initiative and health services staff were most vulnerable, it would have been better to have spent more time seeking initiatives and ideas from health services fieldworkers before setting up the patch committee. This suggestion was enthusiastically supported by the health visitor, the district nurse and their managers.

Once the committee became established NHS staff participated actively in discussions and found it easier to contribute to meetings. They were willing to take on commitments outside the meetings in a way that other members (apart

from local people) were not, for example, writing letters and running the Pimlico Festival stall. Some were not able to attend evening meetings but saw the alternate evening/afternoon proposal as a good compromise and a way of getting greater local community involvement.

Timing and support

The time and effort that went into setting up the patch committee were considerable. Information papers and consultation meetings had to be backed up with individual discussion. The committee took longer to establish its identity, long term agenda and working methods than was originally anticipated.

> ***'There's so much to do. We've spent six months finding out what we're supposed to be doing by which time we're being asked why we haven't done it.'***
>
> ***'We need more time.'***
>
> ***'This is so new, things won't change overnight.'***

The support of a facilitator is required for two major reasons. First, to administer, convene and co-ordinate patch committee activities. Second, and more importantly, to provide the link between the committee and managers and planners. Recommendations were fed formally into the project steering group and informally to the unit general manager at monthly meetings with the project worker. This was a satisfactory arrangement in the short term but in the long term if the patch committee is not given executive responsibility and incorporated into an overall structure it is difficult to imagine how it will continue to function.

5 Lessons and recommendations

The project steering group held a special meeting on 18 September 1987 to discuss the project worker's report and to look at what had been learned from the Pimlico Patch Committee experiment after six months. The group was asked to consider the following questions:—

- Does the project worker's report accurately reflect people's views about the experiment?
- Do you agree with the interpretation of the findings?
- What lessons can be drawn from the work?
- How far has the Pimlico experiment met the broader aims of the locality planning project?
- How can we build on this in future?

The steering group answered the first two questions positively, but went on to add their own perspective to the findings that were presented. In general they felt that the time and effort that had gone into setting up the patch committee had been a worthwhile investment and that many useful lessons had been learned from it. It was recognised that many of the decisions that were taken during the experiment were 'best guesses' at the time, because there was no previous experience on which to draw. The review by the steering group gave the opportunity to check whether these decisions were correct and timely and to consider how things might be done differently in future. In the course of the meeting nine aspects of the experiment were discussed and the steering group's views are summarised below.

Preparation and ownership

The project worker, after consultation, had made what seemed a sensible decision to focus on an existing social services patch. In fact this had been confusing for some participants, particularly health service staff, who felt that the committee was in danger of focussing on social issues which it could do little about rather than issues directly related to primary care services in Riverside.

A greater sense of ownership of the committee could have been created by discussing ideas with health service field workers before it was set up. They

should perhaps also have been more involved in making choices about boundaries, who to invite to meetings, and in organising the introductory sessions.

NHS staff members on the committee did not see their role as that of 'staff representative' or delegate. They neither systematically reported back to their colleagues about discussions nor fed colleagues' ideas into the patch committee deliberations. Thus other health visitors and district nurses working in the patch had no sense of ownership of the project.

NHS staff need help to develop their role as patch committee members. The value of the role could be signalled by setting time aside for participation and making it clear that passing information back to colleagues is a legitimate task. Electing rather than nominating representatives might increase clarity and commitment to these aspects of the role.

Clarifying aims

Many diverse interests are represented on the patch committee. It is inevitable therefore that groups and individuals attend meetings with 'agendas' which reflect their particular concerns and aspirations. For example, the social worker was disappointed that the group was not intended to be a consumer group without professional representation, while his manager hoped that in the long-term the health authority's commitment to patch would lead to the setting up of joint neighbourhood offices. Voluntary groups hoped that the committee would prove an effective way of gaining the ear of the health authority, for example the Migrants Resource Centre proposal for outreach workers.

Since general practitioners are usually the first point of contact with the health service, local people hoped it would influence the delivery of some family practitioner services, for example improving the attitude of receptionists in GPs surgeries, providing a Bengali speaking GP.

These different agendas need to be recognised and the committee given time to get to grips with its aims and role.

User participation

The Pimlico Patch Committee was not primarily an attempt to establish a consumer group or to be in itself a mechanism for public consultation. The intention was to establish a forum with service provider and user representation to discuss the provision of services in the patch and make recommendations for change. The aim was to break down boundaries between providers and users and get them to work together to articulate a grassroots view that would influence health authority decision making. The patch committee is unashamedly an organisationally-led initiative, with all the limitations on full consumer participation that implies, and should be judged in that context.

The patch committee had shown its value and potential as a focus for gathering user views and channelling them into the planning process. It is one of many possible ways of consulting users and if patch planning is to be implemented across the district other methods of building in the consumer view need to be compared and evaluated.

Interprofessional collaboration.

Interprofessional collaboration between staff from different agencies and disciplines was not seen by fieldworkers as a major problem in Pimlico. Therefore in this context the patch committee has a limited role to play in increasing liaison between professionals. It may, however, offer useful opportunities for informal contact that would be more highly valued in other neighbourhoods.

Identifying priorities and use of information

Identifying needs was relatively easy for the patch committee but identifying gaps in the provision of services and drawing up recommendations proved a slower, more frustrating process.

The project worker collated a great deal of local information for the committee. As it turned out, this did not particularly help the committee make decisions about priorities. It was only once priorities had been decided that the patch committee had a focus for asking questions and using information. There is a role for the patch committee convenor to provide a certain amount of basic information but the pace at which it is assimilated and used will be determined by the patch committee.

The committee's information needs are very varied. It needs 'consumer' information, such as which dentists do home visits, how to return aluminium crutches, or how to register with a GP. It needs planning information, such as when the respite care ward is scheduled to reopen and what is envisaged for the EMI day centre. It also needs confirmation or denial of rumour that members pick up from colleagues and community.

The experiment highlights the difficulty of obtaining all these types of information from the NHS. There is a pressing need to provide the public with better information about NHS services and to give NHS staff clearer directions about how to gain access to health authority and FPS resources.

Policy framework

Thinking creatively about changing services was constrained by the lack of clear parameters specifying the patch committee's responsibility. There was uncertainty about how wide-ranging recommendations could be, what aspects of services they could consider and what information would be needed to support arguments for change. The committee needs a clearer picture of health authority policies and a framework within which to make its recommendations.

Servicing and support

At a minimum, patch committees need servicing by a member of health authority staff. The Pimlico experiment has no management involvement and perhaps this was a mistake. A management representative on the group might have helped to overcome some of the difficulties that have been encountered. Which manager could best link with a patch committee would vary from place to place — personal skills in facilitation being just as important as position and status in the organisation. The steering group's preferred model of management involvement would be a manager to convene and service the patch committee but not to chair it.

The committee also needs access to a small budget (c. £1000) to help it achieve its objectives. Among other things, this would have enabled the project worker to provide refreshments at meetings; the Pimlico Festival stall would have been much improved; and the committee could have developed the map for wider use.

Structure

One major obstacle to effective communication between the patch committee and managers and planners is the lack of an adequate structure for the patch committee to feed into. It is an anomaly in the present structure of the community unit. A direct line of communication to the UGM and a special project steering group is a barely satisfactory arrangement, even with only one experimental committee. Other links to management and planning will need to be devised if further patch committees are to be established and the present committee is to succeed in the long term.

The original plans to establish the patch committee did not take into account the role the senior nurse managers currently play in feeding information from grassroots staff to decision making levels. Their involvement in the experiment was peripheral whereas it should have been much more central. In other districts with 'decentralised' or completely patch-based community health services, locality managers or neighbourhood nurse managers are the obvious people to form the link with patch committees.

The credibility gap

The patch committee is seeking to achieve joint planning of services at local level. This is a policy which has run into many problems in the higher echelons of planning but at local level the main problem is to overcome the credibility gap. Since field workers and the public have never before been asked to participate systematically in health authority planning processes, there is a certain amount of scepticism about how seriously recommendations will be taken and what individuals have to gain from joining the committee.

The status of the patch committee as a special project had in some ways been an obstacle to its development. Did it really reflect the will of the organisation or was it a one-off? The special status of the patch committee was inevitable since it was an experiment. Ideally, the authority's commitment to supporting the new approach embodied in the patch committee should have been made clearer from the outset and that message reinforced in as many practical ways as possible.

Recommendations

As part of the review it undertook, the project steering group discussed how, with hindsight, the patch committee could have been established with a firmer base and given more support, thus increasing its chances of meeting its aims. The suggestions that were made are included in the following recommendations.

- A clear explanation of where and how the patch committee fits into management and planning structures should be worked out in advance of establishing the committee. A clear statement of this should be included in a written brief given to the committee.

- One person or a very small planning group should be given responsibility for doing the substantial groundwork necessary to set up the committee. More time should be devoted to preparing health service staff who will be involved, to develop their sense of ownership and investment in the committee.

- The role senior nurse managers play in relation to patch committees is crucial and should be developed further. Their input could help to establish and support committees and they are an important link with management.

- Once the patch committee has identified its focus (eg. elderly people) managers should ensure that members have a clear picture of relevant health and local authority policies and are briefed about what kinds of information and suggestions would be welcomed.

- More effort should be put into securing the commitment and involvement of local GPs.

- Ways should be found to continue the dialogue with managers as the committee develops its ideas and makes recommendations. One way of forging the link between management and the patch committee would be for a local manager to be a member of the committee and be responsible for communication between the patch committee and relevant management and planning groups.

- A realistic timescale should be allowed for the patch committee to establish itself, build its information base and gain confidence to make practical recommendations for change.

- Once the committee is established, responsibility for organising meetings and community liaison should shift from the initial worker or planning group to a core group of active members. To keep momentum going and to monitor progress the patch committee should regularly review its aims and achievements.

- The patch committee's potential as a vehicle for community consultation and participation in the health service should be developed more fully. In any future experiment this role should be given much higher priority and ways found to bridge the credibility gap between health services and the local population.

6 Further developments

The recommendations made by the project steering group in September 1987 are by no means the end of the story of the Pimlico Patch Committee experiment. The patch committee has continued to meet, serviced, after the project worker left, by a worker from the health authority's health education department. A number of the recommendations to make the committee's work more effective have been acted on and, partly because of other developments in Riverside that directly affect the Pimlico area, the committee seems to have found clearer purpose and direction. Its more recent progress from October 1987 to March 1988 is summarised here, along with an account of how some of the lessons from the Pimlico experiment have been applied in another Riverside locality, World's End. A key feature of the World's End Project is that nurse managers took the initiative to establish a patch-based approach. The work is, however, still in its early stages.

The patch committee October 1987 — March 1988

The patch committee continued to meet monthly for the six months following the review by the steering group. Committee members appeared to have three main concerns during this time. The first was to clarify the function and direction of the committee. This was helped by a timely meeting with the unit general manager and by the health authority's consultation on proposals for the new Westminster and Chelsea Hospital. The hospital development, which involved closure of some existing hospitals and rethinking of primary and community care provision, had direct implications for services to Pimlico residents and gave a new focus for the committee's deliberations. (10) The second concern of the committee was to increase participation by local residents in committee meetings; and the third was about practicalities of running the committee — procedures for obtaining information and making sure suggestions and views were channelled appropriately to health authority managers and planners.

Purpose and direction

At the time of the review, patch committee members themselves had expressed worries about not yet having made any detailed recommendations to health authority managers for improving services in Pimlico. The steering group also felt that the committee needed stimulus and guidance from managers about this aspect of its role. The assistant director of nursing services therefore agreed to

make a link with the patch committee, to give direction on its role and development and to help formulate aims for the next six months. This proved to be useful giving an opportunity to discuss procedural matters as well as ideas that were on the drawing board for the new Westminster and Chelsea Hospital and possibly a community-based facility in Pimlico. Committee members were keen to ensure that they would make an input into any development that would affect services to people in Pimlico.

As a result the patch committee set itself four concrete, short-term objectives, which were presented to the steering group:

- to reconstitute the committee by encouraging local residents and paid workers to attend meetings. Ideally at least half the committee will be local residents.

- to discuss the Westminster/Chelsea proposals and their implications and to produce a list of recommendations for the health authority by April 1988.

- to arrange a rolling programme of meetings to consider health issues relevant to the local community. Specialists to be co-opted to these meetings when necessary.

- to formulate recommendations and send them via appropriate channels to the health authority.

The committee immediately requested a meeting with the unit general manager in January to confirm its new direction and to discuss its role and the procedures to be followed when responding to the Westminster and Chelsea Hospital proposals.

This was a productive discussion and the first in a series of meetings planned by the committee to explore different aspects of the proposal and its implications for hospital and primary care services in South Westminster. In February the assistant director of nursing services attended the patch committee meeting specifically to reinforce links with management and planning processes. Members then discussed the primary care plans in the consultation document and put forward their views about requirements for new facilities in the area. The March meeting was addressed by a member of a group opposed to the hospital closures that were part of the proposal.

Later that month the committee organised an open, evening meeting to discuss the Westminster and Chelsea Hospital project consultation document. Inevitably it was a stormy meeting and, although it attracted about 60 members of the public, the only recommendation to be made by the patch committee to the health authority was that the audience was opposed to the closure of the Westminster Hospital. The committee had hoped to get local people's views on what primary health care facilities should be available in South Westminster. The April meeting was to be devoted to finalising comments for submission.

At the end of the six months the committee was still at the stage of discussing how to increase public participation. Members had talked about organising a 'membership drive' with emphasis on getting local residents as well as paid workers to attend meetings. Consideration was also given to meetings being 'open' to anyone who wanted to attend with the aim of getting a relatively stable 'core' group with a lively 'passing through' trade.

Procedures and practicalities

The meetings with the assistant director of nursing services and the UGM helped clarify lines of communication with managers and a link into the health authority's planning system for the patch committee. The health education worker who was servicing the committee was given a brief to collate recommendations and submit these directly to the ADNS. At this stage it was clear that the committee still needed someone to take minutes who could also formulate recommendations from the wide-ranging discussions.

Progress and prospects

By March 1988, a full six months after the review of the patch committee had taken place, tangible progress had been made on several fronts but much remained to be resolved. The Pimlico Patch Committee had made positive recommendations to the health authority concerning primary health care in South Westminster in response to consultation about the proposed developments in Riverside. It had established a clearer line of communication with managers and planners. It had also attracted more involvement of local people.

The World' s End Project

This initiative represents an attempt to transfer some of the lessons from the Pimlico Patch Committee to another locality in Riverside. The review of the Pimlico experiment revealed the lack of involvement of nurse managers as an important missing element. This gap is significant because the Cumberlege report envisages 'neighbourhood nurse managers' as key figures in managing and planning services in a locality. It was therefore considered an important part of the Riverside development project to explore the role senior nurse managers (SNMs) or their equivalent might play in introducing patch-based working.

The project worker and the assistant director of nursing services identified three SNMs (responsible for health visiting, school nursing and district nursing services) who were keen to begin some work on locality-based planning. After initial discussions, they decided to focus on the World's End Estate with the aim of building up a population profile; making links with professionals and community groups on the estate and getting feedback about health provision; promoting use of health services; and improving existing provision.

The World's End Estate has 2605 residents in 743 flats and houses, paying among the highest rents for public sector housing in Europe. Many residents rely

on housing benefit to meet the cost. Just over half the households have dependent children and 17.5% are pensioner-only households. Estate residents come from a wide range of ethnic and cultural backgrounds.

The estate has a very active tenants' association, mother and toddler group and youth clubs. There is a community centre close by and a neighbourhood advice centre and social services sub-office are located on the estate.

Health visitors, school nurses, district nurses and GPs are all based at the World's End Health Centre on the King's Road. Most residents on the estate are registered with the health centre GPs or one of four other practices in the area. Unlike Pimlico, the World's End area had no history of informal meetings of professionals from different agencies. The housing department had set up the World's End Forum to look at the running and management of the estate. Representatives from the health service were invited to attend the monthly meetings but rarely did so.

In June 1987, the 3 senior nurse managers, with the project worker, identified the following aims for three months' exploratory work.

1 To build up a population profile of the World's End Estate which managers could use as a baseline for their observations of health needs and service delivery.

2 To look at ways of obtaining feedback on the provision of health services.

3 To establish links with community groups, other agencies and professionals working on the World's End Estate.

4 To look at local networks and see if these could be used to promote health and the use of existing health services.

5 To identify how health services are currently meeting the needs of the local population.

6 To find ways of improving existing provision of services and make recommendations for change.

With the project worker's help, the SNMs first collated census information about the area and built up a 'community profile'. A lot of time and effort was put into devising a questionnaire for a 'health survey' on the estate that would provide information about aspects of preventive health care that needed to be improved. Representing three different branches of nursing the SNMs initially had different expectations of the survey. These differences were reconciled and the questionnaire was limited to testing what local people thought about existing services. Seventy copies were sent out in November 1987 to a sample of estate residents, but the response was disappointing — only 17 questionnaires were returned. Regrettably, this did not provide the information the nurse managers had hoped for. They did gain, however, in two ways: from the experience of

working together and from learning about the difficulties of designing, using and analysing a questionnaire.

At the same time as designing the survey, the senior nurse managers made contact with all statutory service providers and voluntary groups active on the estate. They had individual discussions about health on the estate and invited representatives from all organisations to a workshop in September 1987 to look at how well health services were responding to these problems.

More than 20 people attended the afternoon workshop, at which the aims of the project were presented and participants discussed health issues in small groups, arriving at a long list of problems and priorities. The major themes running through the workshop were the need to promote self-help; the importance of giving people confidence, self-esteem, and increasing their ability to take responsiblity for their own health; and breaking down barriers between users and providers of services.

The workshop was the first time that many of the participants had met each other, despite having worked on the estate for years. They agreed that it had been a useful way of building links and exchanging ideas and had highlighted the importance of collaboration. Unfortunately no GPs attended, although 12 had been invited to the workshop.

Many suggestions for improving health servies on the estate were made, including providing better information about health authority and GP services; more outreach work and drop-in facilities, including family planning clinics for teenagers; information-sharing between health workers involved with groups on the estate; and provision of creche facilities at clinics. One practical outcome of the workshop was that a booklet is being compiled listing all the agencies and groups operating on the World's End estate and giving brief descriptions of the services they provide. This will be distributed to all the agencies and groups and to health service staff in particular. Community groups have also been contacted and asked to send in requests for health information that their members would find most useful and interesting. If as a result of this preliminary information the groups would like more information, the SNMs will arrange for a member of their staff to visit the group.

These initiatives represent a beginning to encouraging all groups on the estate to work more closely together to improve information about health services and to increase people's access to health care.

In a relatively short time the SNMs themselves felt they had achieved their aims of looking at ways of developing links with the community, getting feedback about health services and building up a population profile. They felt that they had learnt a lot about questionnaires, but in their view one of the most important outcomes was the opportunity the project gave them to work together. It highlighted the advantages of bringing together colleagues from different backgrounds to solve problems. They had also gained confidence and generated further ideas and plans for working with a neighbourhood focus.

References

1 KING D and COURT M. A sense of scale. *Health and Social Service Journal*, 21 June 1984.

2 CANT M. Grassrooting for better services. *NAHA News*, November 1984.

3 Community Health Visiting. *London Community Work Service Newsletter* No 60. June 1984, 12.

4 SOMERVILLE G. *Community Development in Health : Addressing the confusions* King's Fund Centre with London Community Health Resource KFC 85/141. 1985.

5 TENNANT A. et al. Helping hut. *Community Care* 22 November 1984, 19-21.

6 MALIN S. Bridging a health care gap. *Health Service Journal* 19 February 1987, 218.

7 DHSS *Neighbourhood Nursing — a focus for care* Report of the Community Nursing Review Team. London, HMSO. 1986.

8 JONES W. and MITCHELL S. Riverside district twice revisited. *Health and Social Service Journal* 7 February 1984, 162-163.

9 RUZ F. *Out of the shadows* Migrants in Pimlico and Victoria. Report from Migrants Resource Centre, South Bank House, Black Prince Road, London SE1.

10 FEINMANN J. Four hospitals into one might just go. *Health Service Journal* 11 February 1988, 177.

APPENDIX I

RIVERSIDE HEALTH AUTHORITY
Riverside East Community Services Unit
PROJECT WORKER : Decentralisation of community health services

Background
This is a new, two year, full-time post funded by DHSS with one of Riverside Health Authority's two Community Service Units. The project worker will help managers in both units develop a programme for decentralising management and planning of community services by working in depth in one 'patch' in the district.

Two similar posts have been established in other inner London health authorities and the initiative is being co-ordinated by the King's Fund. As well as helping the authorities make further progress with their plans for decentralisation, the Fund and the DHSS hope to learn more about the process of introducing small scale management and planning of primary care services and the benefits and difficulties it may bring.

The general managers of the two community units in Riverside are committed to establishing a 'patch system' for community health services and envisage that it will be in place by 1988/89. The next two years are therefore crucial in terms of developing ideas and plans and agreeing a programme for implementation. The thinking behind the project worker post is that someone who can move freely between the operational and policymaking levels of the organisation will increase the capacity of managers to establish appropriate structures and systems, and will speed the development process. The worker will act as a 'facilitator' who helps existing staff achieve their aims for improving the quality of the services they provide.

The practical focus for the project worker will be one area of Riverside Health Authority, South Westminster, which includes Pimlico, Victoria and Westminster, and has a population of about 40,000 people. By concentrating in detail on the needs and services in one area, the worker will contribute to development and evaluation of the ideas on which the decentralisation programme is based and will help to test practical aspects of its implementation. As the work progresses, the lessons learnt from it will be fed into policymaking and planning groups to benefit service development in the district as a whole.

The post
The first two months will be spent becoming familiar with the district, the community units, the services provided and their organisation, and with the South Westminster 'patch' and the people who work and live there. It is envisaged that the project worker will work closely with the Assistant Director of Community Nursing Services and an administrator, who have both been given a brief to develop the decentralisation programme. The worker will also be a member of the decentralisation planning group which will:

- help the worker set a realistic agenda for the two years;
- give continuing advice and support;
- monitor progress and keep under review issues arising from the work that are relevant to district policy;
- ensure that the lessons from the work in the patch are fed into planning and policymaking.

Questions central to the decentralisation programme that will require exploration in a local context by managers with help from the project worker are:

- how to get field staff to take an active part in planning and monitoring the services they provide;
- how to plan effectively for all groups in the community;
- how to involve and respond to community groups and their representatives;
- what are the appropriate management and planning structures for a patch system;
- what staff development and training are needed to support implementation of the new system.

In practical terms, the worker is likely to be asked to help managers review the services provided in South Westminster and to identify gaps and needs that are not being met. A number of studies have been carried out recently in the locality, and much of the necessary information is readily available, so the project worker will not be expected to do research or to gather information from scratch. The emphasis will be on bringing together the relevant information in the appropriate form and finding ways of using it to help managers, fieldworkers, community groups and others develop services. There are tentative plans to build a primary care centre in the patch and it is likely that this will become a focus for drawing people into the planning process.

To carry out the tasks described above, the project worker will need to build and maintain links with a variety of agencies and individuals outside the community units, including:

Riverside Community Health Council
Community organisations and groups in South Westminster
Kensington, Chelsea & Westminser Family Practitioner Committee
Westminster Social Services Department
Riverside Health Authority Planning Department
Local GPs

The worker will be expected to keep a systematic record of all activities and prepare progress reports and other papers as necessary. Towards the end of the two years, the worker, with advice from the steering group, will write a detailed report describing what has been achieved. This will include an assessment of the value of the work to the district.

During the two years there will be regular meetings of the workers from the three DHSS-funded projects in London. These meetings will provide mutual support and a chance 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 will give practical assistance with this.

Qualities and experience required
We are seeking someone who will take an enterprising approach to the opportunities offered 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 good knowledge of NHS community services and must understand how they are organised and delivered at local level. This will be demonstrated by having worked recently in the NHS, local authority or related organisation. The worker must also have an appreciation of the difficulties of planning and providing primary care services in central London and ideas about how these difficulties might be overcome. The project worker will be a facilitator or catalyst to help existing staff identify what needs to be done and make change happen. This is ***not*** a research post.

The successful applicant is likely to have:

— an interest in the organisation and management of health services;
— some experience of introducing a new initiative in an organisation;
— enthusiasm for innovation and change.

The skills necessary for this post are:

— confidence, tact and sensitivity to work with a wide range of people, including senior managers, local professionals and consumer groups;
— good communication skills, especially the ability to write clearly and concisely;
— good analytical skills, especially the ability to distil the important lessons from complex material.

Management
The project worker will be accountable to Dr Linda Benson, General Manager, Riverside East Community Services Group. The worker will meet Dr Benson regularly to review progress and plans.

The project worker will be based at the Community Services offices in Osbert Street, SW1. Secretarial help will be provided.

Terms and conditions of service
The appointment will be with Riverside Health Authority for a period of two years.

The salary for the post is NHS A & C scale 9, currently £9,137 — £11,222 plus £1,133 LW per annum. Annual leave is 20 days per annum.

Hours of work will be 9am — 5pm Monday to Friday, but some flexibility will be expected in this post. The work will entail travel within Riverside and occasional travel to meetings elsewhere. Travelling expenses incurred in the course of the job will be reimbursed.

28.4.86

APPENDIX II

Patch Committee Terms of Reference

1 The patch committee will have responsibility for advising health service management on health service provision within the patch.

   i. The area covered by the patch will be defined by Area 3 Social Services patch boundaries.

   ii Membership of the patch committee will comprise representatives from the health service, the local authority, the local community and non-statutory organisations working within the area.

   iii. The chairman will be elected by members of the patch committee.

   iv. The committee will meet monthly.

   v. Professional accountability of committee members will be to the existing line management of the relevant agency.

   vi. The project worker will service the group.

   vii. The Community Unit of Riverside Health Authority will be responsible for co-ordinating preparation for the patch committee.

   viii. The patch committee and its future will be reviewed after 6 months.

2 Discussion of individual complaints should be avoided or referred to the relevant system for dealing with complaints against health service employees or general practitioners.

3 Plans for the patch must be made with regard to the existing unit structure and the broader political and financial environment.

4 Members of the patch committee will be expected to represent the views of their colleagues and local people as a whole and opinions expressed must reflect this where possible.

5 Workers from other agencies will be represented on the patch committee but the committee will have no formal input to local authority or any other planning structure outside the health service.

6 For the duration of the experiment all recommendations will be channelled into the health authority planning and management process via the locality planning steering group.

7 Members of the patch committee may also attend steering group meetings by invitation.

8 Steering group members may attend patch committee meetings by invitation.

9 When the patch committee or the advisory groups deem it necessary members from both groups will attend the others meetings.

10 The patch committee may co-opt up to three other members onto the committee at any one time.

11 All co-options and changes in membership of the patch committee must be reported to the steering group.

12 The patch committee will have responsibility for all co-options onto the committee.

13 The steering group will have responsibility for defining membership of the patch committee.

14 All requests for information or resources from the patch committee must receive a response from the unit managers within 3 weeks.

15 The management reserve the right to alter these terms of reference as and when required.

1986

APPENDIX III

CHURCHILL GARDENS PATCH COMMITTEE
MILESTONES

AUGUST 14TH — the idea of setting up a patch committee comprising local fieldworkers from health, housing, social services, voluntary organisations and community representatives is first raised at the meeting of the Locality Planning Steering Group.

SEPTEMBER 22ND — it is agreed at the second meeting of the steering group that Churchill Gardens, an existing social services patch with a population of 8,140 should be the focus for the first patch committee.

OCTOBER 20TH — senior managers who are to be asked to release staff to sit on the patch committee meet with UGM.

NOVEMBER 4TH — a meeting of training interests from social services and the health authority is convened to discuss how to prepare and train the patch committee.

DECEMBER 19TH — First meeting of the Churchill Gardens Patch Committee.

TIMETABLE
August
Maps:
- — fieldworker boundaries
- — location of GPs
- — location of schools
- — geographical boundaries
- — postal districts
- — ward boundaries
- — other agency boundaries
- — transport
- — health service provision
- — other agency provision
- — non-statutory provision

Statistics:
- — NHS
- — Census data (by ward)
- — Non-statutory organisation data

Background information:
- — made contact with other projects exploring initiatives of this kind
- — Library search

September — Early November
A discussion outlining the plans for decentralisation was distributed to all senior managers in the health authority, housing department, social services, non-statutory organisations in Westminster and local community representatives. This was followed up by (and in some cases preceded by) meetings with all of those concerned to discuss the objectives of small scale management and planning of services. Usually more than one meeting was required.

October 20th — all senior managers who were being asked to release staff to attend the patch committee were attended a meeting chaired by the U.G.M.

Contact the Planning Department at Westminster Council and begin negotiations to obtain the small area statistics for the Churchill Gardens area.

October — December
Collate small area statistics

Preparation — It was decided that the first two meetings of the patch committee should be introductory sessions to explain its role and function and to begin to establish a group identity. since the project worker had no experience of this kind of work it required:

- a library search for relevant information
- contacting people with experience of convening multi disciplinary groups (see list attached)
- a meeting of training interests from the health authority and social services

December
Timetable and information pack for patch committee

Meeting with members of the committee

Further meetings with senior managers

December 19th — first patch committee meeting

Helen Dunford
January 1987

APPENDIX IV

PATCH COMMITTEE REVIEW

AIMS	MEASURE	SOURCE
Check the state of knowledge about each other's roles and skills	Time spent discussing roles in P.C. meeting	Minutes of P.C. P.C. agendas
	P.C. participants' view of whether it has helped them to understand the role of others on the committee	Interviews P.C. members
	Who came to P.C. meetings	P.C. minutes
Build up a comprehensive picture of services and resources available within the patch.	How far did the P.C. go in compiling a picture of local resources?	Map
	How helpful was the map in identifying local needs?	P.C. minutes Interviews P.C. members
	Did the map provide additional information which was helpful to P.C. members?	Interviews SNMs Interviews P.C. members Project Worker's field notes
	Did the maps provide information that was of use to managers and steering group members?	Interview Managers Steering Group minutes
Identify examples of good collaboration and referrals	Did the P.C. help members in collaborating with others?	Interviews with P.C. members
	Was there an informal agenda at the meetings?	Field notes Interviews
	Would P.C. members otherwise have met the others on the committee?	Interviews with P.C. members
	Did referrals increase?	Count referrals (special study — not feasible)

AIMS	MEASURE	SOURCE
Identify major health related problems in the patch in order of priority	Did all members of the P.C. agree with the problems identified and the order of the priority?	Interviews with P.C. members Interviews with non-attenders who were sent all P.C. minutes Interviews with members who dropped out Interviews with local NHS staff not on Patch Committee
	How did the problems identified compare with demographic data available?	Comparison with E.D. statistics
Identify gaps in the provision of health services	How were these identified?	P.C. minutes Field notes
	Did all P.C. members agree?	Interviews with regular members Interviews with non-attenders and members who dropped out Interviews with NHS staff not on Patch Committee
Look at ways in which existing resources can be tailored to meet the needs of local community	The project has not reached the stage of being able to do this yet, but do members think this will ever be possible?	Interviews with P.C. members

AIMS	MEASURE	SOURCE
Look at ways of involving the local community in health service planning	Which community groups came to the meetings?	Minutes
	Were the meetings accessible to local people and community representatives?	Comparison in original papers identifying who we thought would attend Interviews with regular members, drop outs and non-attenders.
	How many times did those community groups who dropped out of the group attend?	Field notes Minutes
	Who were the individuals who attended meetings?	Minutes Interviews
	Did they utilise the health service already?	Minutes Interviews
Develop communications network between the operational and planning the health service	How did the P.C. and the NHS Managers and planners communicate?	Minutes P.C. UGM's responses Field notes Steering group minutes
	Do P.C. members feel that the P.C. has a useful role to play in making managers and planners aware of needs and what health services are required?	Interviews with P.C. members Interviews with drop outs and non-attenders Field notes Discussion on the future of the group
	Do local NHS workers not on the P.C. feel it has a useful role to play?	Interviews with non-P.C. workers

APPENDIX V

INTERVIEW CHECKLIST

1 Why did you become involved with the patch committee?

2 Did you meet people at meetings that you wouldn't otherwise have met?

3 Was there anyone you would have liked to have been there who was not involved?

4 Do you think it has helped you to understand the role of others on the committee any better? Whose?

5 Do you think it has helped you to clarify your role? To whom?

6 Do you think the patch committee has affected your relationship with other members of the patch committee?

7 Did it make contacting them and referring easier? Harder? No change?

8 Did you agree with the problems identified by the patch committee and the order of priority?

9 Were there any issues you would have liked to have seen raised at meetings that did not come up?

10 Do you feel there are gaps in the provision of health services in Pimlico? What are they?

11 Do you think the map was a helpful starting point for identifying need?

12 Did it give you any new information or make you aware of resources you did not know were available?

13 Did you feel able to contribute to meetings? Why? Why not?

14 Is there anything you would have liked to have changed about the meetings? Timing, paperwork, people attending, numbers?

15 Do you think the introductory sessions were useful? How could they have been dispensed with?

16 Do you think the patch committee went any way towards making managers and planners aware of the problems in your area?

17 Did you feel you were representing your own view/your colleagues/your profession?

18 Did you report back on the meetings? Who to? How?

19 Can you remember what you hoped to see come out of the patch committee when you first joined?

20 Did it meet your expectations?

21 How would you change it?

22 Do you think this type of consultation has a useful role?

Helen Dunford
1987


572 020000 048572

Helen Dunford has a B.Sc. degree from London University and trained as a nurse at The Middlesex Hospital. She has worked for Nursing Times, on a community based health project in Nepal, and as a primary health care development worker in Riverside Health Authority.

Jane Hughes was co-ordinator of the King's Fund London Programme. She has a degree in medical sociology and previously worked in health services research and development.

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to 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.

Price £5.00
ISBN 0 903060 06X