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**BRIDGING THE BOUNDARIES?
COLLABORATION AND COMMUNITY CARE:
SUNDERLAND 1990-1994**

Margaret Mary Gilley

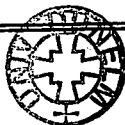
Ph.D.

University of Durham

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1997

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**BRIDGING THE BOUNDARIES?
COLLABORATION AND COMMUNITY CARE:
SUNDERLAND, 1990 - 1994**

Margaret Mary Gilley

Ph.D., 1996

ABSTRACT

The independence of the health and social care agencies makes the coordinated delivery of inter-related and inter-dependent services very difficult. Collaboration in health and social care has been a goal of policy makers for many decades, but it has not been achieved to the degree or to the extent of the aspiration. This thesis examines collaboration in the context of the NHS and Community Care Act 1990, which marked a new stage in the development of community care policy and in collaborative working between health and social services.

The thesis takes the form of a case study set in Sunderland during 1990-1994, from the passing of the Act to the first anniversary of the implementation of its community care elements. It considers firstly, collaboration at a strategic planning level between Sunderland Health Authority and the Local Authority Social Services Department in the development and implementation of community care policy; secondly, the evaluation of a collaborative project at an operational level, in the attachment of a social worker to a general medical practice; and thirdly, the evaluation of a project which tried to strengthen collaborative working within the health service, among district nurses, health visitors and general practitioners. The thesis sets these three pieces of work in a number of contexts: the political setting of the NHS and Community Care Act and the changes it introduced; the literature of collaboration; and a description of Sunderland and its need for health and social care.

The case study showed how difficult it is for organisations to work together. Relationships between individuals tended to be more collaborative than relationships between corporate bodies, but it is important to see the relationship between those individuals in the context of relationships between organisations. The study also found that for the success of joint projects to be sustainable and generalisable, collaboration needs to be present at all levels of the organisations. The thesis also showed that there is as much need for collaboration within the health service as between the health and social services.

The thesis used as a measure a framework of factors which promote collaboration, and found that many elements were lacking in Sunderland. However, in the real world it is necessary to settle for a notion of "pragmatic collaboration" in which joint working is possible even when full collaboration is absent.

To
Professor Peter Kaim-Caudle
my friend and neighbour

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CHAPTER ONE

INTRODUCTION

INTRODUCTION

At the Social Services Conference in 1995, Alan Langlands, Chief Executive of the National Health Service (NHS) emphasised the importance of collaboration between health and social services:

Joint working across health and social services is no longer an optional extra - it is an absolute necessity. We must work together if we are to provide good services tailored to the individual needs of users, if we are to motivate our staff and if we are to get the best value for the money that the public have entrusted to us. ... The next ten years will bring growing interdependence between the NHS, Social Services and other parts of the welfare system. We need to look imaginatively beyond our narrow organisational boundaries if we are to tackle common problems effectively and make the best use of finite resources. We need to understand each others' perspective, respect each others' opinions and promote cooperation - by playing to each others' strengths and eliminating duplication of effort.¹

¹ NHS Executive press release, "Alan Langlands calls on health and social services to work closer together", 21 September 1995.



This call for collaboration was not new. Policy makers had for many years been calling for the health and social services to work together across the organisational boundaries. This thesis examines the nature and effectiveness of that collaboration, as it occurred between the health and social services in one city in north-eastern England, Sunderland, in the years immediately following the NHS and Community Care Act 1990.

THE SEPARATE DEVELOPMENT OF HEALTH AND SOCIAL SERVICES

Let us first consider how these services developed, to see why collaboration was deemed to be necessary. The development of health and social services in Britain is characterised by division. Though public provision of community health services and social services grew from the same root, hospital services and general medical care developed separately. Both community health and social services originated in Poor Law provision from the seventeenth-century and amended in 1834. The Poor Law was superseded by the Local Government Act 1929, which transferred the care of the non-able-bodied to local authorities. Other community services began separately and were incorporated into this provision, including the protection of children from cruelty and deprivation, as well as midwifery and health visiting.

When the National Health Service was established in 1948, it had three distinct branches which were all administered separately: the hospital services, family practitioner services, and the community health services, the last of which were under the local authority. From the beginning, therefore, the NHS lacked integration.

The various social care services developed separately and haphazardly during the twentieth-century. In 1965, the Seebohm Committee was set up to "review the organisation and responsibilities of the local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service"². It identified the cause of the weaknesses in these services as lack of resources, inadequate knowledge and divided responsibility. Hall argues that this definition of the problem limited the solution that the Committee was likely to choose³. The Committee rejected the option of integrating the personal social services with health and possibly education departments as impractical, because social services were undeveloped compared to medicine and education⁴. As a result of the Seebohm Report, Social Services Departments were set up as local government departments. The SSDs unified five strands of social care: the children's and welfare departments of local authorities, hospital almoners, psychiatric social work in hospitals, community mental health services and the home help services developed during the war under the auspices of the Medical Officer for Health. Hall concludes that

the Seebohm reorganization left many of the basic problems of the personal social services unsolved; obtaining adequate resources for this sector, achieving cooperation between different professional groups and agencies, clarifying the role, if any, of the social worker

² Report of the Committee on Local Authority and Allied Personal Social Services (London: HMSO, 1968) § 1.

³ Phoebe Hall, *Reforming the Welfare* (London: Heinemann, 1976) p. 60.

⁴ Committee on Local Authority and Allied Personal Social Services, 1968, §§ 132-136.

in society.⁵

Twenty years later, these problems still impeded the delivery of the services. However, the personal social services grew rapidly during the 1970s. Social workers became increasingly professionalised, with the expansion and reform of formal training schemes.

While the Seebohm Report was being implemented, the government had turned its thoughts to the problems of the NHS. The Blue Paper of 1972 which proposed a reorganisation of the NHS ruled out the possibility of making health and social services the responsibility of one agency, but spoke of the need to ensure that "the two parallel authorities - one local, one health - with their separate statutory responsibilities, shall work together in partnership for the health and social care of the population."⁶ The 1974 reorganisation transferred the management of the community health services from the local authority to the new health authorities. Though this dissolved one barrier, between hospital services and community health services, it served to divide the community health services from the local authority social care services with which they were so closely linked. In any case, community health services remained very much the poor relation of the powerful hospital services, with Family Practitioner Services a separate arm of the health service.

⁵ Hall, 1976, p. 130.

⁶ Keith Joseph, Foreword to *National Health Service Reorganisation: England* (London, HMSO, 1972) p. vi.

Nevertheless, the 1974 changes were marked by a notion of integration⁷. One of the principal aims of the 1974 reorganisation was to establish a mechanism for joint working. Area Health Authorities, which were mostly coterminous with Local Authority boundaries, were set up to plan and liaise with local authorities. The requirement to plan jointly and work together was strengthened over the next 15 years as the framework for planning was established and developed. The response to the division between health and social services, which had itself been deepened by the reorganisation, therefore, was to create a formal bridge over the gap, founded on joint planning and supported by joint finance.

THE NEED FOR COLLABORATION IN COMMUNITY CARE

This history of division and separation was, then, the context in which services were delivered and policies pursued. These barriers and boundaries were present as much within the health service as between the health service and social services. They were not static, but were constantly shifting.

This thesis is concerned with one particular area of policy involving both health and social services. The development of "community care" was an important thrust of social policy from the 1950s. Community care implies that the care of vulnerable people takes place in "the community", rather than in institutions. In practice, "community" is a contentious and ambiguous term. Community care policy is

⁷ David Hunter, "The Impact of the NHS Reforms on Community Care", in M. Titterton, ed., *Caring for People in the Community* (London: Jessica Kingsley, 1994) pp. 12-23 (p. 14).

equally ambiguous and ill-defined⁸. It includes the resettlement of patients from long-stay hospitals and the policy of supporting the elderly and people with disabilities in their own homes for as long as possible. Government policy on community care consistently emphasises the need for collaboration among all those agencies which provide care: health service, social services, housing departments, other local authority services, voluntary sector services, independent sector services and informal carers. How this collaboration is to take place is less clear, and there is a virtual silence about resources to make it happen. There will be a discussion of the development of community care and the issues related to it in Chapter Three.

What, then, is "collaboration"? It is a very nebulous term, often used by policy makers for its emotional impact, rather than for the precision of its meaning. The definitions will be explored in Chapter Four, but the interpretation of collaboration as consorting with the enemy is not without irony in the context of uneasy and uncertain relations between health and social services.

There is also a question about why collaboration is necessary. Collaboration in community care is required by central government in order to "improve resource utilisation by eliminating gaps and overlaps in services; to develop community-based services so that people are kept out of hospital and other institutions; to improve the

⁸ Alan Walker, "The Meaning and Social Division of Community Care" in Alan Walker, ed., *Community Care: the Family, the State and Social Policy* (Oxford: Basil Blackwell and Martin Robertson, 1982) pp. 13-39 (p. 13).

level and quality of service for the elderly, mentally ill and mentally handicapped"⁹.

There is a deeply felt assumption that the different elements of community care should be coordinated, and that collaboration between agencies will result in better quality of care for clients and prevent duplication of resources. This assertion is so strongly held that there is little evidence of research to test it. Benefits are thought to occur in three areas: better quality of care for clients, a more satisfactory way of working for fieldworkers and more efficient use of resources. These will now be discussed in turn.

There is certainly a strong link between the need for different services. People who are chronically ill often have social needs, and people who are socially and economically deprived are more prone to illness and disability. They may need a wide range of health and social services, which are provided by a number of different organisations. In the end, this diversity of provision creates the need for collaboration. As Webb and Wistow point out,

the case for collaboration rests upon the need to secure a higher degree of integration between a range of interdependent but separately administered services - services whose administrative structures are currently organized according to the skills of their providers rather than the needs of their clients¹⁰.

The coordinated delivery of services requires the agencies to collaborate in planning

⁹ Gerald Wistow, "The National Health Service", *Town Planning Review*, 51:3, 1980, pp. 302-305 (p. 303).

¹⁰ Adrian Webb & Gerald Wistow, *Planning, Need and Scarcity: Essays on the Personal Social Services* (London: Allen & Unwin, 1986) p. 142.

those services and in managing them, and requires practitioners and field workers to work together to provide them. There need to be good links and relationships, therefore, at different levels between the organisations, at fieldworker level in both the assessment of needs and the provision of services, and at management levels in commissioning services, strategic planning, and operational planning. Corney points out that "it is important to try to provide a more integrated service catering for the social, emotional and health needs of patients and clients in a coordinated rather than a piecemeal fashion"¹¹. Some studies have demonstrated that collaborative care leads to improved outcomes for clients¹².

Collaboration also yields benefits for the deliverers of care, including mutual trust and support¹³. It can also be a way of harnessing ideas and energies, so that the whole is greater than the sum of its parts¹⁴, and of creating an environment in which participants feel valued¹⁵.

There is also an expectation that collaboration will result in the better use of

¹¹ R H Corney, "Social work and primary care - the need for increased collaboration: discussion paper", *Journal of the Royal Society of Medicine*, 1988, 81, pp. 29-30 (p. 29).

¹² Ian Mackenzie, "All together now - collaboration to improve the care of people with asthma", *Journal of Interprofessional Care*, 9:3, 1995, pp. 245-250.

¹³ Morag McGrath, *Multi-Disciplinary Teamwork* (Aldershot: Avebury, 1991) p. 61.

¹⁴ Mildred D Mailik and Ardythe A. Ashley, "Politics of Interprofessional Collaboration: Challenge to Advocacy", *Social Casework: The Journal of Contemporary Social Work*, 1981, pp. 131-137 (p. 131).

¹⁵ John Nicholson, *How do you Manage?* (London: BBC Books, 1992) p. 68-69.

resources, as Langlands' comment at the beginning of this chapter shows, an expectation established in the early guidance on joint planning¹⁶. One Audit Commission report after another offers evidence of waste arising from a failure to collaborate¹⁷. There is also some local anecdotal evidence. For example, in Sunderland, before the Social Services Department took on the responsibility of purchasing residential and nursing home care in 1993, there was a story circulating about a person who was admitted to a home because the statutory authorities could not agree on the responsibility for providing a commode.

However, though collaboration may have some benefits, there is also evidence from organisational psychology which shows that teams do not necessarily produce more or better ideas, outcomes or problem-solving, and that a sense of cohesiveness does not necessarily result in better performance¹⁸.

Engendering collaboration between health and social services has been a goal of policy-makers for two decades, and has proved to be notoriously difficult. This is curious, given that collaboration is almost universally asserted to be necessary for

¹⁶ DHSS, *Joint Care Planning: Health and Local Authorities*, HC(77)17/LAC(77)10, May 1977, § 1.

¹⁷ Audit Commission, *Making a Reality of Community Care* (London: HMSO, 1986) pp. 29-42; *Community Care: Managing the Cascade of Change* (London: HMSO, 1992) §§ 3, 6, 19-29, 53-61; *Homeward Bound: A New Course for Community Health* (London: HMSO, 1992) pp. 12-14.

¹⁸ Michael West and Rosemary Field, "Teamwork in primary health care. 1. Perspectives from organisational psychology" and "2. Perspectives from practices", *Journal of Interprofessional Care*, 9:2, 1995, pp. 117-122 and pp. 123-130 (pp. 118-120)

the delivery both of government policy to the population in general and of effective care to individuals. The thesis will examine why collaboration is so fraught with problems.

The NHS and Community Care Act 1990 presented a new challenge to inter-agency relations between health and social services. On the one hand, it radically changed the way that the organisations were structured and how they operated; the health service in particular. This inevitably had an impact on the dynamic of joint working. On the other hand, it brought in new responsibilities for the delivery of care to vulnerable people in the community that required collaboration between agencies in order to be effective.

There is, therefore, a need to reassess collaboration between health and social services in the wake of the NHS and Community Care Act. What difference has the Act made to inter-agency relations? How far is it possible to strengthen collaboration between the health and social services and how far is this likely to make community care policies work better? What circumstances foster collaboration, and what factors hinder it?

The study of collaboration between health and social services is not new. Several sociological industries are founded on it. There are a number of different strands, which tend to remain separate. One complicating factor is that collaboration, when it does occur, does not take place at one level: within health and social service agencies it may happen in strategic planning, in the management of special projects,

in operational management generally or between individual fieldworkers. The literatures of collaboration in these different settings tend to be distinct (see Chapter Four). There is a question about how collaboration at one organisational level influences or is influenced by collaboration at another level and about how far particular levels are crucial.

Chapter Four shows that the literature of collaboration tends to demonstrate the inherent difficulties in joint working between agencies or between groups of workers. Occasionally, collaboration proves to be successful and effective, but this is often due to the personal qualities of an individual or small group of people who are in the right place at the right time. Success is difficult to replicate or systematize. On the contrary, the systems and structures are fraught with barriers that make collaboration difficult and sometimes impossible.

THE CONTEXT OF THE RESEARCH

Before moving on to the thesis itself, it is important to establish the context of this research. It was unlike a "normal" piece of academic research in which, ideally, a study is designed to address carefully thought out questions. Rather, the chance to do academic research was opportunistic, as a result of an innovative - and collaborative - project set up in Sunderland.

In 1991, the Health Authority, Family Health Services Authority and Social Services Department in Sunderland established a project funded by the Urban Programme to

research the delivery of primary care in Sunderland. The stated aims of the project were:

- i. To define the need of the population of the inner urban area for primary care services;
- ii. To produce a model for developing primary care services to meet those needs;
- iii. To encourage all constituent authorities in the primary care field to adopt that model.

Though the nature of the funding meant that the project was concentrated on the Sunderland Inner Urban Area, in practice, the work applied to Sunderland as a whole.

I took up the post in April 1991. For practical reasons, the post was based in the Community Health Unit, and because of this, and because of my own background in the health service, the research is inevitably seen primarily from a health service perspective. Furthermore, as I am an unrepentant bureaucrat, it has very much an organisational outlook.

The post was funded for three years. The main outcomes of the post were six pieces of work:

- i. a review of the literature on ill-health and deprivation as it affected

- Sunderland, and a description of the primary, community health and social services in 1991;
- ii. an evaluation of a project in which a social worker was attached to a general practice;
 - iii. an evaluation of a project which explored closer working between district nurses and health visitors and general practitioners;
 - iv. an evaluation of the assessment document introduced for the implementation of community care;
 - v. the evaluation of a series of team-building events for primary health care teams;
 - vi. an analysis of the primary and community health and social services in Sunderland in 1994, following the changes introduced by the NHS and Community Care Act 1990.

Though each was a discrete piece of work, apart from (vi) which brought (i) up to date, they all came from the same background and reflect a similar range of themes. Firstly, the research project itself was a collaborative venture, the project worker reporting to a Board made up of the Chief Executive of the Family Health Services Authority, the Director of Operations from the District Health Authority, the Unit General Manager of the Community Unit and an Assistant Director of Social Services. Secondly, the political context of the project was the implementation of community care legislation and the need to strengthen primary and community health care, and, therefore, clearly form an appropriate basis for the research. However, there remains a question here about the meaning of the research, when the

separate projects were undertaken for one purpose (to test the validity of models of service delivery), and are used within this study in a different way (as a case study of collaborative endeavour). Thus, how this research arose has certain implications for its methodology, which will be considered further in Chapter Two.

THE PARAMETERS OF THE RESEARCH

This thesis looks at collaboration between the health and social services in Sunderland in 1990-1994, in the context of the introduction of the NHS and Community Care Act. Though other agencies also provide services enabling people to be cared for in the community, including other local authority departments, the voluntary sector and the private sector, the thesis concentrates on the relationship between health and social services. It examines collaboration mainly at two levels, at the strategic planning level and between fieldworkers, and attempts to understand how collaboration at one level affects another. There is some discussion of joint management, but this was a fortuitous outcome of the study, rather than a planned element of the research. Though there is a need for services provided by all the other organisations to be coordinated with those provided by the health service and social services departments, this further dimension of collaborative activity is beyond the scope of this study. Indeed, the thesis shows that even collaboration between different parts of one service, the health service, cannot be guaranteed and needs to be worked at.

Sunderland is a deprived urban area in the north-east of England, with high levels

of need for social and health care services (see Chapter Five). It is commonly assumed that if those needs are to be met effectively, good collaboration between health and social care agencies is required. A number of factors were in Sunderland's favour: the Local Authority and Health Authority shared a common boundary, which meant that they did not have to liaise with multiple agencies; the organisational structure of the Social Services Department and its officers had enjoyed remarkable stability up until the research period; and relations between the SSD and the Health Authority were generally good.

The period 1990-1994 marks the introduction of the NHS and Community Care Act to the first anniversary of the implementation of the bulk of the community care measures. The community care policies were planned originally to be fully implemented in 1991, but, as we shall see, this was delayed to 1993. The period covers the years in which the health and social services were preparing for the introduction of community care policies, and the first year in which those policies operated as a package. It was a turbulent time, as the health and social services in Sunderland went through radical organisational changes, mainly due to the new legislation, but also as a result of internal factors.

The aims of the thesis are firstly, to analyse the problems related to attempts at collaboration among the various bodies within the health and social services by the examination of one particular time and place, Sunderland, during 1990-1994, and, secondly to consider some possible practical ways of tackling these problems. These problems are complex, and merely disentangling them requires considerable

intellectual effort of description and critical analysis. Some aspects of these problems are particular to the local social context in its time and place; others are found in the world of health and social services in general.

There are a number of studies of collaboration between health and social services published in the 1970s and 1980s. They showed that expectations of collaboration were very high, and the reality did not match the rhetoric. There is value in looking at these issues again, firstly, to see whether the situation has improved, and secondly, to consider whether the NHS and Community Care Act 1990 has made a difference to the mutual interaction of the different organisations. The value of the local dimension of this study may be to encourage further such studies in other places, so that a body of comparative literature can be built up, and to help people to a better understanding of what is going on in their own organisations.

The case study comprises three main parts. The first is a study of the processes by which the health and social care agencies in Sunderland prepared for the introduction of community care policies. If community care was to be implemented effectively, the agencies had to develop policies and procedures acceptable to both the health service and to social services. The study examines the committee structures set up for this task and their discussions, both in official meetings and behind the scenes, and the decisions emerging from them. The thesis does not examine programmes for particular client groups within community care policy, such as resettlement from long-stay hospitals or care for the mentally ill. It concentrates on the overarching policies and processes set up to deliver care, mainly to older

people and people with physical disabilities. The focus is on collaboration at the strategic / senior management level.

This is followed by studies of two projects which attempted to improve collaboration at fieldworker level. In the first, a social worker was attached to a Primary Health Care Team and gave access to social services for the practice patients. The second was not an inter-agency project at all. It came about because of the difficulty of collaboration between different parts of the health service. This scheme tried to strengthen the working relationship between GPs and health visitors and district nurses. Health visitors and district nurses were employed at the start of the period by the District Health Authority, and later by a NHS Trust, whereas the GPs worked independently in contractual relationship with the Family Health Services Authority (formerly the Family Practitioner Committee). It is interesting to compare similarities and differences between attempts to improve inter- and intra-agency collaboration. It also points to a more fundamental problem. There is often an assumption by the public that the National Health Service is one, integrated organisation. In fact, it is a federation of a number of organisations and there is no guarantee that the different parts will work together. Collaboration is as necessary within the health service as it is between the health service and other organisations.

It is as well to be clear from the outset that there are profound differences between health and social services which can hinder joint working. As separate bodies with different terms of reference and systems of accountability, with separate budgets, based in different locations, collaboration between agencies is not easy, as in the

different way that the services are structured and managed. Social services are organised by departments of the local authority and are accountable to committees of democratically elected representatives of the community. Health services are accountable to authorities, committees or boards with members appointed by the Secretary of State and/or the RHAs. In the past, these authorities included professional representation from doctors, nurses and other health care professions, as well as Trades Union and LA nominees, particularly on the Family Practitioner Committees, but this was weakened by the 1990 Reforms. This meant that the health service was increasingly run by political appointees. In 1996, professional representation on health authorities disappeared altogether, except where the Secretary of State appointed someone who happened to be a health care professional. These differences in the accountability frameworks of health services and social services have a profound impact on their culture and identity and ways of working.

One issue that became more explicit after 1994 (so after the end of the research period), but which was certainly present during the development of community care policies and procedures, was about the financial implications of the boundaries between health and social services. Changes in clinical practice, such as earlier discharge from hospital or the increased use of day surgery, could result in greater demand for social care. Conversely, inadequate social care provision could delay discharge, with financial implications for the NHS, or put a heavier burden on community health service staff.

STRUCTURE OF THE THESIS

Chapter Two describes the methods used in the research, the benefits in taking this approach and the difficulties encountered. The research is, essentially, a case study of some aspects of the experience of collaboration in one city at one period. This method has advantages and disadvantages. As the study included the evaluation of two projects, there is a discussion of evaluative research. As we have already seen, the research arose from particular circumstances, namely the Primary Health Care Project. Chapter Two looks at the implications of being both a researcher and a participant in the events being studied.

Chapter Three sets the scene, explaining the political, economic and ideological influences on the reforms of the NHS and Community Care Act 1990, and reporting on the changes that the Act introduced. There is a great emphasis on collaboration in the community care aspects of the reforms, between health and social services on the one hand, but also incorporating users and carers as major stakeholders. An account of the research into the nature of collaboration is provided in chapter Four, along with studies of collaborative activity at strategic planning level and at the fieldworker level, between GPs and social workers and within Primary Health Care Teams. A framework drawn from this literature is employed in later chapters to examine the circumstances in which joint working takes place, to test whether the joint working arrangements in Sunderland can be described as collaborative. The chapter concludes by posing six questions about the issues to be addressed: firstly, about the usefulness of the framework itself; secondly, about the value of looking

at collaboration at different levels of the organisation; thirdly, about the effectiveness of collaboration in Sunderland; fourthly, whether collaboration can only take place in ideal circumstances; fifthly, about the impact of the NHS and Community Care Act 1990 on collaboration; and, finally, about the impact of collaboration on outcomes for clients.

Chapter Five describes the social and economic circumstances in Sunderland in the early 1990s, the poor state of health among its people, and the health and social services available for the needs arising from such poor health. An account is also given of the links between services on the ground. This was the context in which plans were made and policies developed to implement community care in Sunderland. Chapter Six gives accounts of these developments and of collaboration in relation to certain key aspects of policy: the Community Care Plan, boundaries of care issues between health and social services, the assessment procedure, joint training, the hospital discharge procedure, and care management for long-stay patients with disabilities.

As well as collaboration at the strategic planning level of health and social services, the study also explored collaboration at the fieldworker level. It included the evaluation of two projects: one in which a social worker was attached to a general practice (Chapter Seven), and another which attempted to strengthen relationships between different workers within the health service (Chapter Eight).

The final chapter reviews the themes arising from each chapter. It discusses the key

issues emerging from the study and proposes areas where further research is required. Finally, it draws out the main lessons of the research, which argues for a notion of pragmatic collaboration, joint working that takes account of the messiness and contradictions built in to the dynamic between health and social services.

SUMMARY

This introduction to the thesis explored the separate development of health and social services in Britain. The independence of the health and social care agencies makes the coordinated delivery of inter-related and inter-dependent services very difficult. The device by which coordination is sought is the notion of collaboration between the agencies. Collaboration in health and social care has been a goal of policy makers for many decades, but it has not been achieved to the degree or to the extent of the aspiration.

This thesis examines collaboration in the context of the NHS and Community Care Act 1990. The Act introduced changes which altered the dynamics between the agencies and was also responsible for a new imperative for collaboration. It marked a new stage in the development of community care policy and in collaborative working between health and social services. It is, therefore, important to review the impact of the Act on the concept and practice of collaboration.

The thesis takes the form of a case study set in Sunderland during 1990-1994, from

the passing of the Act to the first anniversary of the implementation of its community care elements. It looks at collaboration at a strategic planning level between Sunderland Health Authority and the Local Authority Social Services Department in the development and implementation of community care policy. It goes on to evaluate a collaborative project at an operational, field-worker level, in the attachment of a social worker to a general medical practice. The final part of the case study is drawn from the evaluation of a project which tried to strengthen collaborative working within the health service, among district nurses and health visitors and general practitioners. The chapter summarises the content of the thesis, which sets these three pieces of work in a number of contexts: the political context in which the NHS and Community Care Act was born and the nature of the changes it introduced; the literature on collaboration; and a description of Sunderland and its need for health and social care.

This chapter also considered the way this research came about. The research was based on work undertaken as part of the researcher's employment, which involved evaluating several projects. In addition, the researcher observed and recorded the development and implementation of community care policy in Sunderland which, again, was work in which she took part. The researcher's closeness to her subject put her in a unique position to study collaborative relations between health and social services.

The next chapter describes how the research was carried out, looking at the methods used and the difficulties encountered.

CHAPTER TWO

RESEARCH METHODOLOGY

INTRODUCTION

The purpose of this chapter is to discuss issues relating to the research methods used in this study. It starts with the questions arising from the nature of the Primary Health Care Project itself. It goes on to describe the methods employed in all the projects making up the Primary Health Care Project, and the additional study undertaken as part of this research.

The Primary Health Care Project, as described in Chapter One, was itself the outcome of a collaborative venture, and was set up to investigate the need for and the provision of primary health care, though this also took in community health and community care services. How this study arose itself raises a number of methodological issues. Firstly, the Project Worker's role essentially came to be about evaluating projects. This raises the question about the nature of evaluation and its relation to the research process. Secondly, there is the question of the relationship of research to policy

making, given the expectation that the Primary Health Care Project would influence the way that policy and services developed. A third question relates to the role of the Project Worker as researcher/participant. There is a need to examine the nature of this role and its influence on the research.

THE NATURE OF EVALUATION

There is often a stated belief in the health service and social services that new projects and new ways of delivering services should be evaluated. In practice, however, evaluation is usually undertaken half-heartedly, if at all. Evaluation is, after all, expensive, demanding and time-consuming. Thus, many innovations are implemented without any formal assessment of their value or success. That is not to say that they are not evaluated at all, because participants and managers observe the development of a project and have some judgement about its merits (and may well alter the project accordingly), even though the process, the values against which the project is being measured, and the outcomes are not often explicit.

But what is evaluation, and how does it relate to research? A number of definitions have been offered. Suchman distinguishes evaluation as "the general process of assessment or appraisal of value" from "evaluative research", the use of "empirical social research methodology for the purposes of conducting ... evaluative studies"¹. Pollard defines evaluation as "social research directed towards answering questions

¹ Edward A Suchman, *Evaluative Research* (New York: Russell Sage Foundation, 1967) p. 7.

about the design, implementation, and outcome of social programs".² Ong criticises this approach because it excludes evaluation undertaken through clinical procedures or cost-effectiveness analyses³. For Bulmer, the aim of evaluative research is to "discover whether a particular policy is actively accomplishing what it set out to accomplish"⁴ and to endeavour to ascertain how far outcome differences between two periods is the result of external happenings.

In simplified terms, evaluation is a process which assesses social (or other) programmes by identifying the criteria for success in a project, collecting data about the project, comparing it to the criteria and then making a judgement about whether or not the project has been successful. The judgement can then assist decision-making. In practice, the process can be more complicated, because different stakeholders may have various criteria for success. In their evaluation of a psychogeriatric day hospital, Smith and Cantley construct a research methodology which takes account of the different criteria of success held by different groups of participants⁵. Evaluation can also have unintended consequences. Guba and Lincoln assert that "evaluation is

² William E Pollard, "Decision Making and the Use of Evaluation Research", *American Behavioral Scientist*, 30:6, 1987, pp. 661-676 (p. 675).

³ Bie Nio Ong, *The Practice of Health Services Research* (London: Chapman & Hall, 1993) p. 84.

⁴ M Bulmer, "Evaluative Research and Social Experimentation", in M Bulmer, ed., *Social Science and Social Policy* (London: Allen & Unwin, 1986) pp. 155-179 (p. 155).

⁵ Gilbert Smith and Caroline Cantley, *Assessing Health Care* (Milton Keynes: Open University Press, 1985).

always disruptive of the prevailing political balance"⁶, and that the evaluator should anticipate this at the start of the study and determine whether the worth of the evaluation will outweigh the upset it causes.

A better understanding of evaluation may be achieved by comparing it with other activities. Research can be defined as the critical analysis of data in order to tackle a question. Evaluation is, therefore, a type of research, because data is analysed critically, but the nature of the research question is specific and relates to the measurement of value in a social programme. Suchman, taking a positivist approach, contrasts research with evaluation. The objective of research is "the discovery of knowledge, the proof or disproof of a hypothesis" and success in research is about "the scientific validity of its findings". On the other hand, the objective of evaluative research is "to determine the extent to which a given program or procedure is achieving some desired result". Its success is "dependent upon its usefulness ... in improving services".⁷ Evaluation is not a "weaker" form of research. It must be just as rigorous in its methods. As Suchman says, "evaluative research is still research and it differs from nonevaluative research more in objective or purpose than in design or execution."⁸ Another way of understanding the difference between research and evaluation is the notion of distance: evaluation occurs much closer to the project, while research takes a step back from the project in order to gain an overview, and

⁶ Egon G Guba and Yvonna S Lincoln, *Effective Evaluation* (San Francisco: Jossey-Bass Publishers, 1988) p. 299.

⁷ Suchman, 1967, p. 21.

⁸ *Ibid.*, p. 82.

understand the implications of the project in a wider context.

Some writers distinguish between "basic" or "pure" and "applied" research, though there are many variants on the terms and definitions used. Basic research is about acquiring knowledge for its own sake. Though applied research has been defined as the application of basic research to practical situations, the definition offered by Nas *et al* is more apt. They describe it as "research for practical use within a certain field of problems"⁹. Evaluative research would come within the scope of applied research. The relationship between basic research and applied research has been understood in different ways: Bulmer perceives basic research and applied research as two ends of a continuum¹⁰, while Payne and colleagues see them as entirely separate activities¹¹.

Two other terms are helpful for understanding evaluation in the health and social services. "Monitoring" is the continuous and systematic surveillance of a programme against specific norms¹². Evaluation may include a process of monitoring, but the assessment of value goes beyond the scope of monitoring. "Audit" has been described as the "method used by health professionals to assess, evaluate and improve care of

⁹ PJM Nas, WJM Prins and WA Shadid, "A Plea for Praxeology", in G Clare Wenger, ed., *The Research Relationship: Practice and Politics in Social Policy Research* (London: Allen & Unwin, 1987) pp. 18-42 (p. 25).

¹⁰ Martin Bulmer, *Social Policy Research* (London: Macmillan, 1978) pp. 3-43 (p. 9).

¹¹ Geoff Payne, Robert Dingwall, Judy Payne and Mick Carter, *Sociology and Social Research* (London: Routledge & Kegan Paul, 1981) pp. 142-159.

¹² Colin Palfrey, Ceri Phillips, Paul Thomas, David Edwards, *Policy Evaluation in the Public Sector* (Aldershot, Avebury, 1992) p. 9.

patients in a systematic way, to enhance their health and quality of life"¹³. It is a form of evaluation, but one which concentrates on activities which accompany the diagnosis and treatment of patients and uses a particular methodological approach. In contrast, evaluative research focuses on a wider range of activities, employing a wider range of techniques.

Coulter identifies four levels of evaluation in health care: evaluation of individual treatments, of patterns of care, of organisations, and of health systems¹⁴. The fieldwork described in this thesis, the account of joint planning between the health authorities and social services department would be placed at Coulter's third level and the studies of projects operating in Primary Health Care Teams would belong to the second level. The fourth level would include policy evaluation, the evaluation of government programmes¹⁵.

Within the Primary Health Care Project, the procedure of evaluation followed a similar pattern in each project. The Project Worker prepared an evaluation proposal setting out the aims of the evaluation and how it would be carried out. The evaluation proposal was discussed with the Project Board, with those involved in the project to

¹³ Donald and Sally Irvine, eds., *Making Sense of Audit* (Oxford: Radcliffe Medical Press, 1991) p. 16.

¹⁴ Angela Coulter, "Evaluating the outcomes of health care", in Jonathan Gabe, Michael Calnan, and Michael Bury, eds., *The Sociology of the Health Service* (London: Routledge, 1991) pp. 115-139 (p. 116).

¹⁵ For example, see Colin Palfrey, Ceri Phillips, Paul Thomas, David Edwards, 1992; Christopher Pollitt, "Occasional Excursions: A Brief History of Policy Evaluation in the UK", *Parliamentary Affairs*, 46:3, 1993, pp. 353-362.

be evaluated (the subjects of the evaluation), and with any other interested parties. In one project, the evaluation of the assessment procedure for Care in the Community, it was possible to pilot the evaluation method, in order to make improvements before the full evaluation took place. The evaluation was carried out by the Project Worker using a variety of quantitative and qualitative methods, and then analysed. Reports were written on the basis of the data, which included recommendations about the future direction of the project.

RESEARCH AND POLICY MAKING

One thing that interested me about my post was my expectation of being able to influence policy in certain areas. I soon found that the connection between research and policy-making is an uneasy one¹⁶. Two questions need to be addressed, namely, how far should policy-makers influence research, and how far research can and does influence policy-making.

As for the first question, Loseke sees dangers in research being directed by policy-makers, arguing that policy-makers tend to pose a narrow set of questions that ignore sociological complexity and to prefer quantitative methodologies¹⁷. When policy-makers control research questions and methods, the independence of evaluation is

¹⁶ For example, see Christopher Pollitt, Stephen Harrison, David J Hunter and Gordon Marnoch, "No Hiding Place: On the Discomforts of Researching the Contemporary Policy Process", *Journal of Social Policy*, 19:2, 1990, pp. 169-190.

¹⁷ Donileen R Loseke, "Evaluation Research and the Practice of Social Services: A Case for Qualitative Methodology", *Journal of Contemporary Ethnography*, 1989, 18:2, pp. 202-223 (p. 203).

reduced. Bulmer, on the other hand, defines evaluation research in terms of its utility to people making decisions and for the purpose of answering questions posed by policy-makers¹⁸.

The second question is how far research can influence policy. There is an assumption that policy-makers commission research in order to provide information that will help make decisions. In practice, this is often not the case. Thomas found little evidence that government funded research had much influence on policy in government departments¹⁹. Projects were more likely to be taken up where they struck a responsive chord within departments, and where the researcher had worked within government²⁰. As Booth points out, research is only one source of knowledge available to policy-makers, who will assess the value of research in terms of how it conforms to what is already known about the subject and its usefulness in offering a new perspective on problems²¹. Policy-makers may use research in many ways: not so much as evidence for a particular action, but to legitimate policies already chosen, to give the appearance of rationality to a chosen policy, or as a means of control. Research can also be used as a means of postponing action²². Weiss, too, indicates a number of ways in which social science can be used in the policy arena, though none is without problems.

¹⁸ Bulmer, 1986, p. 155.

¹⁹ Patricia Thomas, *The Aims and Outcomes of Social Policy Research*, (London: Croom Helm, 1985).

²⁰ *Ibid.*, p. 62.

²¹ Tim Booth, *Developing Policy Research* (Aldershot: Avebury, 1988) p. 231.

²² Thomas, 1985, p. 86.

Research can generate knowledge, solve problems, confirm an entrenched position, be a tactic to show that "something is being done", a slow drip in the pool of knowledge by which society is gradually enlightened, or an intellectual exercise for its own sake²³.

Research can be promoted to have a greater influence on policy, and Thomas describes a number of strategies²⁴. However, she concludes that "research will not of itself make the policy process more rational. To act on the assumption that it will do so is at best harmful to the morale of all concerned and at worst seriously wasteful of the time and money of research and funding body alike."²⁵

In any case, the way policy decisions are made is not necessarily rational. The decision-making process is complex. Decisions may emerge from negotiation between a number of parties taking account of various sources of knowledge and various interests. Pollard argues for an expanded framework for examining how evaluative research is used in decision-making, because evaluation studies can affect decision-making and problem-solving in a number of ways²⁶. They can lead to a better understanding of the problem, they can assess the value of alternative solutions, and they can help to guide the way a project is implemented.

²³ Carol H Weiss, "Meanings of Research Utilization", in Martin Bulmer, ed., *Social Science and Social Policy* (London: Allen & Unwin, 1986) pp. 31-40.

²⁴ Thomas, 1985, pp. 98-113.

²⁵ *Ibid.*; p. 113.

²⁶ William E Pollard, 1987, p. 675.

The impact of evaluation on existing policy is a little different. The purpose of evaluation is not to develop policy but to test its effects. Its role is to confirm or modify the application of policy.

The role of the Primary Health Care Project was not to solve the problems of developing policy in community health and social care. Its purpose was to provide information that would be useful in decision making: firstly, in bringing together what was known about the health and socio-economic needs of Sunderland, and secondly, in testing the impact of new models of delivery. However, it seemed to me that each of the four members of the Project Board also had his own hopes and expectations for the project, from being seen to be promoting a new and innovative scheme to seeing the Project as a peg on which to hang developments, or the evaluation of developments, already planned or under consideration.

RESEARCH METHODS

This section addresses the choice of research methods and the reasons for them. Several research methods were used, combining a mixture of quantitative and qualitative techniques. The principal reason for choosing a method was the nature of the material to be studied. As far as research methods go, I was most fortunate. The Primary Care Project Board encouraged qualitative research methods as well as the collection of quantitative data. I was asked to "tell the story" and not just produce the figures.

This approach by senior management was, perhaps, unusual. The culture of the NHS, with managerialism on the one hand and doctors aspiring to scientific method on the other, generally favours research that produces hard quantitative evidence. The epitome of medical research methodology is the randomised double-blind controlled trial. Qualitative methods are designed to help the researcher understand the social world and how it works, and how and why this shapes human behaviour. They have, in the past, been frowned upon as unscientific²⁷. However, there is evidence that qualitative research methods are becoming more acceptable within the NHS²⁸. Loseke calls for the use of qualitative methods in evaluative research on the grounds that quantitative research is "too narrow to furnish guides for public policy"²⁹ and Lincoln observes that "qualitative data provide us with insights that sheer numbers never can"³⁰.

The research described in this thesis is essentially a case study. The subject is health and social services in Sunderland in the period 1990-1994. It addresses the question of the impact of the NHS and Community Care Act 1990 on collaboration between health and social services. The case study is in four parts: firstly, a description and analysis of the primary and community health services and social services in

²⁷ Catherine Pope and Nicholas Mays, "Opening the black box: an encounter in the corridors of health services research", *British Medical Journal*, 306, 1993, pp. 315-318.

²⁸ Nicky Britten and Brian Fisher, "Qualitative research and general practice", *British Journal of General Practice*, 1993, pp. 270-271.

²⁹ Loseke, 1989, p. 204.

³⁰ Yvonna S Lincoln, "Sympathetic Connections Between Qualitative Methods and Health Research", in *Qualitative Health Research*, 2:4, 1992, pp. 375-391 (p. 389).

Sunderland during the period; secondly, a description and analysis of the planning processes employed for developing community care policy. The third part is an evaluation of social worker attachment to general practice (the Social Worker Attachment Project); the fourth is the evaluation of a project in which general medical practitioners were given responsibility for managing district nurses and health visitors (the Direct Management Project).

As a research design, the case study has its problems, because it limits an understanding of the research question to one time and one place. However, it enables the researcher to use a variety of research methods to explore some of the more subtle messages of the situation under study³¹.

An important issue in research methodology is the design of the sample³². In this study, the sample was not so much designed as designated. Sunderland was the subject of the research not just because there were good reasons for studying it, but because certain officers happened to instigate a research project, and happened to appoint as a researcher a deputy hospital manager who took the idea of research seriously. As it happens, there were good reasons for studying Sunderland: as a unitary Local Authority with boundaries coterminous with those of the health authority, collaboration should have been easier than in other places with more complex geographical relationships, and certainly should have been easier to study; as a place that had

³¹ Martin Bulmer, *Social Science and Social Policy* (London: Allen & Unwin, 1986) pp. 190-194.

³² Sara Arber, "Designing Samples", in Nigel Gilbert, ed., *Researching Social Life* (London: Sage Publications, 1993) pp. 68-92.

already been the subject of a similar study some years before³³, it was possible to compare developments arising from the impact of new policy; as a deprived inner urban area, it could be argued that Sunderland was especially in need of inter-agency co-ordination, in order to deliver integrated health and social care that would go some way to meeting the multiplicity of need.

At another level of sampling was the choice of "case" to study. The projects which formed a part of the study were not selected by the researcher as a means to understanding collaboration. They were more or less independent projects which the researcher was asked to evaluate as part of her job because they were seen to be about developing primary care. The practices in which the projects took place were chosen not because they were typical of general practice in Sunderland, but because it was thought that the projects had a good chance of working there. The people who were interviewed were the people who happened to work in those practices. Out of all this happenstance, meaning evolved, by means of a naturalistic or grounded theory approach³⁴. Originally, I planned that my academic research should concentrate on the development of primary health care. As my range of skills was used more widely and my interests spread, I began to see the projects as belonging to a context, namely the development of community care policy following the NHS and Community Care Act, and that the inter-linking theme was collaboration. The only part of the study which I chose myself and which did not belong to the duties of my post was the study of

³³ B Hardy, A Turrell, A L Webb, G Wistow, *Collaboration and Cost-Effectiveness*, (Loughborough: Centre for Research in Social Policy, 1989).

³⁴ Guba and Lincoln, 1988, pp. 67-68.

joint planning processes.

A combination of several methods was chosen in order to provide different means of collecting evidence in order to paint as rich a picture as possible, and to validate the data collected³⁵. Both quantitative and qualitative methods were employed, and used together form a powerful tool for understanding the social world. Quantitative methods, in the form of government statistics and the statistical analysis of questionnaires, offer a structured picture of the subject in numeric terms that can be compared over time or with other subjects. However, they do not give reasons for the way things are or convey the feelings about the way things are. Qualitative methods can provide insights here. They were appropriate to this research, as the study concerned the construction of relationships between health and social services and within the primary health care team. As Lincoln says, "complex behaviour and social patterns ought to be investigated using inquiry models that allow for the display and consideration of complex interactions."³⁶

The methods of the first part of the study include the use of statistics such as census data, and comparative statistical data such as performance indicators, as well as information from the ground about the services available.

The account in the study of joint planning processes was produced in two stages. In the first phase, documentary evidence, such as the minutes of various meetings and

³⁵ *Ibid.*, p. 121.

³⁶ Yvonna S Lincoln, 1992, pp. 375-391 (p.378).

local policy documents, was used to produce a preliminary account of events, supported by a certain degree of participant observation. I had good access to all the documentary evidence in the Social Services Department, District Health Authority and Family Health Services Authority, including informal data, such as file notes, and some correspondence. The minutes were useful to establish dates of decisions and other developments, and the policy documents showed the ideas that were current at different stages of the process. They provided the formal, official tale, but, on the whole, despite some informal file notes, they lacked the human dimension of the story. There were occasions, however, when the documentary evidence told more than was intended, by betraying attitudes and values that the participants would probably have preferred to keep hidden. Triangulation was made possible because documents from different sources were used, and because other methods were also used to confirm the evidence³⁷.

In the second phase, interviews were used to validate and flesh out the account. Interviews were carried out with as many officers of the Health Authority and Local Authority who had been directly involved in the planning processes during the implementation of community care as were available or accessible. Most of the ten people interviewed were still party to the continuing development of community care policies, though one had retired, one had moved away from Sunderland to a very different post, and one had reverted to operational management. One officer from the Regional Health Authority was also interviewed. Interviews were also sought with another retired officer, who agreed at first, but then did not respond to approaches to

³⁷ Guba and Lincoln, 1988, p. 257.

set a date. I was never told the reason for the lack of response: I can only guess that the process was too threatening, too tiring, too demanding or just inconvenient.

The respondents were all given the preliminary account, drawn from written material and were asked to comment on it as part of the interview and correct any misperceptions as they saw it. This method helped to demonstrate openness on my part and helped to stimulate recollections. The process was also a way of validating the work. There was a danger that it could have unduly influenced responses, but I found that the respondents were comfortable about telling me where my account was not quite right. All those who took part were accustomed to reading and editing long documents.

The main purpose of the interviews was to recall events and attitudes to what was going on. For this reason, the most appropriate method for interviewing was the semi-structured approach³⁸. A list of questions was drawn up and used as a guide, leaving the researcher to ask additional questions or probe deeper as appropriate (see Appendix A). The questions were not appropriate for the RHA officer, and in this case, the interview was unstructured. Most of the interviews were face-to-face. One was carried out over the telephone, as the respondent had moved to Scotland. This was less successful for two reasons: firstly, because the respondent was no longer working with the issues and had to work harder to recall events and his own responses to them. This was also true of the respondent who had retired. Secondly, though structured

³⁸ Nigel Fielding, "Qualitative Interviewing", in Nigel Gilbert, ed., *Researching Social Life* (London: Sage Publications, 1993), pp. 135-153 (p. 136).

interviews can be conducted quite effectively over the telephone using the CATI method, as I experienced during the research when our household was part of the 1994 Labour Force Survey, the telephone limits participants to verbal communication and the non-verbal messages are lost. Semi-structured interviews work best face-to-face, where communication encompasses body language, especially eye-contact, and vocal sounds, as well as the environment in which the interview takes place.

The interviews were recorded on an office dictating machine, while I made a brief note of key issues during the interviews. Respondents were comfortable with this, and were free to inform me if they were giving me information for my own benefit which was not for quoting. The interviews were transcribed verbatim. They were used as a check to the account drawn from the documents and to provide the human dimension. Respondents added their own perspectives to the story. Some of these were individual and personal. They gave useful background information, but are not cited in the account. Some transcripts supplied insights that have been included in the text. Not all the questions used in the interviews were used in the thesis. For instance, one question asked about the importance of collaboration in planning for community care. All the respondents found it important - they would, wouldn't they - and the question did not elicit any useful information.

The rest of the case study is taken up with the evaluation of two projects. In practice, the Social Worker Attachment Project and the Direct Management Project were demonstration projects, set up as much to attract interest and commitment to these models as to measure their value. Suchman points out that demonstration projects

should have similar operating conditions to the circumstances in which they would work when implemented on a wider scale. However, most demonstration projects are set up in ideal conditions to show the possibility of such schemes rather than their feasibility³⁹, as indeed these were. Pilot studies, therefore, have an inherent tendency to overestimate the advantages of the project.

The evaluation of the Social Worker Attachment Project was what Bulmer calls an "after-only" study, an attempt to measure the effects of a policy after it has been introduced⁴⁰. This research design has its weaknesses: there is no control with which to make comparisons: the effect of the policy change is not monitored over time; it can be difficult to separate the effects of the policy innovation from artifacts. However, it was the only design possible in the circumstances, given that I came into post shortly after the attachment had begun. Bulmer argues that this research design is useful in throwing light on the delivery of services to clients.

Individual interviews were chosen for those directly involved with the project as personal views were required from them. The interviews were semi-structured, with freedom to allow the evaluator to pursue additional issues as appropriate (see Appendix A). They were conducted after the project had run for six months, and were held with the social worker, members of the practice (doctors, district nurse, health visitor, practice manager and receptionists), and some of the patients. Interviews were held with as many clients and carers as possible, once cases were closed. Cases were

³⁹ Suchman, 1967, p. 77.

⁴⁰ Bulmer, 1986, pp. 172-173.

excluded if the social worker had not seen the client but had acted as a liaison, where contact had been minimal, if clients were confused, or if the doctor thought an interview would be detrimental to the patient's condition. During the interviews with members of the practice, respondents were asked to discuss five cases referred to the social worker.

In addition, the Social Worker collected data about the clients on index cards, which afforded useful information about the clients (age, sex, whether receiving state benefits, tenure, size of household), the type of referrals and interventions made and resources employed. This data was collated manually. It was used to quantify information about the clients and the social worker's workload. The researcher also had free access to the practices and to meetings associated with the projects, and direct observation yielded much valuable information.

As part of the evaluation, case comparisons were undertaken in order to identify similarities and differences in the way cases were handled in different settings: in the practice, in hospital and in an area team. Senior representatives from each setting met together to compare twenty cases from six pre-selected categories. It was not possible to match clients exactly for age, sex and tenure, though they were matched by category. Cases were selected by the social workers. This exercise enabled us to compare the way the cases were handled in different settings, and offered some useful insights into the special contribution of social work in a practice setting.

In the Direct Management Project, there was an attempt to measure the impact of the

project on the dynamics of the PHCTs by comparing the responses to interviews at different stages of the project. It was, in Bulmer's terms, a "before-and-after" study⁴¹. Interviews were held with members of the three practices involved in the project in three stages. In the first round, which took place just as the project got underway, in April-May 1992, 39 members of practices were interviewed. This was a baseline by which the future shape of the PHCTs could be compared. In the second round, in autumn 1992, 22 members of practices were interviewed. Receptionists, included in the original interviews, were not interviewed at this stage, because of pressure of time and because they appeared to be less involved in the project. Practice managers were interviewed, however, and they reported any changes relating to their staff. In the third and final round, in spring 1993, interviews were carried out with 40 members of PHCTs. The interviews were semi-structured, though probably a little more structured than the interviews undertaken in the study of joint planning processes (see Appendix A).

The interviews included questionnaires to measure the impact of the changes on the teams (see Appendix A). Questions were included about the way the Primary Health Care Team functioned, using a system developed by Pearson⁴² based on work by Dyer⁴³. A range of five responses was possible to each of the nine questions. At one

⁴¹ Bulmer, 1986, p. 171.

⁴² P Pearson, "Evaluating teambuilding" in P Pearson and J Spencer, eds., *Promoting Teamwork in Primary Care: A Research Based Approach* (Edward Arnold, in press).

⁴³ W Dyer, *Teambuilding: Issues and Alternatives* (Reading, Mass.: Addison-Wesley, 1987) p. 123.

end of the scale was a statement which indicated a high level of teamwork and at the other a statement indicating a lack of it. The statements moved from negative to positive and from positive to negative in different questions, so that respondents could not give an automatic response. Responses to these questions were scored by allocating five points for each statement chosen at the positive end of the scale and one point for each statement at the negative end. The points were multiplied by the number of choices made at each of the five points in the scale and divided by the number of responses, thus giving an average for the team or other category by which respondents had been grouped. Average scores for each of the nine questions were added together to give a total score. The maximum possible score using this method is 45 and the minimum is nine.

Group interviews, or focus groups, were also used where individual responses were less important. They had the advantage of saving time, and the dynamic of the group, with ideas and feelings being bounced around a number of people, served to deepen the level of discussion. Stewart and Shamdasani describe this dynamic in terms of synergism, snowballing, stimulation, security and spontaneity⁴⁴. In other words, the interaction of individuals enables ideas to develop and grow, and expands the range of issues covered. The group can become a safe place where ideas and feelings can be expressed which would not necessarily be addressed in individual interviews, and also creates a setting in which less conventional responses can be made. The group interviews were held with groups of district nurses and health visitors who were not

⁴⁴ David W Stewart and Prem N Shamdasani, *Focus Groups: Theory and Practice* (Newbury Park: Sage Publications, 1990) p. 19.

involved in the project, and with nurse managers. These groups discussed their thoughts and feelings about the project. These interviews were not recorded. Brief notes were made during the sessions and were written up as soon as possible afterwards, while the memory was still fresh. This inevitably meant that some of the material was lost, though the key points provided useful data. In this study, this was probably not important, as the study concentrated on the experience of those participating in the project rather than those on the outside. In retrospect, it might have been more useful if the focus groups had talked about their own experiences of district nursing and health visiting rather than about the project, as this might have produced a useful comparator.

Observation was an important aspect of all three studies, both participant and non-participant observation. I was very much part of the world that I was studying. In the study of joint planning processes, I attended meetings and was involved in developing policies and processes. In the evaluation of social worker attachment, I attended PHCT meetings and spent time in the practice observing what was going on when I was present to conduct interviews. In the study on direct attachment of district nurses and health visitors, observation was based on (i) attendance at meetings with the practices when the project was being set up, (ii) the monthly meetings between the Sector Manager and the community nurses, (iii) PHCT meetings (iv) informal conversations with those involved. The ethnographic element of the research was valuable experience because it gave me an understanding about the culture of each environment, the people who worked there and their world-views. The subjects I interviewed were people I already knew, and who knew me; there was some trust between us, and some

internalised judgements which helped to validate the information yielded by the interviews. Guba and Lincoln summarise the advantages of observation as a method of inquiry in sociological research:

observation (particularly participant observation) maximizes the inquirer's ability to grasp motives, beliefs, concerns, interests, unconscious behaviours, customs, and the like; observation (particularly participant observation) allows the inquirer to see the world as his [*sic*] subjects see it, to live in their time frames, to capture the phenomenon in and on its own terms, and to grasp the culture in its own natural, ongoing environment; observation (particularly participant observation) provides the inquirer with access to the emotional reactions of the group introspectively - that is, in a real sense it permits the observer to use *himself* as a data source; and observation (particularly participant observation) allows the observer to build on tacit knowledge, both his own and that of members of the group.⁴⁵

However, there are also problems with the technique of observation. It is heavily dependent on the personal interpretation of the researcher, who may be influenced by the values of the culture under scrutiny. The reliability of the researcher is important here and is difficult to demonstrate. The issue of values is interesting. The aim of traditional, "scientific" sociological investigation was to be value-free. However, as Barnes points out, it is "unrealistic to expect social policy researchers to be 'value-free' and to have no interest in the exploration of how such values may best be applied in practice."⁴⁶

⁴⁵ Guba and Lincoln, 1988, p. 193.

⁴⁶ Marian Barnes, "Introducing new stakeholders - user and researcher interests in evaluative research", *Policy and Politics*, 21:1, 1993, pp. 47-58 (p. 50).

THE ROLE OF THE RESEARCHER/PARTICIPANT

The role of researcher/participant brought a number of advantages. Firstly, it gave ready access to information held by the District Health Authority, Family Health Services Authority, the Social Services Department, and some access to information from other departments within the Local Authority. This access was enabled by the structure of the Project, with representation on the Project Board by the DHA, FHSA and SSD, which meant that all these agencies had an interest in the success of the project.

Secondly, it gave me access to the subjects involved in the projects and helped to make me acceptable to them. This is not always the case: staff members can be suspicious of and resistant to evaluation by the organisation, and the evaluator can be regarded as an unwanted intruder. This was not my experience. This may have been because of cultural factors. Doctors, nurses and social workers are in general committed to science and to social science. It may also relate to the personal attributes of the researcher: I usually find that people do not find me threatening and that I can engender trust fairly easily.

Thirdly, it enabled me to understand the context from the inside. I came to the project from a background of operational management in a small hospital. The three environments in which I now had to work, community health services, primary health care services and social services were all unfamiliar, and I had to adjust to three separate cultures very quickly. However, because I was working from within these

environments, I was in a different position from a researcher looking in from the outside, and was able to pick up clues and signals about the cultures of the agencies from formal and informal interactions with individuals and groups that were happening all the time and were not necessarily directly related to the projects I was evaluating.

On the other hand, there are dangers inherent in the role of researcher/participant, of which I had to become aware. There is a risk, for instance, that the researcher/participant may be unduly influenced to produce the outcome desired by the organisation. In particular, there may be pressure for a project to succeed. People want their ideas to work, to be successful. The evaluator needs confidence to see and state the problems, and this only comes with experience. The first evaluation report, on social worker attachment, was unremittingly favourable; the second recognised unfavourable as well as successful factors.

There has, in the past, been a desire for objectivity on the part of the researcher, as a means of guaranteeing the reliability of the findings. In practice, objectivity is difficult to achieve, and, in any case, may not be an appropriate aim. Barnes argues that researchers are stakeholders in research about public services, along with those who commission the research and those who are part of the study. She points out that "those undertaking such work are not in the business solely to contribute to the sum of human knowledge, but because they want to play a part in the development of public services."⁴⁷ Barnes goes on to say that "their involvement in a particular evaluative project may be prompted by their interest in, and/or commitment to, values

⁴⁷ Barnes, 1993 (p. 49).

associated with the project or service being evaluated. It would be unrealistic to expect social policy researchers to be 'value free' and for them not to have an interest in the exploration of how such values may best be applied in practice". However, researchers do need to be aware of and be explicit about the view of life that they hold. This is the approach I have tried to take.

OTHER DIFFICULTIES OF THE RESEARCH

The research was also helped considerably by the support of the Project Board and the willing cooperation of those involved in the projects. However, it is important to explore the difficulties and limitations of doing research in the manner described. One problem has already been mentioned, namely the fact that the practices chosen for the projects were recognised as being "good" practices. This meant that the outcomes of the evaluations were more likely to be successful, and the results can be regarded as somewhat skewed. In this thesis, however, the material has been used in a different way. When these projects are used as case studies of collaborative activity between health and social services, different conclusions can be drawn, and the distortion built in to the evaluations is less significant.

Most of the problems occurred with the Social Worker Attachment project. The first problem encountered here was the lack of clarity among senior managers about the criteria of success. This arises from the lack of experience of senior managers in commissioning research and from the difficulties in agreeing criteria.

In the Direct Management Project, interviews were held at the beginning and end of the project, making it possible to make comparisons of the PHCT. This was not possible with the Social Worker Attachment, which had begun a few weeks before I came into post. It was, therefore, difficult to compare the social worker attachment with the way the practice had operated before the attachment. An attempt was made to use routinely collected management information about social services activity as an indicator of the relation of social work to practices with no social worker. However, there were a number of problems which, in the end, made this impossible. Firstly, social workers did not always record a client's GP. Secondly, GPs often asked a District Nurse or Health Visitor to make the referral to Social Services, and so the link with the GP would not necessarily be recorded. Thirdly, the management information system did not readily impart data about activity, and the data I requested arrived very late, was obviously flawed and had to be discarded. The Case Comparison exercise was used to try to overcome the lack of comparative information, and did provide some useful insights about the way similar cases were handled in different settings.

A further problem was the timescale for evaluation. The social worker attachment was originally planned to last six months, and the evaluation was undertaken at that point. Though the attachment had clearly had an impact on the practice and its patients, there are dangers of evaluating too early, because not all the effects may be apparent. On the one hand, benefits may take a long time to become apparent. This was the case with the Direct Management Project, where benefits were only beginning to be seen after twelve months. On the other hand, there was a risk that a "honeymoon" phase might mask some of the difficulties.

Another potential problem was the "Hawthorne effect"⁴⁸, that the process of being studied might itself produce a good outcome.

The use of the case study approach raises the issue of generalisability. How far can a study of Sunderland be applied to a wider area? To what extent can the experience of inter-agency working in one place be regarded as typical? In the end, we ask with Pontius Pilate, "what is truth?" Is this study merely true of Sunderland, or does it identify a more general truth? How reliable and how valid is this study? In traditional quantitative studies, the generalisability of research was measured in terms of its replicability. If the results could be reproduced, the research was regarded as reliable. Qualitative research does not work that way: the use of small samples, for instance, makes it difficult to apply the research to larger groups⁴⁹. Qualitative research has, in the past, revelled in its non-generalisability. This has been based on an understanding of human behaviour as conditioned by its context, so that laws of human behaviour which are context-free, or which apply to any setting, are just not possible⁵⁰.

Mays and Pope note that reliability in qualitative research demands the maintenance of meticulous records of interviews and observations and detailed documentation of the

⁴⁸ Hubert M Blalock and Ann B Blalock, *Methodology in Social Research* (New York: McGraw-Hill, 1968) p. 340.

⁴⁹ Jeanne Daly and Ian McDonald, "Introduction: the problem as we saw it", in Jeanne Daly, Ian McDonald, and Evan Willis, *Researching Health Care: Designs, Dilemmas, Disciplines* (London: Tavistock/Routledge, 1992) pp. 1-11, p. 10.

⁵⁰ Janet Ward Schofield, "Increasing the Generalizability of Qualitative Research", in Martyn Hammersley ed., *Social Research: Philosophy, Politics and Practice* (Milton Keynes: Open University Press, 1993) pp. 200-225 (p. 201).

process of analysis. Qualitative research tends to be stronger on validity than it is on reliability⁵¹.

Dingwall identifies three tests for validity in qualitative research. The first is the context in which the research takes place and the features shared with other environments. The second is the researcher's self-consciousness about the difficulties and contradictions which are part of the research. The third is the extent to which the various players being studied are treated even-handedly.⁵² Avis identifies three further tests. Firstly, research methods should be open to scrutiny. In the second place, the relationship between the evidence and concepts should be explicit. Thirdly, the research should make sense in relation to other studies in the field and theoretical concepts about the subject⁵³. The researcher also needs to be conscious about his/her own assumptions about the nature of reality, and how this will influence the research.

THE MEANING OF THE RESEARCH

Before I take leave of this discussion of the nature of this research and its methods, there is a need to explore the link between the projects studied within the Primary Care

⁵¹ Nicholas Mays and Catherine Pope, "Rigor and qualitative research", *British Medical Journal*, 311, 1995, pp. 109-112.

⁵² Robert Dingwall, "Don't mind him - he's from Barcelona': Qualitative methods in health studies", in Jeanne Daly, Ian McDonald and Evan Willis, *Researching Health Care: Designs, Dilemmas, Disciplines* (London: Tavistock/Routledge, 1992) pp. 161-175, p. 169-172.

⁵³ Mark Avis, "Valid arguments? A consideration of the concept of validity in establishing the credibility of research findings", *Journal of Advanced Nursing*, 22, 1995, pp. 1203-1209 (p. 1208).

Project, on which I was employed, and this thesis. A distinction has been made between research and evaluation. Part of the fieldwork for this thesis is based on two pieces of evaluative research. However, the evaluations are used in this thesis in a different way from their original purpose. In other words, a different application has been given to the fieldwork as described in this thesis from that which appeared in the evaluation reports. This has been achieved, firstly, by setting the projects in a wider context, namely, the development of community care policy and its implementation in Sunderland. Secondly, it was not sufficient for the purposes of this thesis to conclude with an assessment of how far this or that project was a successful way of delivering services to clients. It was necessary to go beyond that and adjudge the implications of the projects for the research question, which is about the nature of collaboration between health and social services. If I may mix my metaphors, this led to a curious and unexpected experience akin to standing in a hall of mirrors, in which I was, on occasion, observing myself as a player in the game. The next chapter is not so much about the game as the stadium - the political and organisation of community care reform - in which the game was played.

CHAPTER THREE

THE CONTEXT OF COMMUNITY CARE

INTRODUCTION

The setting for collaboration between the health and social services in the first half of the 1990s was extremely complex. Alongside the development and implementation of Community Care Policy, great changes were taking place in government approaches to policy and the public sector, and in the way that the statutory agencies, particularly the health service, were structured and managed. These changes made collaboration difficult, because agencies had to address internal reorganisation and adjust to new ways of working, but they also made collaboration all the more necessary. This chapter takes account of the political and organisational background and of how Community Care Policy was developed and implemented.

THE POLITICAL AND ORGANISATIONAL CONTEXT

The NHS and Community Care Act was the dish resulting from a recipe of

incompatible ingredients mixed and brought to the boil in a tense and combative kitchen as an unsatisfying stew of contradictory flavours. Gunn calls these various ingredients "Thatcherism's search for the 'Five Es' - economy, efficiency, excellence, enterprise and effectiveness".¹ These are the elements which created the environment for the NHS and Community Care Act 1990, and in which Community Care Policy was then implemented.

Firstly, however, it is necessary to take a step back and into the setting in which Thatcherite ideology took root in the health and social services: the changing pattern of demography, the failure of rational planning to deliver services that met needs in a controlled and cost-efficient way and the continuing economic crisis.

Long-term demographic changes were altering the population for whom policy was being made and to whom services were delivered. These included the burgeoning number of older citizens who were also living longer, the increasing divorce rate and the growing number of single parent families. All this meant greater demands on health care, social security and social care services.

The Governments of the 1970s promulgated planning systems in the health service and Local Authorities based on a "rational comprehensive" model. They were "rational" because of the assumption that planning decisions could be made objectively, and "comprehensive" because it was expected that every aspect of an

¹ Lewis Gunn, "Public Management: a third approach?", *Public Money and Management*, 1988, pp. 21-25 (p. 21).

issue could and would be taken into account.² An important feature of rational planning was the assumption that rationality implies coordination. As Challis and colleagues observe,

Coordination is above all the rationalist's technique for embracing the complexity and interrelatedness of social issues and problems, and there can be no doubt that at times rational planning has come to resemble the triumph of administrative technique over the craft of politics³.

Within the health service, the planning system operated within a "command-and-control" framework, characterised by the retention of the responsibility for decision making at national level, while operational management was delegated to the local level⁴. By the end of the 1970s, however, there was growing disillusionment with the capacity of these systems to deliver, because of the prescriptive nature of the planning system, the lack of clear objectives and the failure to evaluate outcomes.⁵ Norton and Rogers add,

Those who attempted to apply a rational need based model found

² T Rathwell, "Health Services Planning: Observations on the Relationship between Theory and Practice", in ed. M Clarke, *Planning and Analysis in Health Care Systems* (London: Pion Ltd., 1984) pp. 119-141 (p. 121).

³ Linda Challis, Susan Fuller, Melanie Henwood, Rudolf Klein, William Plowden, Adrian Webb, Peter Whittingham and Gerald Wistow, *Joint Approaches to Social Policy* (Cambridge University Press, 1988) p. 25.

⁴ Richard B Saltman and Casten von Otter, *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems* (Milton Keynes: Open University Press, 1992) p. 5.

⁵ *Ibid.* pp. 5-6.

themselves trying to operate a process largely alien to practical experience and subject to the problem of the basic lack of information about the type and amount of needs.⁶

However, the vision of coordination remained.

Small argues that the Conservative Party was influenced in the late 1970s by von Hayek who argued that the inevitable outcome of central economic planning was totalitarianism⁷. In other words, there was also a political rationale for abandoning the rational planning model. In 1980, the new Conservative Government called for a simplification of the health service planning system⁸, which led in due course to the 1982 reorganisation.

The Thatcher Government came to power in 1979, after years of economic depression precipitated by the oil crisis of the early 1970s. Economic problems included inflation, unemployment and overspending in the public sector. One aspect of the strategy for recovery was curb on over-spending in the public sector. Social Security and the health service, which both absorbed large proportions of central government expenditure and in which expenditure tended to increase rapidly, were key targets. The Government has consistently denied "cuts" in the NHS, but it has tried to control

⁶ Alan Norton and Steve Rogers, "The Health Service and Local Government Services", in ed., Gordon McLachlan, *Matters of Moment* (Oxford: Oxford University Press, 1981) pp. 109-152 (p. 141).

⁷ Neil Small, *Politics and Planning in the National Health Service* (Milton Keynes, Open University Press, 1989) p. 156.

⁸ DHSS, *Patients First*, 1980.

the rate of growth. Greater controls were placed on expenditure in the health service and social security, through mechanisms such as the Value for Money initiative, competitive tendering, "efficiency savings", the Audit Commission and the National Audit Office. Controls were also put on Local Authority spending through "rate-capping" and frequent changes to funding systems. As Rhodes shows, "the 'problem' was not local but central overspending. To cope with its own overspending, the centre sought to 'off-load to the periphery' to minimize the rise in public expenditure."⁹

Some of these mechanisms also put other conservative policies into operation. Flynn shows that competitive tendering for services introduced into the Local Authorities for building, road construction and maintenance, represented a market-oriented approach to public services.¹⁰ Opening-up these services to the private sector and the reduction of direct control over the labour force decreased the independence and autonomy of the Local Authorities and weakened the power and influence of the Trades Unions.

The Conservative government of the 1980s introduced radical changes based on "new right" ideologies. Flynn identifies the ideas that shaped the development of the public sector in this period: the exercise of individual choice through the operation of free markets; an assumption of inferiority, in quality and quantity, of production in the public sector to that of the private sector; and a growing distrust with the public sector

⁹ R A W Rhodes, *Beyond Westminster and Whitehall* (London: Unwin Hyman Ltd, 1988) p. 238.

¹⁰ Norman Flynn, *Public Sector Management* (Hemel Hempstead: Harvester Wheatsheaf, 1990) p. 47.

which was seen as wasteful, inefficient, and expansionary.¹¹

This ideology was based on a confidence in the power of markets. Markets made possible competition, which was seen as creating the conditions for cost-efficiency and quality. Where free markets were not possible, market-like mechanisms were introduced, such as the "internal market" of the NHS, and the "mixed economy" of social care. Market strategies included the separation of purchaser and provider functions, the introduction of contracts and competitive tendering and the stimulation of new providers in social care.

Hunter points out that for markets to succeed, there must be surplus capacity, which can be wasteful. Transaction costs are likely to be high. Market strategies would tend to divert attention from effectiveness of care and efficacy of treatment towards costs and processes¹². In practice, the markets for health and social care have been very much controlled in "recognition that we are dealing here with political as well as economic markets in which the costs of failure include political as well as financial embarrassment."¹³

The private sector was directly encouraged by the policies of the Conservative government. Private health insurance was encouraged. Restrictions were removed

¹¹ Flynn, 1990, pp. 10-13.

¹² Hunter, 1994, p. 17.

¹³ Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen, *Social Care in a Mixed Economy* (Buckingham: Open University Press, 1994) p. 143.

from private medical care. Though not deliberately designed to foster the private sector, the change of rules to support private residential care through social security payments had a marked impact on the increase of residential and nursing care homes in the private sector.

Another aspect of the "new right" strategy was the emphasis on the individual rather than the collective. This had a double impact: on the one hand, there was an emphasis on consumerism, on individual choice of goods and services rather than on assuming that the public would accept the services that the state deemed would be good for it. On the other hand, there was an emphasis on self-help and self-reliance rather than state control. For example, the introduction of charges for eyesight testing and dental checks emphasised individual responsibility for health. In social care, individuals were expected to make their own provision as far as possible, with state provision only for those who could not make alternative arrangements.

Although the Thatcher government adopted the New Right approach to policy, it did not do so in a thoroughgoing manner. Cutler and Waine show that the implementation of New Right policies was not consistent during the 1980s, and that, in particular, policy for the health and personal social services tended towards a watered down version of New Right ideals¹⁴. Even the introduction of market philosophies into the health service via the so-called "internal markets" and to the personal social services through the "mixed economy of care" could be seen to

¹⁴ Tony Cutler and Barbara Waine, *Managing the Welfare State* (Oxford: BERG Publishers Ltd, 1994) pp. 16-23, 133-135.

represent a failure to introduce "a fully-fledged competitive market in which consumer choice would be based . . . on that personal power to inflict economic pain on unsatisfactory producers which consumer payment alone can bring."¹⁵ Though the delivery of services was "marketised", they were funded from public finance as they had always been, and consumer preferences were represented by agents in the form of GPs, Health Authorities, care managers and the like.

Alongside the government's interest in markets was an assumption that the public sector had to take on the managerial and financial methods of the private sector and become more business-like. Pollitt quotes Michael Heseltine, from the time when he was Secretary of State for the Environment:

Efficient management is a key to the [national] revival ... And the management ethos must run right through our national life - private and public companies, civil service, nationalized industries, local government, the National Health Service.¹⁶

The virtues of managerialism were regarded by the Government as a truth held to be self-evident. Better management meant a more effective use of resources and better control over the performance of the business, in this case, the delivery of health care.

Managerialism embodied all of Gunn's 'Five Es'.

¹⁵ David G Green, *The NHS Reforms: Whatever Happened to Consumer Choice?* (IEA Health and Welfare Unit, 1990) pp. 1-13.

¹⁶ Christopher Pollitt, *Managerialism and the Public Services* (Oxford: Basil Blackwell, 1990) p. 3.

The first application of managerialist balm to the financial wounds of the health service was the management enquiry led by Roy Griffiths, managing director of Sainsburys. The report, which was driven by a concern to obtain the best value for money, found similarities between business management and the management of the health service:

We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important.¹⁷

The Griffiths reforms sought, first, to replace the administrative function with general management, which was accountable for its actions and results; and, second, to bring in managers from outside the health service. Clinicians were to be involved in management, including the management of budgets. Saltman and von Otter note that the Griffiths reforms met only with limited success, though they did help lay the foundation for later reforms¹⁸. The main problem with implementation was that the new wine was put into old wine-skins: that the private sector style managers were placed in a centralized command-and-control planning structure, which restricted their ability to act.

The introduction of business management techniques to the public sector has since been challenged. The "new public management" approach asserts that public

¹⁷ DHSS, "NHS Management Inquiry", DA (83) 38, October 1983.

¹⁸ Saltman and von Otter, 1992, pp. 25-26.

management differs from business management and therefore requires a different set of skills, methods and values. It argues that the success of business management in the public sector has been limited.

Harrow and Willcocks argue that "the differing organizational contexts of private and public services management demonstrates [sic] that efforts to close the gap between the managerial practices of the sectors is inappropriate at best, and at worst represents risk-taking on an extensive scale."¹⁹ The use of management techniques in the public sector, therefore, needs to take account of the different environment. Stewart and Ranson find that the public sector differs from the private sector in terms of its values, its relationship to customers who are also citizens, its public accountability and in its delicate balance between various pressures and dilemmas.²⁰ The distinctive character of the public sector lies in its focus on collective tasks and purposes, rather than the private sector's concern for the individual and personal.²¹ One element of this distinctiveness is the need for cooperative relationships between different agencies in order to achieve a collective purpose.²² In other words, collaboration. Cutler and Waine also criticise managerialism for putting more emphasis on the form of

¹⁹ Jenny Harrow and Leslie Willcocks, "Public Services Management: Activities, Initiatives and Limits to Learning", *Journal of Management Studies*, 27:3, 1990, pp. 281-304 (p. 300)

²⁰ John Stewart and Stewart Ranson, "Management in the Public Domain", *Public Money and Management*, 8, 1988, pp. 13-19.

²¹ Stewart Ranson and John Stewart, "Citizenship and Government: The Challenge for Management in the Public Domain", *Political Studies*, 37, 1989, pp. 5-24 (pp. 6-11).

²² Ranson and Stewart, 1989 (pp. 21-23).

management than on the activity to be managed²³ and for its dubious premise that professionals must be controlled at all costs²⁴.

Pollitt challenges the ideological nature of managerialism and its application to the NHS on four grounds: firstly, that it lacked internal coherence; secondly, that it could not operate realistically in the domain of public services; thirdly, it furthered the interests of particular groups at the expense of others; and finally, that the value systems it incorporated were not appropriate to the public services.²⁵

Another dimension of the managerial theme was the tension between the devolution of managerial power to the periphery, where services are delivered, and the growing control from the centre. Metcalfe and Richards explain the rationale behind the drive towards decentralization:

Decentralization of authority and responsibility is one of the most common prescriptions for improving efficiency and effectiveness in large organizations ... In the public sector, decentralization is generally prescribed as a means of liberating managerial potential shackled by bureaucratic restrictions.²⁶

The Griffiths Report, for instance, wanted responsibility to be "pushed as far down

²³ Cutler and Waine, 1994, p. 5.

²⁴ *Ibid.*, p. 148.

²⁵ Pollitt, 1990, pp. 111-146.

²⁶ Les Metcalfe and Sue Richards, *Improving Public Management* (London: Sage, 1990) p. 77.

the line as possible, i.e. to the point where action can be taken effectively." Hoggett identified two types of decentralisation²⁷. The first is "internal" decentralisation, in which management is devolved to units within the organisation. The decentralisation described by Griffiths is of this type. The other type is "external", in which functions are devolved to agencies outside the organisation (in other words, contracting out). Hoggett is enthusiastic about the trend towards decentralisation, which he regarded as a "qualitative change in techniques of operational control which are post-bureaucratic in character".²⁸ He was, perhaps, speaking too soon. Any decentralisation which took place in the NHS was balanced by increasing control from the centre. Similarly, Social Services Departments, obliged to adopt decentralising strategies by the NHS and Community Care Act, were subject at the same time to a barrage of directives about fulfilling their responsibilities under the Act. Metcalfe and Richards argue that the two movements are not necessarily opposed, but can be complementary, and that a balance between them is required.²⁹ Cutler and Waine, on the other hand, deny that decentralisation had any place in central/local relations, rather "it was centralisation with a limited degree of operational autonomy"³⁰

A factor which moderated Thatcherite policies in the NHS was its popularity with the public. Public opposition to reforms, particularly when they were seen to involve

²⁷ Paul Hoggett, "A New Management in the Public Sector?" *Policy and Politics*, 1991, 19:4, pp. 243-56 (p. 244).

²⁸ *Ibid.*, p. 255.

²⁹ Metcalfe and Richards, 1990, p. 79.

³⁰ Cutler and Waine, 1994, p. 135.

"cuts", was often mobilised by doctors and nurses from within the NHS. This contrasted with the rather cosy relationship between organisations representing medical interests and the Department of Health in the past³¹. Another theme, therefore, was the pincer movement to squeeze the professionals until the pips squeaked, a movement felt as much by lawyers, teachers and academics as by the medics. Flynn identifies some of the techniques used: the denigration of public sector professionals; the erosion of their relative pay, status and self-esteem; and financial stringency on non-pay essentials.³²

Community Care policy was legislated for by central government but implemented by local government and the NHS. It required local government to work closely with the health service for the policy to work. However, relations between central government and local government could hardly be described as collaborative, and were marked more by coercion and constraint. It is important to look at the relations between them, because they created the context in which the policy was expected to flourish.

The relationship between central government and local government is complex, and has been described as a "maze".³³ The complexity arises from the interdependence of central government and local authorities.³⁴ It is characterised by "mutual mistrust

³¹ Small, 1989, pp. 22-26.

³² Flynn, 1990, pp. 17-20.

³³ Rhodes, 1988, p. 4.

³⁴ R A W Rhodes, *The National World of Local Government* (London: Allen and Unwin, 1986) p. 16.

of central and local government ... fuelled and sustained by financial concerns"³⁵. Though central government has legislative power and control over resources, local government has local knowledge and expertise, legally defined powers and freedoms and control over employed personnel. Central government needs local government to implement its policies. However, central government, to a large extent, creates the framework within which local government operates. This framework includes the structure of local government. In 1986, the government abolished the Greater London Council and the metropolitan county councils, of which Tyne and Wear was one. In 1991 the government announced a review of Local Authority structures. Though Sunderland was not affected, neighbouring authorities in Cleveland and County Durham were subject to review. Central government also controlled the means of financing local government. In April 1990, the community charge, or "poll-tax", replaced the rating system, to be replaced in its turn in 1993 by the council tax. The framework also incorporated funding mechanisms. During the 1980s, central government increased its control over Local Authority spending.

Through its control of the framework in which local government operated, central government had a strong influence on the success or otherwise of the implementation of policy at local level. There was generally a failure to recognise that policies implemented in one sector could have an impact on the demand faced by another, for example, the promotion of the independent sector through financial policies to encourage private nursing and residential care homes had a major impact on hospital

³⁵ Gerald Wistow, quoted in *Community Care: Planning and Cooperation*, House of Commons Session 1989-90 Social Services Committee, Eighth Report, (London: HMSO, 1990) p. xviii, § 60.

provision. As well as creating the framework, central government developed the policies that local government then implemented. Another strategy in central/local relations was to give new responsibilities to local authorities without any increase in resources to assist the task, on the assumption that better management of existing resources would release the funding required. This tactic was used with responsibilities arising from the Mental Health Act 1983³⁶, the Children Act 1989 and the NHS and Community Care Act 1990. With the last, funding was transferred to the Local Authorities from the Department of Social Security, but this was to pay for residential care, or home care to help maintain someone at home. There was no new money to cover the administrative structures required to implement the policy or to take account of new needs arising from demographic change³⁷. By failing to support its policies with adequate resources, central government delegated the problems inherent in the policy to the local level, forcing Local Authorities to ration care³⁸.

Peter John argues that local government social services departments were comparatively free of central government control.³⁹ They were one of the last Local Authority functions to get the Thatcherite treatment. The NHS and Community Care

³⁶ Flynn, 1990, p. 47.

³⁷ For example, see evidence from Colin Smart in *Community Care: Planning and Cooperation* (1990) p. xxiii, § 84.

³⁸ Geoff Fimister and Michael Hill, "Delegating implementation problems: social security, housing and community care in Britain", in Michael Hill, ed., *New Agendas in the Study of the Policy Process* (London: Harvester Wheatsheaf, 1993) pp. 110-129 (p. 127).

³⁹ Peter John, *Recent Trends in Central-Local Government Relations* (Policy Studies Institute for the Joseph Rowntree Foundation, 1990) p. 54.

Act 1990 not only opened up the SSDs to greater intervention from the Centre, but introduced the market ideology into social care. SSDs had to separate the assessment of services from their delivery, and to commission services from the independent sector.

NHS REFORMS IN THE 1990S

The NHS and Community Care Act 1990 embodied the Thatcherite ideals of markets and managerialism. It was the product of three White Papers: *Promoting Better Health*, published in 1987, *Working for Patients* and *Caring for People*, both published in 1989. *Promoting Better Health* put forward the Government's proposals for primary health care services. *Working for Patients* set out a radical agenda for reforming the health service on market lines. *Caring for People* was the Government's response to Roy Griffiths' proposals on care in the community. A full discussion of *Caring for People* is offered later in this chapter, but before we turn to Community Care Policy itself, it is important to explore the impact of the other white papers on the NHS.

Promoting Better Health was the outcome of a major review of primary health care. Its stated objectives were to make services more responsive to the needs of the consumer, raise standards of care, promote health and prevent illness, give patients choice in obtaining primary care services, improve value for money and enable clearer priorities to be set for Family Practitioner Services in relation to the rest of the health

service⁴⁰. There is evidence of several of Gunn's five Es here.

*Working for Patients*⁴¹ was the outcome of the NHS Review announced by Mrs Thatcher in January 1988. It emerged from wide public debate about the funding of the NHS, coming to a crisis over the lack of funding for heart operations for children in a Birmingham hospital. In the end, as Butler says, "what had begun as a defensive reaction to public and professional concern about the underfunding of the NHS became eventually the springboard for radical change that had no direct concern with money at all."⁴² Timmins comments, "it was the review that nobody wanted ... it had been the most awful mistake"⁴³. At the heart of *Working for Patients* was the creation of a market for health services, in which District Health Authorities as "purchasers" were separated from "providers", the hospital and community health services. The provider units were enabled to become independent, self-governing trusts, with control over their own management structures, personnel and pay conditions, and engagement in the market. At the same time, large General Practices could opt to hold budgets to purchase drugs and certain diagnostic and hospital treatment services for their patients. This was regarded as the "wildcard" element of the reforms⁴⁴. Tombs

⁴⁰ *Promoting Better Health: the Government's Programme for Improving Primary Health Care*, CM 249 (London: HMSO, 1987)

⁴¹ Cmnd 555, *Working for Patients* (London: HMSO, 1989).

⁴² John Butler, *Patients, Policies and Politics: Before and After Working for Patients*, (Milton Keynes: Open University Press, 1992) p. 13.

⁴³ Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London: Fontana Press, 1996), p. 458.

⁴⁴ June Huntingdon, "Playing a wild card", *The Health Service Journal*, 25 April 1991, p. 20.

criticised the purchaser/provider split because it threatened both the internal integration of health and social care organisations and inter-agency coordination between them leading to a "scene more likely to resemble a collision course than one of cooperation and coordination within an acceptable and coherent plan"⁴⁵. Fundholding was also a potential barrier to collaboration because it directed the attention of GPs to the performance of the fund rather than to achieving good community care outcomes for patients through cooperation with other agencies and professionals. It also reinforced the social services stereotype of GPs being overly concerned with their incomes.

In order to support this "internal market", alterations were made to the command structures of the health service through the creation of a policy board at departmental level, and reforms of Regional Health Authorities, District Health Authorities and Family Practitioner Committees. Funding for services was channelled through the RHAs and DHAs, and was calculated according to the number of people living in a district rather than by the RAWP formula, weighted according to a number of factors, including the services already available in a district. A system was devised to take account of the cost of capital assets in treatment.

Other changes resulted from the *Working for Patients* element of the NHS and Community Care Act. Medical audit systems were introduced. The contracts of hospital consultants were transferred from Regional Health Authorities to District

⁴⁵ David Tombs, "Purchasing and providing: is the split viable?" in Isobel Allen, ed., *Health and Social Services: the new relationship* (Policy Studies Institute, 1991) pp. 16-24 (pp. 22-23).

Health Authorities or self-governing trusts, and the criteria for distinction awards were extended to include management skills. The oddest proposal, however, was to provide tax relief for private health insurance for people over the age of 59, a reform which sat outside the logical coherence of the rest of the package⁴⁶, and was there only at the Prime Minister's insistence⁴⁷.

Working for Patients generated a great deal of fire and heat in debate. It was bitterly opposed by organisations representing NHS professionals and by Trades Unions. The British Medical Association spent £3m in opposing the proposals⁴⁸. What was not in dispute was that something needed to be done about the NHS; rather, arguments concentrated on the degree to which the NHS was to be bent to fit Tory policies and the hidden agendas which were perceived to be lurking behind every clause. The White Paper did not, in fact, address the fundamental problems of the NHS. Butler comments that "Missing from the White Paper ... was any coherent analysis of the underlying problems producing the symptoms. ... *Working for Patients* was akin to a solution looking for a problem ... an ideology in search of an application."⁴⁹

Despite the fierce opposition, the government pressed on with the reforms, and the first self-governing trusts, or NHS Trusts, as they came to be known, came into being in April 1991, when the first general practices were also given their own budgets for

⁴⁶ Butler, 1992, pp. 41-42.

⁴⁷ Timmins, 1996, p. 463.

⁴⁸ Butler, 1992, pp. 59.

⁴⁹ *Ibid.*, pp. 47-48.

secondary care services.

Meanwhile, another development was taking place in primary health care. The new contract for general medical practitioners introduced in 1990 incorporated recommendations in *Promoting Better Health* with developments announced in *Working for Patients*. It made changes to the terms of service for GPs and altered the remuneration system. It also strengthened the contractual relationship between the general practitioner and the Family Practitioner Committee (FPC), which became the Family Health Services Authority (FHSA) and made it easier for patients to change their doctor. The terms of service were made more specific. Previously, a doctor could do more or less what he wanted to do. Now, he was required to be responsible for the care of patients at all times, undertake health promotion and disease prevention, be available for consultation for a minimum of 20 hours a week, make practice leaflets available to patients, and supply an annual report to the FPC.

The aim of the new payment system was to give better remuneration to those doctors who provided a high quality service. Capitation accounted for a larger proportion of income, up to 60% from 47%, with enhanced payments made for patients aged 75 and over, and for new patients. Target payments were introduced for immunisation and cervical cytology; payments for these services were only made once the doctor had immunised or screened a given percentage of the target population. Sessional fees were available to practices which held health promotion clinics. Payments were also made to GPs who carried out minor surgery, in the hope that this would reduce hospital waiting lists by removing minor cases. Payments for out of hours services

were made at two levels, with a higher fee going to GPs who made visits themselves rather than those using a deputising service. A new postgraduate education allowance was introduced, and an allowance to GPs who undertook the training of medical students.

The new Contract was universally unpopular with GPs as being "ill thought out, impractical, and likely to limit patient choice and reduce standards of care".⁵⁰ Some features of the Contract were welcomed, such as payments for child health surveillance, minor surgery, registering new patients, practising in a deprived area and reimbursement of computer costs. However, a number of elements were not supported by research: there was no evidence to show that screening the over-75s or offering health checks to patients who had not seen the GP in three years were effective. Indeed, the latter requirement was quietly dropped. The 1990 Contract created a lot more work for general practice⁵¹. GPs argued that they were more stressed as a result of the introduction of the Contract, were worried about the effect of the new arrangements on the relationship between doctor and patient and the increased paperwork and administration⁵². The new Contract was compared unfavourably with the previous contract,⁵³ the 1965 Family Doctor Charter, which

⁵⁰ John W Chisholm, "The 1990 contract: its history and content", *British Medical Journal*, 300, 1990, pp. 853-856 (p. 854).

⁵¹ David Hannay, Tim Usherwood, Maria Platts, "Workload of general practitioners before and after the new contract", *British Medical Journal*, 304, 1992, pp. 615-618.

⁵² Sybil Myerson, "The New Contract and Relationships in General Practice", *Journal of Management in Medicine*, 6:1, 1992, pp. 19-24 (pp. 20-2).

⁵³ Chisholm, 1990 (p. 853).

arose as a salve to the malaise within general practice at the time. In contrast, the 1990 Contract generated a great deal of unease within the service.

One important concern about the 1990 Contract was its impact on providing a general medical service in deprived areas like Sunderland. Tudor Hart and colleagues argued that the new contract

accelerates previous trends, promoting investment in high earning practices serving affluent areas, where care is easier, and discourages investment in practices whose earnings are lowest, whose patients are poorer and sicker, whose costs are higher, and whose clinical work is more difficult⁵⁴.

Like Tudor Hart, Jarman, talking about the NHS Review, was also concerned about subjecting health care to market forces, which could result in those with least need receiving the greatest number of services⁵⁵. As Tudor Hart says, "fed by the market, the inverse care law thrives"⁵⁶.

A further criticism of *Working for Patients* is that it failed to take account of the community care reforms proposed by *Caring for People*, and failed to provide a

⁵⁴ Julian Tudor Hart, Colin Thomas, Brian Gibbons, Catherine Edwards, Mary Hart, Janet Jones, Margaret Jones, Pam Walton, "Twenty five years of case finding and audit in a socially deprived community", *British Medical Journal*, 302 1991, pp. 1509-1513 (p. 1509).

⁵⁵ Brian Jarman, "General practice, the NHS review and social deprivation", *British Journal of General Practice*, 41, 1991, pp. 76-79.

⁵⁶ Tudor Hart, Thomas, Gibbons, Edwards, Hart, Jones, Jones, and Walton, 1991, pp. 1509-1513 (p. 1509).

coordinated approach to the development of hospital and community health services with community care⁵⁷. Indeed, the emphasis of *Working for Patients* was very much on acute hospital services and general medical services⁵⁸. Wistow argues that the failure to integrate the two strands of policy properly could lead to the disintegration of the community care reforms⁵⁹.

The reforms of the NHS in the early 1990s generated a great deal of activity in restructuring Health Authorities, developing the purchasing role of Health Authorities, and developing NHS Trusts and fundholding. Reorganisations did not just happen once; they could take place several times, as District Health Authorities started to merge to create bigger and managerially more cost-efficient districts, and as District Health Authorities began to develop joint management arrangements with Family Health Service Authorities. A concern with internal structures and processes meant that collaboration with Social Services Departments (SSDs) in developing community care was likely to be a low priority.

COMMUNITY CARE

Community Care Policy, therefore, was being implemented at a time of great turmoil in the health service. It was to create an almost equal amount of turbulence in the

⁵⁷ Butler, 1992, p. 68.

⁵⁸ Hunter, 1994, (pp. 13-14).

⁵⁹ Gerald Wistow, "Aspirations and realities: community care at the crossroads", *Health & Social Care in the Community*, 3:4, 1995, pp. 227-240 (pp. 228-229, 236).

social care sector.

"Community care" is a mother-and-apple-pie term which summons up nice warm feelings and images. Policy-makers have tended to capitalize on this, but the cosiness of the term hides considerable difficulties. The meaning of community care is very difficult to unravel. Indeed, the House of Commons Social Services Committee noted that

the phrase "community care" means little in itself. It is a phrase used by some descriptively and others prescriptively: that is, by some as a shorthand way of describing certain specific services provided in certain ways and in certain places: by others as an ideal or principle in the light of which existing services are to be judged and new ones developed. It has in fact come to have such general reference as to be virtually meaningless. It has become a slogan, with all the weakness that that implies.⁶⁰

"Community" is usually understood as a spatial term, referring to a locality. However, the local geographical community may be completely different from the social community which surrounds a person. The word "community" has many meanings; 94 different sociological definitions have been identified⁶¹. The term "care" can also be understood in different ways. Bulmer refers to three levels of caring: general concern for someone, practical and psychological support which does not

⁶⁰ *Community Care with special reference to adult mentally ill and mentally handicapped people*, House of Commons, 2nd Report of the Social Services Committee Session 1984-85: volume 1, p. x, § 8.

⁶¹ G A Hillery, "Definitions of community: areas of agreement", *Rural Sociology*, 1955, 20:2, pp. 111-23, cited in Martin Bulmer, *The Social Basis of Community Care* (London: Allen & Unwin, 1987) p. 28.

involve physical contact, and what is now often called "personal care", defined by Bulmer as physical tending of an intimate kind⁶².

Community care policies flow from two sources: mental health services and personal social services. The former leads to an understanding of community care as the resettlement of long-stay patients into the community; the latter to the care of vulnerable people more generally. Bulmer identifies four ways in which "community care" is understood in policy terms: care provided outside institutions; care provided by professionals outside institutions (for instance, community nursing); care provided by voluntary organisations and informal carers; and care designed to maintain as normal a life as possible⁶³. Evandrou, Falkingham and Glennerster argue that there has been a change in the way the term has been understood by policy-makers, from a concept of care beyond hospital to care by the community⁶⁴.

Community Care Policy is a very wide ranging collection of welfare initiatives, involving health, social care, housing and social security, the care of different client groups, deinstitutionalisation, the development of services in the community and the matching of services with need. The following account is in two parts. The first gives a chronological account of the development of policy from 1986 to 1994,

⁶² Martin Bulmer, *The Social Basis of Community Care* (London: Allen & Unwin, 1987) p. 20-21.

⁶³ *Ibid.*, p. 12-13.

⁶⁴ Maria Evandrou, Jane Falkingham, Howard Glennerster, "The Personal Social Services: 'Everyone's Poor Relation but Nobody's Baby'" in John Hills, ed., *The State of Welfare* (Oxford: Clarendon Press, 1990) pp. 206-273 (pp. 212-213).

drawing out the theme of collaboration. The second explores the development of particular issues which are important to this study, namely, the production of Community Care Plans, defining the boundary between health and social care, the involvement of GPs and arrangements for coordinating hospital discharges.

COMMUNITY CARE: POLICY AND IMPLEMENTATION

There were elements of "community care" in health policies from the 1950s, including support for elderly people at home and the transfer of care from hospital to a community setting of people who have mental illness and learning disabilities⁶⁵, but the history of community care is "one of painfully slow progress towards timid goals" characterised by "the absence of clear policy and detailed planning"⁶⁶.

The watershed between the more recent history of community care and the past was the Audit Commission's report *Making a Reality of Community Care*, published at the end of 1986. It is of particular interest to this study, as Sunderland was one of the areas visited in the preparation of the report and received a draft version⁶⁷ three months before the final publication. This gave Sunderland an early insight into the changes taking place in the philosophy and development of community care.

⁶⁵ Alan Walker, "The meaning and social division of community care" in Alan Walker, ed., *Community Care: the Family, the State and Social Policy* (Oxford: Basil Blackwell and Martin Robertson, 1982) pp. 13-39 (pp. 14-15).

⁶⁶ *Ibid.*, p. 16.

⁶⁷ Called more prosaically "Community Care and Joint Planning" and dated September 1986.

The Audit Commission found serious grounds for concern about the lack of progress towards realising 'care in the community'. This could, it argued, only be addressed if fundamental problems were to be tackled, and this would require radical measures. It reported that progress was very slow in many areas. Targets for de-institutionalising care and for establishing services in the community for people with a mental handicap and those with a mental illness had not been met. In addition, there was considerable variation between authorities in the level and type of services available. For instance, Local Authority spending on adults with a mental handicap varied by a factor of six to one, and the number of residential home beds for older people by a factor of ten to one. Future prospects of moving towards community care were also poor. Community services were not being developed, particularly for the mentally ill.

The report goes on to show that shifting the balance of care to the community was inhibited by disincentives in the planning and financial infrastructure. Firstly, it was difficult to engineer a shift of services and resources within the systems for allocating finance to the agencies involved. Local Authorities which invested in new community services were penalised financially. Joint Finance was no longer adequate to "pump prime" new projects. Secondly, there was a lack of finance to bridge the gap between recouping the costs of running down long-stay institutions and setting up community services. Thirdly, residential homes were replacing long-stay hospital provision for older people, transferring the costs of care from the NHS to Supplementary Benefits. Benefits were more readily available, and at a higher amount, for residential rather than domiciliary care, which created a perverse incentive

towards residential care. Fourthly, community services were provided by a large number of organisations leading to considerable difficulties in planning and coordination. Fifthly, the report identified staff problems: shortages of certain occupations, problems of retraining staff in long-stay hospitals, and the lack of joint training.

The report called for radical solutions. In the September 1986 draft, one of the options put forward was to "redefine demarcation lines between agencies more precisely"⁶⁸, which was to dominate the early stages of planning for community care in Sunderland. This was dismissed in the final report: "there must be a doubt as to whether this is feasible or desirable"⁶⁹. Instead, the report recommended allocating responsibility for some client groups (people with a mental or physical handicap) to Local Authorities, for others (mentally ill) to the NHS and a jointly funded budget to purchase services for older people.

As a result of the Audit Commission report, the Secretary for State for Health, Norman Fowler, commissioned Roy Griffiths to carry out a review of community care policy. Sir Roy was asked to "review the way in which public funds are used to support community care policy and to advise me on the options for action that would improve the use of these funds as a contribution to more effective community care".⁷⁰

⁶⁸ Audit Commission Study Team, Draft Report, "Community Care and Joint Planning", September 1986, p. 80, § 199.iii (a).

⁶⁹ *Ibid.*, § 173 p. 75.

⁷⁰ Sir Roy Griffiths, *Community Care: Agenda for Action* (London: HMSO, 1988) p. iii, § 2.

By the time Griffiths reported in February 1988, the future of the NHS was under considerable debate. Mrs Thatcher had just announced the NHS Review, which would, as one official put it, "think the unthinkable" about the NHS⁷¹.

Griffith's response to the Audit Commission's call for a radical approach was to "spell out responsibilities, insist on performance and accountability and to evidence that action is being taken; and ... to match policy with appropriate resources and agreed timescales."⁷² He rejected the option of restructuring as being too disruptive. He recommended that there should be a government minister for community care, to take responsibility for providing direction, creating appropriate structures and monitoring success. Social services departments were to take the lead in arranging care in the community. They would be responsible for assessing the needs of individuals and organising their care, and for assessing the community care needs of the area and developing plans with other agencies for meeting them. Griffiths also proposed that SSDs would assess the needs of individuals for residential care. The responsibility for health authorities was the provision of health care services and should not extend beyond this remit. Griffiths expected GPs to inform SSDs of the social care needs of their patients.

The report was met initially by resounding silence from the Government. The

⁷¹ Michael Jones, "Why the Lady Turned", *Sunday Times*, 31 January 1988, p. A13.

⁷² Griffiths, 1988, § 20, p. vi.

emphasis in the Griffiths Report on the enabling role of the local authorities introduced the notion of the split between the commissioning and provision of services well before it became enshrined in the NHS Review⁷³. However, the proposal to give the lead to Local Authorities was "the most heretical solution possible"⁷⁴, because of the strong antipathy between central and local government which existed at the time. There was also concern about the ability of the Social Services Departments to respond to the challenges posed by Griffiths: acquiring new skills, responding to needs rather than to statutory responsibilities, introducing new systems, working with the private and voluntary sector.⁷⁵ Meanwhile, other groups were declaring an interest. The Royal College of General Practitioners felt that "team care through general practice should be the focal point for community care"⁷⁶.

A Government White Paper was eventually published in November 1989, but did not include all the elements of the Griffiths package. It was founded on the notion of "welfare pluralism" and the "internal market", but was marked by inherent tensions⁷⁷.

Caring for People outlined six key objectives:

⁷³ Timmin, 1996, pp. 474-475.

⁷⁴ Chris Heginbotham, "Blinkered approach has missed target", *The Health Service Journal*, vol. 98, no. 5093, 24 March 1988, p. 329.

⁷⁵ David J Hunter and Ken Judge, *Griffiths and Community Care: Meeting the Challenge*, (London: King's Fund Institute, 1988) Briefing Paper 5 (pp. 14-15).

⁷⁶ The Royal College of General Practitioners, "Summary Statement on 'Working for Patients' and related Documents", prepared by the Council at its meeting on 15th April 1989.

⁷⁷ Bob Hudson, "Social Policy and the New Right - the Strange Case of the Community Care White Paper", *Local Government Studies*, Nov/Dec 1990, pp. 15-34 (p. 32).

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.
- to ensure that service providers make practical support for carers a high priority.
- to make proper assessment of need and good case management the cornerstone of high quality care.
- to promote the development of a flourishing independent sector alongside good quality public services.
- to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- to secure better value for taxpayers' money by introducing a new funding structure for social care.⁷⁸

Achieving this would require seven major changes. Firstly, local authorities would take responsibility for social care, including the assessment of the needs of individuals, planning care and securing delivery of that care within the resources available. Secondly, they would produce plans for developing community care services. Thirdly, they would be expected to make maximum use of the independent sector. Fourthly, funding for residential and nursing home care would be transferred from the Department of Social Security to the Local Authorities, together with the responsibility for providing public support to those who needed it. Fifthly, Income

⁷⁸ DoH, *Caring for People: Community Care in the Next Decade and Beyond* (London: HMSO, 1989) § 1.11, p. 5.

Support and Housing Benefit would be made available to eligible applicants living at home or in independent residential or nursing homes. Sixthly, LA inspection and registration units would be separated from the direct provision of services and would be responsible for monitoring standards in LA care homes as well as those in the independent sector. Finally, there would be a specific grant to promote developments in social care for people with a serious mental illness.

Thus, *Caring for People* extended the requirement for collaboration between Local Authorities and Health Authorities to include service users and carers and the voluntary and private sector of service provision. With subsequent guidance, this requirement continued to be strengthened, making the dynamics of collaboration ever more complex, particularly for Social Services Departments, who now had to woo several organisations and parties at once. The introduction of competition was also a potential impediment to collaboration⁷⁹.

The need for co-ordination in assessment and the provision of services and collaboration between fieldworkers and agencies was a constant theme throughout the guidance. The following assertion in *Caring for People* is typical in exhorting collaboration without addressing the difficulties:

... it is essential that the caring services should work effectively together, each recognising and respecting the others' contribution and responsibilities. ... it will be essential for each of the relevant services

⁷⁹ DoH, *The Government's Plans for the Future of Community Care: The Government's reply to the third, fifth, sixth, seventh and eighth reports from the Social Services Committee*, Session 1989-90, § 14, pp. 30-31.

to keep in mind the interests and responsibilities of the other, to recognise that particularly at the working interface there is frequently much common purpose; to cross-refer cases when appropriate; and to seek and share advice and information when relevant. There is no room in community care for a narrow view of individuals' needs, nor of ways of meeting them.⁸⁰

There was an important shift, however, in the approach to collaboration, in that the focus moved away from joint planning machinery to an emphasis on the effective delivery of care⁸¹.

Caring for People created a new framework for collaboration by clarifying the roles of health and social services, allocating the responsibility for assessment and care management to social services, redefining joint planning in terms of outcomes rather than machinery, and by increasing financial incentives through mental illness specific grants and the transfer of funding from social security to social services⁸².

By the time *Caring for People* was published, the White Paper *Working for Patients* had also been produced. The effect of both documents was to change the scope of relations between health and social services radically. There will be further discussion of this in Chapter Five. *Caring for People* recognised the need for a new approach

⁸⁰ DoH, 1989a, § 2.20.

⁸¹ Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen, *Social Care in a Mixed Economy* (Buckingham: Open University Press, 1994), p. 4.

⁸² Gerald Wistow, "Community Care Futures: Inter-Agency Relationships - Stability or Continuing Care", in Michael Titterton, ed., *Caring for People in the Community* (London: Jessica Kingsley Publishers, 1994) pp. 24-41 (p. 25).

to collaboration between them.⁸³ It promised to simplify procedures for joint planning and look again at joint finance. The real emphasis, however, was on clarifying who did what, picking up Griffiths' theme of clear responsibilities and accountability, though how far it was successful has been questioned.⁸⁴

The White Paper on community care was followed by a report which set out the agenda of the groups working on the practical details of the policy.⁸⁵ The areas covered by the groups were case management and assessment, inspection and quality assurance, purchasing and budgeting development, community care planning, mental illness specific grants, training and complaints procedures.

The National Health Service and Community Care Act became law in April 1990, with the implementation of the community care element planned for April 1991, at the same time as the structural changes to the NHS. The Act required Local Authorities to prepare and publish a Community Care Plan annually, and to undertake to assess the needs of anyone who might require services. Both of these made it necessary for health and social services to work together. Collaboration was no longer an optional extra, but was essential for the implementation of community care. The Act also made provision of grants of money for services for people suffering from mental illness and transferred funding of nursing homes and residential care

⁸³ DoH, 1989, chapter 6, "Collaborative Working", pp. 49-52.

⁸⁴ Wistow, Knapp, Hardy and Allen, 1994, p. 23.

⁸⁵ Social Services Inspectorate, *Caring for People: Implementation Documents*, Department of Health, CI (90) 3, January 1990.

homes from the Department of Social Security to the Social Services Departments of Local Authorities⁸⁶.

The key features of community care policy were

- the separation of the commissioning of services from their provision,
- the involvement of service users and carers,
- changing the focus of Local Authorities from the delivery of services to meeting the needs of clients

In June 1990, the Secretary of State for Health, Kenneth Clarke, announced that the introduction of some aspects of community care might have to be delayed because local authorities were not ready to implement them.⁸⁷ In fact, the delay occurred because the local councils responsible for SSDs informed the government that without additional funding to set up the infrastructure, poll taxes would rise by around £15 per head. As the poll tax was already very unpopular, this was a considerable threat to the government. The delay was, therefore, political rather than organisational.⁸⁸ The political expediency went further: the government was faced with the difficulty of delivering two complex programmes - the NHS reforms and community care - at the same time. And one of them had to go, at least for a moment⁸⁹.

⁸⁶ *The National Health Service and Community Care Act 1990*, Part III, §§ 42-50.

⁸⁷ *The Times*, 23 June 1990, p. 4, column a.

⁸⁸ *The Times*, Thursday 12 July 1990, leader article, p. 15.

⁸⁹ Timmins, 1996, p. 477.

The mental health aspects of community care policy were implemented in 1991: the Mental Health Specific Grant (MISG) and the Care Programme Approach (CPA). In addition, changes were made in SSDs to develop the split between the purchasing and provision of services, inspection units were set up and complaints procedures instituted. 1992 saw the publication of the first round of Community Care Plans. The remaining reforms were implemented in 1993. These included the transfer of funding from the DSS to the Local Authority SSDs for new admissions to nursing and residential care homes, and the introduction of assessment and care management procedures.

It was several months before the Department of Health issued further guidance on the implementation of community care, but following the drought, the trickle developed into a great flood. The volume of policy and guidance issuing from the DoH and SSI was immense. In Sunderland, this was supplemented by additional guidance from the Northern RHA and later by the Community Care Support Force. The guidance documents established the key values and principles of community care. Districts were expected to develop the details for their areas. Some circulars served to keep districts on course and remind them of the matters they should be working on and the deadlines they were expected to achieve. Appendix B lists the guidance and other key documents on community care.

The very first policy guidance, published towards the end of 1990, emphasised that

"effective collaboration is the key to making a reality of community care".⁹⁰ This collaboration was seen as necessary at all stages of the process: in planning, assessment, care management, commissioning and service delivery. Emphasis was placed on joint plans for community care. The process of assessment should take account of all needs for care services, which required the involvement of other agencies. There should be clear systems for enabling this to take place.⁹¹ Local Authorities and Health Authorities should work jointly to commission new services.⁹² LA and HA inspection units should have a joint strategy and be prepared to work and train together.⁹³

Further guidance on Care Management and Assessment was published in June 1991 in three parts.⁹⁴ It advised Authorities to share values and training systems and to establish joint procedures for managing care. The Audit Commission declared its commitment to audit and monitor progress with community care, including mechanisms for joint working⁹⁵

⁹⁰ DoH, *Community Care in the Next Decade and Beyond: Policy Guidance* (London: HMSO, 1990) p. 4.

⁹¹ *Ibid.*, chapter 3.

⁹² *Ibid.*, chapter 4.

⁹³ *Ibid.*, chapter 5.

⁹⁴ DoH Social Services Inspectorate, Scottish Office Social Work Services Group, (a) *Care Management and Assessment: Summary of Practice Guidance*, (b) *Care Management and Assessment: Practitioners' Guide*, (c) *Care Management and Assessment: Managers' Guide* (London: HMSO, 1991).

⁹⁵ Audit Commission, 1992a, pp. 2, 39-43.

A letter in March 1992, which came to be known as the first Foster/Laming letter, identified the eight key tasks for the agencies for 1992/93⁹⁶. These were to ensure that systems were in place for undertaking assessment, for placing clients in residential and nursing homes, training staff, discharging patients effectively from hospital, purchasing and charging arrangements, and for informing the public, and ensuring that the financial and management infrastructure was in place. Authorities were also required to clarify the roles of GPs and primary health care teams. However, guidance on this matter was not published until the following year.

The NHS Management Executive established the Community Care Support Force in September 1992 to assist Local Authorities and Health Authorities to implement Community Care. One of its leaders from January 1993 was on secondment from the Northern Regional Health Authority. The Support Force produced documents and checklists and organised training events, giving particular attention to Authorities which were regarded as weak. What was interesting was that the NHS was taking the initiative in steering a policy which was designed to give Local Authorities and social care agencies the lead role.

A second Foster/Laming letter, published in September 1992 emphasised the need for "agreed strategies governing health and local authority responsibilities for placing people in nursing homes, and the numbers likely to be involved during 1993-4", and for agreements on "how hospital discharge arrangements will be integrated with

⁹⁶ Andrew Foster and Herbert Laming, *Implementing Caring for People*, Department of Health EL (92) 13 / CI (92) 10, 11 March 1992 (first Foster/Laming letter).

assessment arrangements"⁹⁷. These came to be known as the 31 December agreements. Shortly afterwards, a DoH memorandum made the payment of the Special Transitional Grant to Local Authorities conditional on evidence that such agreements had been made⁹⁸, thereby putting financial pressure on Authorities to comply with the timetable.

More guidance on assessment arrived in December. A recent court case had established that if a local authority identified a need in assessment, it was obliged to meet that need. This had raised considerable anxieties about whether LAs would be able to meet all needs assessed. The new guidance, stated that "authorities do not have a duty to assess on request, but only where they think that the person may be in need of services they provide"⁹⁹. This put a lot of emphasis on screening people for assessment. However, the Sunderland SSD took the policy that anyone who asked for an assessment would receive one.

In March 1993, shortly before full implementation of the community care reforms, another DoH letter identified the first priority for health and local authorities as the need to ensure that arrangements for assessments, securing care and managing budgets

⁹⁷ Andrew Foster and Herbert Laming, *Implementing Caring for People*, Department of Health EL (92) 65 / CI (92) 30, 25 September 1992 (second Foster/Laming letter).

⁹⁸ DoH, *Memorandum on the Financing of Community Care Arrangements after April 1993 and on Individual Choice of Residential Accommodation*, EL (92) 67, 2 October 1992.

⁹⁹ Herbert Laming, *Implementing Caring for People: Assessment*, Department of Health CI (92) 34, 14 December 1992.

were effective. In addition, the key tasks for the next year were the development of assessment and care management systems, involving users and carers in the planning and delivery of services, shifting the balance of resources towards non-residential care, further development of joint planning and commissioning, improving collaboration with the housing authority and developing relationships between purchasers and providers¹⁰⁰.

Another letter from the DoH reiterated the March letter, and said that "joint working between health and social services should be developed further, with an extension of joint training, and joint planning"¹⁰¹. It also laid out the monitoring programme for the next round of SSI/RHA evaluation.

The judgement on the first six months of the new community care arrangements was that they "had gone relatively smoothly, with fewer problems than some were predicting and few *causes celebres*"¹⁰². Involving GPs and other members of the Primary Health Care Team (PHCT), however, was "patchy"¹⁰³. The same circular emphasised that, though the process of implementing the arrangements had resulted in more joint working between SSDs and the NHS, there was a continuing need for

¹⁰⁰ Alan Langlands and Herbert Laming, *Implementing Caring for People*, Department of Health EL (93) 18/CI (93) 12, 15 March 1993.

¹⁰¹ Herbert Laming and Alan Langlands, *Community Care Implementation and Monitoring*, Department of Health EL (93) 48.

¹⁰² DoH, *Community Care*, EL (93) 119, 23 December 1993, enclosing "Community Care National Monitoring - September 1993, Summary of Findings".

¹⁰³ *Ibid.*, § 10.

collaboration and joint working¹⁰⁴.

Towards the end of the research period, the volume of guidance had slowed down to a mere trickle once more, concerned mainly with routine matters such as allocations of and conditions for the Special Transitional Grant and Mental Illness Specific Grant. By this time, the chief output from the Department of Health consisted of the reports on the monitoring exercise and special studies. If the volume of guidance and the number of DoH circulars were an indicator of the government's interest in community care, by March 1994, the end of the research period, the focus had shifted away from community care as such towards the needs of the severely mentally ill.

COLLABORATIVE ISSUES IN COMMUNITY CARE

This section examines four themes of community care policy which are particularly important for this study of collaboration between health and social services in Sunderland: Community Care Plans (CCPs), defining the boundary between health and social care, General Practitioners and Community Care and hospital discharge arrangements. It sets out the policy and guidance in these areas, and the findings of national studies where these had been undertaken.

Community Care Plans

¹⁰⁴ *Ibid.*, see § 9 of the circular and §§ A26 - A28 of the Annex - Priority Areas for Long-Term Development.

Section 46 of the NHS and Community Care Act 1990 required local authorities to make plans for the provision of community care services and to keep these under review. For the first round of CCPs, authorities were required to publish plans by 1 April 1992 and annually thereafter¹⁰⁵. They were, therefore, among the earlier visible signs of the community care provisions of the 1990 Act. Plans were to be based on a local assessment of needs, and include the policy on key operational areas, together with a strategy for quality assurance and a statement of available resources. The policy guidance gives a long list of items that should be included in CCPs¹⁰⁶.

In September 1991, a DoH circular reminded Local Authorities of their obligations to produce annual community care plans, and required them to produce the first plans by 1 April 1992. Wide consultation was expected in the preparation of these plans¹⁰⁷. The Northern Regional Health Authority had already issued local guidance recommending Health and Local Authorities produce plans jointly, asking them to consult the public at an early stage in the process, and advising on the content of plans¹⁰⁸.

The 1992/93 plans varied considerably in style and content and the process which

¹⁰⁵ DoH, *Secretary of State's Direction - Section 46 of the NHS and Community Care Act 1990: Community Care Plans*, Local Authority Circular LAC (91)16, September 1991.

¹⁰⁶ DoH, 1990a, chapter 2.

¹⁰⁷ DoH, 1991.

¹⁰⁸ Northern Regional Health Authority, "Community Care Planning: Information Pack and Guidance", July 1991.

produced them, and have been described as "position statements rather than strategic documents"¹⁰⁹.

The second Foster/Laming letter offered guidance on the second round of Community Care Plans, which should "reflect jointly agreed objectives and be fully compatible with agencies' other strategy documents and purchasing plans" and "demonstrate stronger co-operation with housing authorities"¹¹⁰.

Community Care Plans had to fulfil different functions in relation to three audiences: information for the public, a planning tool for the purchasers and providers of local services, and to provide the Department of Health with a means of monitoring developments locally¹¹¹. Whether one document could achieve all this was very doubtful. The problem for Sunderland, as for other Local Authorities, was deciding which of these functions to concentrate on.

In the first year, the requirement to collaborate comprised the need to produce plans jointly with the health authorities and to consult with housing agencies, voluntary organisations representing users and carers, and service providers. This was strengthened the following year, when local authorities were required to consult with representatives of the independent sector and to state what methods of consultation

¹⁰⁹ Gerald Wistow, Ian Leedham and Brian Hardy, *Community Care Plans: A preliminary analysis of a sample of English Community Care Plans*, Department of Health, (London: HMSO, 1993) p. 32.

¹¹⁰ DoH, *Implementing Caring for People*, EL (92) 65, p. 3 § 8.

¹¹¹ Wistow, Leedham and Hardy, 1993, p. 33.

have been used¹¹². More consultation took place in the second round of plans, though not all authorities complied with the new Directive on consulting with the private sector¹¹³.

Defining the Boundary between Health and Social Care

The boundary between health and social care is important for service users because it marks the line between services which are free and those for which a contribution may be required. It is important for the agencies, because it sets out the extent of their funding responsibilities. In practice, the boundary is very difficult to define, and is constantly shifting. There was a recognition in *Caring for People* that the line between health and social care was blurred, and that "health and local authorities will need to decide locally about how they share objectives, responsibilities and funding of different services and, where change is to be made, how it is to be achieved and over what timescale."¹¹⁴ In other words, the definition of the boundary was a matter of local negotiation, and not subject to national guidance. The boundary is particularly apparent in two areas: in the community, between home nursing and home care; and in institutional care, between hospitals and nursing homes. This latter is usually referred to as "continuing care".

¹¹² DoH, *Community Care Plans (Consultation) Directions 1993*, Local Authority Circular LAC(93)4, January 1993.

¹¹³ Brian Hardy, Gerald Wistow and Ian Leedham, *Monitoring and Development: Analysis of a Sample of English Community Care Plans 1993/94*, Department of Health (London: HMSO, November 1993) pp. 3-4.

¹¹⁴ DoH, 1989, p. 50.

The guidance on care management and assessment recognised the overlap between LA home care and HA auxiliary nursing care, and suggested that "the coherent delivery of care plans may be enhanced by the development of community care assistants who bridge both roles."¹¹⁵ However, it still did not explain how the agencies would agree responsibility for funding care at the boundaries. The Audit Commission commented that there was "little agreement" on the matter by 1992.¹¹⁶

Agreement on continuing care responsibilities was one of the "31 December agreements". The issue became a matter for public debate in 1994, after the end of the research period, when the Ombudsman publicly criticised Leeds Health Authority because a man had been discharged from free hospital care to a nursing home, where the family had to contribute. As he had continuing health care needs, the Ombudsman deemed that the Health Authority was still liable for his care¹¹⁷. The issue at stake was the point at which a patient's needs stopped being "health" and started to be "social". Two drafts of a circular reminding Health Authorities of their responsibilities for continuing care were circulated for comment before the final version was published¹¹⁸. However, the document still insisted that the boundary had to be agreed locally. This issue is discussed in Chapter Nine.

¹¹⁵ DoH Social Services Inspectorate, Scottish Office Social Work Services Group, (1991a) § 93, p. 23.

¹¹⁶ Audit Commission, 1992a, § 19, p. 10.

¹¹⁷ Health Service Commissioner, *Second Report for Session 1993-94: Failure to provide long term NHS care for a brain-damaged patient* (London: HMSO 1994).

¹¹⁸ DoH, 1995a, HSG (95) 8.

The boundary between hospital and nursing home was complicated by the transfer of the responsibility for funding nursing home care to the local authorities. This meant that they were paying for nursing care, which previously belonged almost entirely within the province of the NHS. Underlying the tension between health and social services, therefore, was a more fundamental debate about the nature of different models of care and the relationships between them: medicine, nursing and social care¹¹⁹.

General Practitioners and Community Care

The perception of the role of GPs in community care was watered down during this period. GPs had originally been assigned a key role, although how they would be incorporated into the process of community care was not explained¹²⁰. By late 1992, following a study commissioned by the Department of Health¹²¹, this was "important, but not central"¹²². There had been concern from GPs that their involvement in community care could compromise their role as patient's advocate¹²³, require them to work beyond the requirements of their contracts, and mean a great deal of extra

¹¹⁹ Wistow, 1995, pp. 235-236.

¹²⁰ DoH, 1990, p. 35 § 4.11-4.13.

¹²¹ DoH, *Implementing Caring for People: The Role of the GP and Primary Healthcare Team*, 1994a, p. ii.

¹²² Foster and Laming, 1992b, EL (92) 65, p. 4 § 12.

¹²³ Dr I G Bogle, Chairman of the General Medical Services Committee, Letter "What's Happening to Community Care?", British Medical Association, 2 July 1992, p. 2 § 3.

work¹²⁴. There was an expectation that the requirement in the 1990 GP Contract that GPs would undertake annual health checks of the over-75s could be linked to assessment procedures for community care¹²⁵. The Department of Health sent guidance to GPs in October, supported by a booklet produced by the British Medical Association, which took a reassuring tone about the implications for general practice¹²⁶. In early 1993, the BMA published a survey which found that a high proportion of GPs did not know about and had not been involved in arrangements for community care. Local Authorities found it very difficult to alert GPs to the changes¹²⁷. The fragmented nature of general practice lay behind these difficulties¹²⁸, as well as GPs' preoccupation with other matters, such as the new contract and GP fundholding. Within weeks of the survey, the Department of Health published a further booklet to try and engage GPs in the issues¹²⁹. On the eve of implementation, the DoH released to the press a copy of a letter from the Secretary of State to the Chairman of the GMSC recording "the progress made in helping family doctors

¹²⁴ Ian Leedham and Gerald Wistow, *Community Care and General Practitioners* (Leeds: Nuffield Institute for Health Service Studies, University of Leeds, 1992) Working Paper Number 6, p. 9.

¹²⁵ DoH, 1994, p. 8.

¹²⁶ General Medical Services Committee, *GPs and Community Care*, British Medical Association, October 1992.

¹²⁷ Barbara Miller, "Ignorance is bliss", *Health Service Journal*, 14 January 1993, p. 12.

¹²⁸ DoH, 1994, p. 16.

¹²⁹ DoH, *General Practitioners and "Caring for People"*, FHSL (93) 9, February 1992.

prepare to play their part in the new care assessment arrangements"¹³⁰. Following the implementation of community care, the issue of engaging GPs remained a problem.¹³¹ Hudson argued that five issues needed to be addressed if progress was to be made: the clash of cultures between GPs and social services, stretched resources within primary care, the tension between the role of advocate and the need to ration services, the additional burden on GP workload as a result of deinstitutionalisation, and the increasing number of private residential and nursing homes.¹³²

Hospital Discharge Arrangements

Although this thesis does not address the issue of arrangements for discharging from hospital specifically, it is considered here because it provides important background to planning community care and to collaboration at an operational level. Effective discharges from hospital require cooperation between health and social care practitioners and between different health care workers. Patients discharged from hospital are also an important source of referrals to district nurses.

In fact, discharge arrangements did not feature highly in the community care policy documents. In 1989, the Department of Health issued separate guidance on the

¹³⁰ DoH, *Virginia Bottomley outlines progress towards community care by GPs*, H93/677, 31 March 1993.

¹³¹ DoH, 1994b (p. 6).

¹³² Bob Hudson, "Breaks in the Chain", *Health Service Journal*, 21 April 1994, pp. 24-26.

discharge of patients from hospital¹³³, which was for the most part ignored. The release of the Special Transitional Grant was made subject to agreement between the health service and local authority over arrangements for discharging patients from hospital, thus making what had been a voluntary requirement mandatory. The issue gave rise to mutual distrust, with NHS Trusts afraid that instituting discharge procedures could lead to "bed-blocking", by keeping patients in hospital while support arrangements were put in place, and local authorities accusing the health service of cost shunting, as an ever increasing number of people were discharged to nursing homes¹³⁴. Underlying the dispute was the

tension between two competing notions of good practice. On the one hand, a perspective which is narrowly concerned with the most cost effective use of hospital resources (and hence with rapid through-put); and on the other one which emphasises the importance of needs-led assessments and choice for individuals.¹³⁵

A study of hospital discharge arrangements found that they were "in an evolutionary state"¹³⁶. The existence of agreements did not necessarily mean that they were workable and robust. This study indicates the tension between the drive to make cost-effective use of hospital resources and the requirement to assess the needs of individuals properly and enable them to make choices about future care.

¹³³ DoH, *Discharge of Patients from Hospital*, HC (89) 5, February 1989.

¹³⁴ Henri Giller and Norman Tutt, "Pass the Parcel", *Community Care*, 18-24 May 1995, p. 18.

¹³⁵ Melanie Henwood & Gerald Wistow, *Hospital Discharge and Community Care: Early Days* (Leeds: Nuffield Institute for Health, January 1994) p. 6.

¹³⁶ Henwood and Wistow, 1994, p. 5.



CONCLUSION

This chapter has given an account of the political philosophies prevailing during the 1980s and 1990s when community care policy was developed and implemented. It went on to describe the 1990 NHS Reforms and their impact on the NHS, and to set out the policy and guidance on community care. Two particular movements underpinned the development of community care: the drive towards increasing efficiency and cost-effectiveness on the one hand, and the consumer-oriented approach with its emphasis on user-centred services and increased choice on the other. There was a fundamental tension between these two ideologies¹³⁷, which would, in due course, affect relationships between the health service and social services.

The community care reforms emphasised the need for collaboration between health and social services, but also included other local authority services, and extended the notion of collaboration to include users, carers and voluntary organisations. Collaborative activity was, to some extent, built into the processes of local policy development and implementation and eligibility for funding. However, this did not address the fundamental problems in collaboration, which will be discussed in the next chapter.

¹³⁷ Wistow, 1995a, pp. 230-231.

CHAPTER FOUR

THE LITERATURE OF COLLABORATION:

CONCEPTS AND PRACTICE

INTRODUCTION

The purpose of this chapter is to review the literature on collaboration focussing particularly on health and welfare, in order to explore theoretical concepts of collaboration and studies of collaborative practice. It will try to reach an understanding about what collaboration is, how it works, and the circumstances which foster or hinder it and how it seems to relate to Sunderland. It will look at studies of collaboration at different levels: between health and social service agencies for the purpose of planning and coordinating services, and between professionals providing the services, looking specifically at relations between social workers and GPs, and among members of primary health care teams. Though most studies tend to tackle collaboration at one level, this thesis will consider how collaboration is understood at different levels, in order to bring out similarities and differences and to expand and deepen an understanding of how people from different organisations work (or fail to work) together. The findings of the studies considered

will be brought together into a model of factors which promote collaboration at different levels. This framework will then be used in the case study to measure collaboration.

WHAT IS COLLABORATION?

The concept of collaboration is difficult to define. Barritt finds that in practice the terms collaboration, coordination, integration and co-operation are used interchangeably¹. Booth distinguishes between two of these terms, saying that "coordination means working independently but in harmony; collaboration means working together"². Webb and Wistow define collaboration as "the pursuit of a coordinated course of action by two or more actors, usually through face-to-face interaction, by means of achieving consensus about a field of mutual interests and goals which are to be furthered by mutually acceptable means"³. Lee and Mills place collaboration at one end of a spectrum representing levels of involvement in health service planning. They say,

Collaboration implies that the organisations or groups in question have equal rights to be involved in the formulation of each other's goals and in their achievement where these are matters of mutual responsibility, concern and interest. In other words, collaboration implies shared decision-making by equal partners with overlapping

¹ Adrian Barritt, *Innovations in Community Care* (Family Policy Studies Centre, 1990) p. 12.

² Timothy A Booth, "Collaboration between the Health and Social Services", *Policy and Politics*, 1981, 9:1, pp. 23-49, p. 25.

³ Webb and Wistow, 1986, p. 155.

responsibilities.⁴

For Lee and Mills, the notion of equality is crucial, a theme to which we shall return. As we shall see, it is absent from the relationships between social workers and general medical practitioners and between primary health care workers, and is cited as one of the fundamental reasons for the failure of collaboration.

Davidson does not use the term collaboration, but sets out five types or levels of interorganisational relationship. Here, collaboration is probably equivalent to federation:

communication	talking together, sharing information.
cooperation	working together on small projects.
coordination	working together becomes more formalised, but still over limited and defined tasks.
federation	goals and tasks defined more precisely, supported by formal structures.
merger	organisations give up their individual identities and merge to form a new organisation ⁵ .

Most of these levels were present in relationships between different parts of the health and social services in Sunderland in 1990-1994. The relationship between the DHA and FHSA in 1992-1994 was one of a developing merger. Relationships between Sunderland Health Commission and the Social Services Department fell

⁴ Kenneth Lee and Anne Mills, *Policy-Making and Planning in the Health Sector* (London: Croom Helm, 1982) p. 129.

⁵ Davidson, 1976, pp. 119-121.

mostly within the coordination/federation types. In practice, relationships between agencies or between members and departments of different agencies will fall into various levels of any typology proposed, depending on who or which departments are involved or when collaboration is measured or what issue is at stake or what external pressures are exerted. Relationships are constantly in flux. At any time, a range of levels of collaboration may exist between and within organisations as complex as the health and social services, between different departments or individuals, over different projects, and at different levels of the organisation. In practice, "collaboration" does not describe a steady state as much of the literature implies, but must include a package of varying relationships. What is important is that the balance of relationships inclines towards the collaborative.

Challis and colleagues argue, in the context of a study of policy coordination, that at the local level, collaboration is needed to implement policy. They note that "the term 'collaboration' has warmer and more personal overtones than the term 'coordination', but in practice it did not imply too many cosy chats about mutual interests - it merely entailed some attempt to harmonise the actions of large organisations characterised by divergent interests"⁶. Collaboration is taken to be the "process of interaction in which two parties identify mutual interests and freely agree to work together towards a common goal"⁷.

⁶ Challis, Fuller, Henwood, Klein, Plowden, Webb, Whittingham, Wistow, 1988, p. 26.

⁷ *Ibid.*, p. 27.

The Challis definition of collaboration is already presenting some challenges for inter-agency coordination. Firstly, though the two parties, the Health Authority and the Local Authority, have a mutual interest in the provision of health and social care services in the community, the interests of both organisations are far wider than that. In the health service, investment in the acute sector is considerably greater and the political power of that sector has always been much stronger than investment in and the "clout" of the community health services. Though community care has become a larger part of the business of SSDs, it is still subservient to child care. Thus, though the agencies share some mutual interests, both have much wider concerns and more dominating goals. Secondly, working together for the development of community care was not so much "free" as enjoined. There is an issue about whether collaboration can exist if it is enforced. However, even where collaboration is required, agencies may choose to be wholehearted or reluctant in their response, so that an element of will and commitment is involved.

Collaboration can occur at different levels in organisations. Glennerster identifies four kinds of collaboration⁸:

Joint strategic planning

Developing strategies that will determine the approach in which policies are implemented; long-term time scale.

Joint operational planning

Planning the detail of how things will be done; more immediate time scale.

Cooperative service provision

The provision of services by one agency which takes account of the problems of services provided by another agency.

⁸ Howard Glennerster, *Planning for Priority Groups* (Oxford: Martin Robertson, 1983) p. 108.

The distinction between the middle two categories is blurred, and they can be grouped together under the heading "operational coordination". Three levels are used more commonly. Booth calls them strategic, operational and practitioner⁹, while Hunter and Wistow speak of joint planning, joint management and joint working¹⁰.

Which terms are used in the literature to describe the process of coming together depends to some extent on whether that which is coming together is policy, agencies or actors. Things are coordinated, people collaborate. When policies are brought together, they are coordinated. Agencies can either coordinate their activity or can collaborate. Actors are described as collaborating.

This thesis looks at how agencies and individuals work together across all three levels. The language used, therefore, is principally that of collaboration, though where authors have employed other terms, these are used.

⁹ Tim Booth, "Collaboration and the Social Division of Planning", in Joyce Lishman, ed., *Collaboration and Conflict: Working with Others* (Aberdeen: University of Aberdeen Department of Social Work, 1983) Research Highlights No. 7, pp.10-32 (p. 12).

¹⁰ David J Hunter and Gerald Wistow, *Elderly People's Integrated Care System (EPICS)* (Leeds, Nuffield Institute for Health Service Studies, 1990), pp. 9-13.

UNDERSTANDING COLLABORATION

The models of collaboration suggested in the literature can be assigned to one of two theories of human nature. The first, apparently cynical (or realistic!), approach perceives human nature and the organizations people belong to as self-centred, and assumes that people and organizations seek to meet their own needs and protect their own interests. Within this approach, there are several models with many variations, of which we shall examine a few. The chief ones are partisan mutual adjustment, the exchange model and the political economy model.

Lindblom argues that co-ordination in policy is achieved by "partisan mutual adjustment", in which "partisans", agencies which pursue their own interests, "mutually adjust" by adapting to decisions made by other agencies and themselves trying to influence other agencies by manipulation or negotiation, usually on an informal basis¹¹. Partisan mutual adjustment is the non-interventionist, *laissez faire* approach to policy co-ordination and collaboration. In other words, co-ordination will happen anyway, without effort, simply because it is convenient. Harrison and Tether argue that it is not a good way of developing policy, because it tends to defend the *status quo*, with slow and uncertain progress¹². The process of adaptation and informal influence is not a helpful way of understanding inter-agency

¹¹ Charles E Lindblom, *The Intelligence of Democracy* (London: Collier-Macmillan, 1965), pp. 9-16.

¹² Larry Harrison and Philip Tether, "The Co-ordination of UK Policy on Alcohol and Tobacco: The significance of organisational networks", *Policy and Politics*, 1987, 15:2, pp. 77-90 (pp. 81-83).

coordination in Sunderland in the early 1990s, when the health and social services were undergoing rapid change and were required by the government to work together to implement policy. Adaptation and influence take time, and the world was moving too fast. However, the converse proposition may be more helpful in our understanding, that collaboration fails when it is not convenient.

The exchange model describes interorganisational relations in terms of a system of exchanges between interdependent agencies. Exchanges include the referral of clients, as well as give and take in the form of labour, funds, equipment and information¹³. Exchanges take place so that each agency can fulfil its function (in this case, the provision of health care or the provision of social care) and acquire (or one might add, protect) resources. The nature of the exchange is influenced by the power an organisation holds¹⁴ with more powerful organisations benefitting most from the exchange. Organisations are more likely to interact by means of exchange if this is to their mutual advantage. However, even in situations where one organisation perceives a greater need to interact than another, exchange can still take place, especially if the agency with less need to interact perceives the other organisation as having compatible goals, as important to its own functioning, as having influence over its organisation, and as aggressively pursuing its interests¹⁵,

¹³ Sol Levine and Paul E White, "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships", *Administrative Science Quarterly*, 1960-61, 5, pp. 583-601 (p. 586).

¹⁴ Karen S Cook, "Exchange and Power in Networks of Interorganizational Relations", *Sociological Quarterly*, 1977, 18, pp. 62-82 (p. 66).

¹⁵ Stuart M Schmidt and Thomas A Kochan, "Interorganizational Relationships: Patterns and Motivations", *Administrative Science Quarterly*, June 1977, 22 pp. 220-

though the relationship between these agencies is likely to tend more towards bargaining and conflict than exchange. Policy makers, therefore, need to take account of the distribution of power between organisations as well as the problems of coordination, and may have to be more proactive in promoting coordination between organisations¹⁶ than if the balance of power is equal and the organisations perceive real benefits in working together.

The exchange model is helpful in developing an understanding of inter-organisational relations. Within the health and social services in Sunderland, exchanges may be said to occur when, say, a GP refers a patient to specialist hospital services; when the patient is discharged from hospital to the care of community health and social services, and when long-stay patients are discharged to the community from mental illness and learning disability hospitals with an accompanying transfer of resources from health to social services. However, there is perhaps more scope for the exchange system in the US, where welfare agencies compete for clients to obtain resources and are generally organised to provide a limited range of services. In Britain, the DHA and SSD are not competing directly for resources, and account for the bulk of health services and social services in an area. Exchange theory does, however, apply in that the way one body organises its services does have resource implications for the other agency. This was very much an issue in 1995, after the end of the period studied in this thesis, in the debate

233 (pp. 229-230).

¹⁶ *Ibid.*, p. 232.

about continuing health care¹⁷. In their study of voluntary and statutory collaboration, Leat, Smolka and Unell describe the relationship between the voluntary and statutory bodies as founded on a system of exchanges of finance, services and information¹⁸ and this is probably even more true after the NHS and Community Care Act stimulated the development of contracts between social services and the voluntary sector.

However, some writers insist that the exchange model only applies to voluntary activities, not where collaboration is mandated¹⁹, as in community care policy. Furthermore, though some interactions between the health and social services may be described in terms of exchange, particularly where routinised procedures (such as referrals) are concerned, the exchange model does not adequately describe the complexity of relations at either the strategic or practitioner levels.

The political economy model sees organisations as working in networks, within which they are constantly trying to build up their own resources, so that "interactions at the level of service delivery are ultimately dependent upon resource acquisition"²⁰, the chief resources being money and authority. Benson regards the

¹⁷ DoH, 1995a.

¹⁸ Diana Leat, Gerry Smolka and Judith Unell, *Voluntary and Statutory Collaboration: Rhetoric or Reality?* (London: Bedford Square Press|NCVO, 1981) p. 111.

¹⁹ Levine and White, 1960-61, pp. 588-589; Cook, 1977, p. 77.

²⁰ J Kenneth Benson, "The Interorganizational Network as a Political Economy", *Administrative Science Quarterly*, 1975, 20, pp. 229-249 (p. 231).

nature of the relationship between organisations as dependent, firstly, on the environment in which they operate, and secondly on the balance between four factors: agreement on the role and scope of the organisations; agreement on what the organisations are going to do and how they are going to do it; the regard in which the various organisations hold each other; and the way they collaborate and coordinate activities. Booth argues that this model does not represent relationships between the health and social services, where in some areas of care (older people, people with a mental illness, people with learning disabilities) there is little agreement about the role and scope of the organisations; where the organisations do not agree about how people will be treated and cared for; where professionals often have little regard for each other; and where the degree of coordination in the delivery of services is variable²¹.

Leach develops Benson's framework, applying it to inter-organisational relationships between planning authorities in Britain. He posits a hierarchy of organisational interests that may exist alongside the explicit goals of an organisation. These organisational interests are the "implicit, unstated aims of organisations which reflect the common interests of its members in terms of career prospects, status and power."²² He points out that they are tendencies and not absolute predictors of behaviour. At the most fundamental level of Leach's hierarchy of interests is the will to survive when the organisation is threatened (as we have seen in recent years

²¹ Booth, 1983, p. 19.

²² S N Leach, "'Organisational Interests' and Inter-organisational Behaviour in Town Planning", *Town Planning Review*, 1980, 51, pp. 286-299, p. 288.

in the response of certain London hospitals to the threat of closure). Where their existence is guaranteed, organisations will strive to protect their functions and resources. Where there is no threat to these, the organisation will tend towards growth, and are likely to seek autonomy, because this helps preserve stability by enabling them to control their relationships with other agencies. They will also tend to promote a positive public image.

<u>STATE OF THE ENVIRONMENT</u>	<u>RESPONSE OF THE ORGANISATION</u>
Under threat	Organisation fights for survival
Where survival is assured	Organisations protect existing functions and resources
Where there is no threat	Organisations seek sustained growth ²³

Leach illustrates his observations about autonomy by describing the tendency in planning departments at county and district level to become self-sufficient. This autonomy is about the creation of barriers. Within the health care services, health provider units have found greater autonomy by becoming NHS Trusts, and general medical practices are independent organisations which tend, as we shall see in Chapter Seven, to maintain their barriers, particularly towards social services. However, though autonomy may be more comfortable for the organisation, it may restrict the patient's access to services, if, for example, a hospital discharges a patient before necessary social care services have been put in place.

Booth identifies the key implications of these models for an understanding of

²³ *Ibid.*, pp. 280-292.

collaboration between health and social services:

- Organisations will only collaborate if it suits their goals, or the goals of individuals within the organisation.
- Organisations will not work together merely for the public good.
- The success of collaboration is dependent on the balance of incentives and constraints influencing the parties.
- Organisations will pursue their own interests in order to secure their own survival and the security of their members.
- Organisations tend to seek to maximise their autonomy and reduce their interdependency.
- Organisations need to agree their legitimate spheres of operation and authority; otherwise these will be a source of constant irritation and conflict²⁴.

Other models of collaboration are underpinned by an altruistic *weltanschauung* in which "the concept of caring is central to human motivation"²⁵. This might be regarded as the "naive position"²⁶, but is important because it establishes collaboration as a value to aspire to. This is a prescriptive model of collaboration, rather than a descriptive one.

²⁴ Booth, 1983, p. 22.

²⁵ Dee G Appley and Alvin E Winder, "An Evolving Definition of Collaboration and Some Implications for the World of Work", *The Journal of Applied Behavioral Science*, 1977, 13:3, pp. 279-290 (p. 284).

²⁶ See Booth, 1988, p. 44.

Kraus promotes a view of collaboration as "a cooperative venture based on shared power and authority. It is non-hierarchical in nature. It assumes power based on knowledge or expertise as opposed to power based on role or role functions. It utilizes Theory Y²⁷ assumptions about people."²⁸ Kraus is reacting against competition as the key value and way of operating in organisations. He proposes a long list of cultural and organisational values which are found in and honoured by collaborative organisations. Collaborative organisational structures are not hierarchical; structures and processes are built round the work to be done, rather than being made to fit in with pre-existing, given structures. In collaborative organisations, functions are not assumed to be of a higher or lower order (e.g. the work of the receptionist in general practice is perceived to be a lower order than that of the nurse which is subordinate to that of the doctor), but are seen as complementary and interdependent. This again reflects a notion of equality. Problems are not seen as threats, but as issues to be resolved.

Appley and Winder define collaboration as "a relational system in which: 1) individuals in a group share mutual aspirations and a common conceptual framework; 2) the interactions among individuals are characterized by "justice as

²⁷ Theory X and Theory Y are described by Donald McGregor in *The Human Side of Enterprise*, 1960, and summarised by Charles Handy in *Understanding Organisations*, 2nd ed. (Penguin Books, 1981) p. 29. Theory X proposes that the average worker is by nature lazy, gullible, self-centred, resists change, and needs to be led. Theory Y believes that where people are like this, they have been made so by their experience in organisations, but that by nature people can be motivated, want to develop, assume responsibility, and work for the good of the organization.

²⁸ William A Kraus, *Collaboration in Organizations: Alternatives to Hierarchy* (Human Sciences Press, 1980) p. 19.

fairness"; and 3) these aspirations and conceptualizations are characterized by each individual's *consciousness* of his/her motives toward the other; by *caring* or concern for the other; and by *commitment* to work with the other over time provided that this commitment is a matter of *choice*.²⁹

Kraus, Appley and Winder are all talking about collaboration within groups, intra-organisational rather than inter-organisational collaboration. This is important for the notion of teamwork explored in the Social Worker Attachment and the Direct Management Project, but is less helpful in understanding collaboration between organisations at the strategic level, or between individuals working in separate organisations.

At the organisational level, the "optimistic tradition" of inter-agency relationships is rooted in the whole notion of rational planning, with its assumption that within all organisations at all levels, the system can over-ride sectional interests and work towards the greater good of the client or community³⁰. In other words, organisational altruism. These assumptions underlie the whole machinery of collaboration that was set up in 1974 and the statutory obligation of joint planning through Joint Consultative Committees. Even though commitment to rational planning has evaporated, its effects are still felt, and Health Authorities and Local Authorities continue to consult jointly. Evidence of faith in collaboration is found

²⁹ Appley and Winder, 1977, p. 281. Italics as in text.

³⁰ Challis, Fuller, Henwood, Klein, Plowden, Webb, Whittingham, Wistow, 1988, p. 33.

in a stream of Department of Health circulars. "I want to see as close collaboration between health authorities and local government as possible", wrote Patrick Jenkins in the letter included in the handbook *Care in Action*³¹. Even when the planning system was revised and simplified, it was expected that mutually developed service plans and proposals for joint projects would be included in district strategies and annual programmes³². This collaboration included the independent and voluntary sectors, as well as the statutory agencies. Draft guidance issued in 1986 (but never formally ratified) declared that "the time is ripe for a new thrust towards genuine and close collaboration among all agencies caring for vulnerable people". It recognised that though "considerable progress has been made in many areas in developing joint planning and collaboration between health and local authorities ... there is still room for considerable improvement"³³.

There is, therefore, a range of models of collaboration which are distinguished by motive and purpose. These could be arranged as a spectrum of collaboration reflecting the different orders of motivation, and the model would have some validity, in that different individuals and different organisations do have different value systems and motivators. In truth, however, this model is not just about what makes people collaborate, but embodies an aspirational, almost ethical, reality and

³¹ DHSS, *Care in Action: Handbook of Policies and Priorities for the Health and Personal Social Services in England*, HC (81) 3, February 1981, p. ii.

³² DHSS, *Health Services Development: The NHS Planning System*, HC (82) 6, March 1982, Appendix A, § 5.2.

³³ DHSS, *Draft Guidance Circular on Joint Planning and Collaboration*, DA (86) 13, January 1986, § 2.

an observed reality. What Kraus and his colleagues are describing, and the exhortations by the DHSS are requiring, is an aspiration, "This is how we would like it to be", while Benson and others are saying, "This is how we see people and organizations behaving". Challis *et al* also take this approach. Their study is of policy coordination, but their findings also apply to collaboration at other levels. They note that "the notion of organisational altruism is unfounded as a generalised concept, but it is effective as a motivating agent - especially when combined with some element of single agency and individual benefit."³⁴ They propose a synthesis of these approaches, which they call the "planned bargaining" model, which "starts from the assumption ... that it is the proper role of governments to create a framework for strategic planning, in which coordination will have a part to play. But it further assumes ... that the implementation of such a strategy is problematic and liable to be distorted or frustrated by organisational self-interest, local bargaining and so on."³⁵ Within this model, coordination is not a self-evident good, as the costs to the parties involved may outweigh the benefits. Therefore, the framework of strategic planning should be designed to minimise costs and maximise benefits. This includes making funds available for coordinative activities, and ensuring that the structure does not give mixed messages at different levels of policy. Furthermore, the framework should include systems which recognise and reward coordination, and should help to develop an organisational culture in which coordination is valued. The structure itself will not engender coordination: that can only come from the

³⁴ Challis, Fuller, Henwood, Klein, Plowden, Webb, Whittingham and Wistow, 1988, p. 265.

³⁵ *Ibid.*, p. 272.

individual actors.

The costs identified by Challis *et al* include personal costs to individuals, such as the effort required, being seen to be involved in marginal rather than mainstream activity, threats to career development and the cost of playing the role of a supplicant asking for assistance. There are also costs to the agencies. Collaborative activity can require additional funding. Though resources are sometimes available, joint finance for instance, they are often short term or tapered, so that mainstream funding is required in the long term if the project is to continue. There are other costs of time and administrative effort to maintain the machinery of collaboration, possible loss of control or the need to compromise. Yet collaboration could bring benefits: personal benefits through building relationships and better understanding; institutional benefits through acquiring a reputation for being good at working together. It may be possible to achieve more by working together than by working separately, so that the whole is greater than the sum of the parts. Even though special funding schemes were a double-edged sword, they were a way of attracting extra funding into an area. There can also be opportunities spreading the cost and the responsibility for services between agencies. Challis and colleagues also found that though benefit to clients was never the only motivating force, there was a measure of altruism when the costs were not too great and there were other benefits.

McGrath sets out three prerequisites for effective collaboration: a framework for collaboration and accountability, commitment from participants, and the authority

of participants to implement collaborative decisions³⁶. The last insight is important: collaboration needs to take place at the appropriate level, between actors who are empowered to act. Where participants have to refer back to a higher authority, such as community nurses needing to check with nurse managers before they can undertake a new activity in the primary health care team, there is a built-in stumbling-block to collaboration.

Davidson proposes a framework of three sequential stages: the environment in which the organisations operate, the characteristics of the organisations themselves, and the structure and process for coordination³⁷. The first stage includes external factors like the level of turbulence, the economy, political pressures, legislation, funding, demography. The second is concerned with internal matters, like the organisation's resources and domain and the need to work with other organisations. The third stage, the "how" of collaboration, includes factors such as the structure and history of collaborative mechanisms, the behaviour of individuals, role conflict and leadership. The circumstances in one of these dimensions may favour collaboration, but in another may mitigate against it. One problem, of course, is these dimensions are never static, and circumstances which are favourable at one time may alter. The sequential nature of Davidson's framework does not allow for the real-world messiness of collaborative activity. Services need to be jointly planned and delivered even where some omens are not good. However, Davidson's framework

³⁶ Morag McGrath, "Inter-agency Collaboration in the All-Wales Strategy: Initial Comments on a Vanguard Area", *Social Policy and Administration*, 1988, 22:1, pp. 53-67 (p. 62).

³⁷ Davidson, 1976, pp. 122-135.

provides a way of drawing together the different perceptions of how collaboration works and what factors facilitate it and is used in this thesis as the basis of a framework for analysing the factors that promote collaboration (see p. 174). There is a fourth category. Many studies refer to the attitudes required of individuals when working together with people from different organisations, which are not accounted for in Davidson's framework. Furthermore, the framework will be adapted to look at collaboration at different levels of activity: strategic, operational and practitioner.

Van de Ven and Walker found that the kind of resources over which coordination takes place also makes a difference to the quality of the relationship. Coordination over client referrals was more personal and informal than coordination over financial transactions³⁸. Thus, there is likely to be something different about collaboration at the practitioner level from collaboration between strategic planners.

COLLABORATION BETWEEN HEALTH AND SOCIAL SERVICES :

DISCUSSION OF PRACTICE

The rest of this chapter will review the research into collaboration between the health and social services in Britain, taking account of studies at two different levels. In strategic planning, there are studies of joint planning between the agencies, and of the impact of joint finance on joint planning. This is usually discussed in terms of inter-agency coordination. In fieldwork, inter-professional

³⁸ Andrew H Van de Ven and Gordon Walker, "The Dynamics of Interorganizational Coordination", *Administrative Science Quarterly*, 1984, 29, pp. 598-621 (p. 618).

collaboration is usually perceived in terms of "teamwork". Though there are many strands to the literature on teamwork, this chapter will concentrate on the two related most closely to the fieldwork undertaken in this research: namely studies of collaboration between social workers and health professionals, and of collaboration among various kinds of (mainly health) practitioners in primary health care teams.

Inter-Agency Coordination

The government requirement that the health service plan jointly with the Local Authority was grounded in the concept of rational planning (see Chapter Three). In 1974, Joint Consultative Committees (JCCs) were made mandatory to facilitate collaboration over services of common concern³⁹. For the next dozen years, the joint planning system was developed and refined. Joint Care Planning Teams (JCPTs) for different client groups were established in 1977 and Joint Finance was made available to fund jointly agreed projects⁴⁰. Adjustments to the system resulted from reorganisation in the health service⁴¹. Membership of JCCs was extended to include representatives of voluntary organisations⁴² and Family Practitioner Committees⁴³.

³⁹ *National Health Service Reorganisation Act 1973*, § 10(1).

⁴⁰ DHSS, 1977, Appendices 1 and 2.

⁴¹ DHSS, *National Health Service Restructuring: Collaboration between the National Health Service and Local Government*, Circular HN (82) 9 / HN (FP) (82) 5 / LASSL (82) 3, February 1982.

⁴² DHSS, *Voluntary Organisation Representation on Joint Consultative Committees, and Extension of the Joint Finance Arrangements*, Circular HC (84) 9 / LAC (84) 8, March 1984.

The studies of inter-agency coordination are in marked contrast to the expectations that lie behind the planning guidance. The case studies of the 1980s demonstrate the failure of joint planning. Glennerster's study of Wandsworth and Hounslow showed that the planning process did not match the vision created by central government⁴⁴. Booth, in his study of Calderdale, comes to a similar conclusion, saying that "much of the collaboration that has taken place has been a lot more like liaison than planning"⁴⁵. Challis *et al* found that "systematic rational planning was poorly developed across localities, client groups and arenas" and "the degree and productiveness of interaction between agencies varied considerably"⁴⁶. They go on to say that they "found inter-agency arenas to be largely characterised by limited and conditional interaction rather than by frequent and free relationships; by attempts to resolve existing problems rather than to anticipate future ones; and by relatively small scale and isolated examples of 'ad-hocery' and opportunism rather than coherent and consistent implementation within some grand design."⁴⁷

There were several practical arrangements which hindered collaboration. The Report of the Working Group on Joint Planning cited lack of coterminosity between health

⁴³ DHSS, *Family Practitioner Committee Representation on Joint Consultative Committees and Consolidation of the Joint Consultative Committee Orders*, Circular HC(FP)(85)8 / HC(85)13 / LAC(85)9, March 1985.

⁴⁴ Glennerster, 1983.

⁴⁵ Booth, 1981, Part 1, p. 47.

⁴⁶ Challis, Fuller, Henwood, Klein, Plowden, Webb, Whittingham and Wistow, 1988, p. 207.

⁴⁷ *Ibid.*, p. 269.

and local authorities, uncertainty about resources, differences in the structures and financial systems, differences in the constitutions and decision-making processes, professional differences, territorial defensiveness⁴⁸. But the problems went deeper than these. The failure of joint planning to engender collaboration is due, at least in part, to the mistaken assumptions of government about how health and local authorities work. Underlying the rhetoric, the policy and the imposition of planning processes, are two assumptions: that health and local authorities would want to work together for the good of their clients, and that they would behave rationally to provide more effective services by working together⁴⁹. Simultaneously, there were a great many practical difficulties in the way of collaboration: health and local authorities have different organisational structures, different administrative and political cultures, different sources of finance, different planning cycles, different relationships with central government and different planning objectives. In addition, there was "the very powerful need to protect organisational interests, philosophies, priorities and a satisfactory professional self-image"⁵⁰.

Nocon identifies ignorance as one reason for the failure of joint planning and collaboration⁵¹. This ignorance is built into the system, because joint planning is usually a task which is bolted on to an agency's responsibilities and not an integral

⁴⁸ Working Group on Joint Planning, *Progress in Partnership* (London, DHSS, 1985) pp. 8-9.

⁴⁹ Booth, 1988, p. 44.

⁵⁰ Webb and Wistow, 1986, p. 158.

⁵¹ Andrew Nocon, "Forms of ignorance and their role in the joint planning process", *Social Policy and Administration*, 23:1, 1989, pp. 31-47.

part of them. Nocon identifies six types of ignorance that hinder joint planning:

Structural Ignorance	Failure to understand how the organisations work
Ideological Ignorance	Failure to understand value-systems, political structures, goals and means to achieving them
Professional Ignorance	Barriers between professional groups in different agencies and within agencies
Procedural Ignorance	Failure to understand how to get things done
Personal Ignorance	Nobody knows everything; some do not know what they should
Positional Ignorance	Ignorance as a stance adopted to achieve certain ends

I certainly experienced ignorance as a barrier to joint working, arising in part out of the failure of SSD officers to understand the nature of purchasing in the health service and the nature of control this gave the purchasers over the providers. Yet, I heard a health service manager at a workshop describe the purchaser/provider split in social services as "undeveloped", which indicated his ignorance, because he assumed that the complete separation of purchasing and provision found in the health service model was "correct" and the internal separation with social services was half-hearted. If ignorance inhibits joint planning, then a willingness to learn and better understanding should assist it, though characteristics such as trust, commitment, willingness to learn and better understanding cannot be systematised or mandated. If they are to flourish, they require a culture which values them.

Collaboration was not just a problem between local authorities and health authorities.

Hunter and Wistow cast doubts on whether there was coordination between the two

arms of the DHSS⁵².

Though the research demonstrates the failure of the joint planning process to allow collaboration between health and social services, and the failure of joint finance to facilitate joint planning, Wistow argues that the picture is not wholly bleak, and that there have been some gains, though they are more limited than the DHSS guidance intended and are concentrated on structures and processes rather than skills and tactics⁵³. Lee and Mills argue that "co-ordinating structures can at best provide a framework for collaboration, but they do not guarantee it"⁵⁴.

Joint Management

There have been very few studies of collaboration over the management of joint projects or coordination of services. Wistow and Brooks report that it is a particularly complex form of inter-agency coordination⁵⁵. By the time a project has come to be jointly managed, it has successfully been jointly planned, and will enshrine a set of collective objectives and formal agreements relating to unusual working arrangements with multi-agency accountability. The study by Wistow and

⁵² David J Hunter and Gerald Wistow, *Community Care in Britain: Variations on a Theme* (London: King Edward's Hospital Fund for London, 1987) p. 24.

⁵³ G Wistow, "Health and Local Authority Collaboration: Lessons and Prospects", in Gerald Wistow and Tessa Brooks, eds., *Joint Planning and Joint Management*, (London: Royal Institute of Public Administration, 1988), p. 22.

⁵⁴ Lee and Mills, 1982, p. 161.

⁵⁵ For example, see Wistow and Brooks, 1988, p. 24.

Brooks of five such projects finds that much success is due to "having the right people in the right place at the right time", but identifies four key imperatives. The first is clarity of purpose about the collective aims and objectives of the project, as well as an acknowledgement of the additional aims and objectives that agencies may have about the project. The second is about commitment to the project, as demonstrated by stable representation and from senior officers of all agencies involved, and ownership by all the agencies. The third factor is robust and coherent management arrangements, with clearly defined accounts of responsibility and accountability and policies about how the project will work and its relationship and reporting arrangements to the parent organisations. The fourth mark of successful projects is that the organisations are willing to learn from the project and have set up systems to monitor progress and are willing to report on and promote success⁵⁶.

In a study of an integrated care project in Leeds, Hunter and Wistow offer six guidelines for success and a warning⁵⁷. A collaborative project must exist for a reason, and not for its own sake. The agencies should be committed to working in this way and the project should be jointly owned by the organisations involved. There should be clear identification of responsibility and lines of accountability, and all the other elements of the service system should understand its role and how it fits in the whole pattern of service delivery. The individuals involved should have entrepreneurial and networking skills. The authors conclude by pointing out that "collaboration is not a panacea for problems whose origins lie in basic funding

⁵⁶ *Ibid.*, pp. 214-221.

⁵⁷ Hunter and Wistow, 1989, p. 16.

shortages or in systemic malfunctioning in the care infrastructure"⁵⁸.

The key messages of these studies is supported by the account of another project in Rothwell⁵⁹, which also recommended the earmarking of resources to create a common fund to support such projects.

Inter-Professional Collaboration (1): Social Workers in General Practice

The literature on collaboration between social workers and primary health care practitioners falls into four categories. The early literature is comprised mainly of studies of social worker attachments and analysis of how they work. These studies usually identified the importance and benefits of collaboration. After the honeymoon period, the literature began to address the problems of collaboration and the reasons why social workers and GPs found it hard to work together. As social work became more established as a profession, arguments against collaborating with general practitioners started to appear. Meanwhile, a parallel body of literature explored relationships between social workers and community nurses.

How attachments work

Ratoff identifies three types of collaboration between social workers and general

⁵⁸ *Ibid.*, p. 16.

⁵⁹ Ray Higgins, "Working together: lessons for collaboration between health and social services", *Health and Social Care*, 1995, 2, pp. 269-277 (pp. 274-275).

practitioners⁶⁰; Corney adds a fourth⁶¹.

- (i) In attachment schemes, social workers are based with the primary care team for at least part of the time and work with patients registered with the practice using a "medical social work" model⁶². Over time, these schemes can lead to the development of greater understanding between the actors about roles, responsibilities and constraints and appropriate referrals. However, a good relationship between a practice and a social worker does not necessarily mean better collaboration between the practice and social services in general.
- (ii) Liaison schemes are where a social worker attends a general practice regularly to collect referrals and discuss progress with clients. The social worker often passes on cases to colleagues, but acts as the contact with the practice. There are some favourable reports of this type of collaboration⁶³, but liaison schemes offer less opportunity for mutual education.
- (iii) Where primary health care teams and social service departments are accommodated in the same building without formal links, the relationship is

⁶⁰ Len Ratoff, "More social work for general practice?", *Journal of the Royal College of General Practitioners*, 1973, 23, pp. 736-742 (pp. 737-739).

⁶¹ Roslyn Corney, "Social Work in General Practice", in Joyce Lishman, ed., *Collaboration and Conflict: Working with Others* (University of Aberdeen Department of Social Work, 1983) Research Highlights No. 7, pp. 94-125 (p. 99).

⁶² *Ibid.*, p. 100.

⁶³ Brian McKinstry, "Successful liaison between the health team and social workers in Blackburn, West Lothian", *British Medical Journal*, 1987, 294, pp. 221-222; G N Marsh, *Effective Care in General Practice* (Oxford, Oxford University Press, 1991) p. 24.

described as "association". An example in Sunderland is the Galleries Health Centre in Washington.

- (iv) The "weakest" relationship is where social workers visit practices to provide information about services, with no discussion about referrals or clients. The Team Manager Link Scheme proposed in Sunderland was of this type (see Chapter Seven).

Research attention is centred on attachment and liaison schemes. The classic studies of social worker collaboration with general practice describe the early social worker attachment schemes. Forman and Fairbairn report on a project in Barnstaple which ran from 1963-1966⁶⁴, and Goldberg and Neill describe a social worker attachment project in Camden in the second half of the 1960s⁶⁵. Both studies report on the type of clients seen and the work undertaken, and relationships with the primary health care team.

Several benefits of attachment are reported:

- the special skills of the social worker in interviewing and understanding personal relationships become available to the practice⁶⁶.
- attachment provides a social work service that is more acceptable to clients

⁶⁴ JAS Forman and EM Fairbairn, *Social Casework in General Practice* (Oxford University Press, 1968).

⁶⁵ Goldberg and Neill, 1972.

⁶⁶ Madge Dongray, "Social work in general practice", *British Medical Journal*, 1958, ii, pp. 1220-1223 (p. 1220).

and less-stigmatising⁶⁷.

- the practice is able to address social and emotional needs as well as medical ones⁶⁸: what Evans and colleagues refer to mechanistically as "joint machinery for recovery"⁶⁹.
- attachment offers easy access to welfare services⁷⁰.
- it is a means of educating doctors and other members of the primary care team about social services⁷¹ and the social implications of illness.
- social work in general practice, like hospital social work, can provide a service to clients not usually referred to social services⁷²
- attachment provides the opportunity to address social and emotional problems⁷³, both those arising out of illness, and those which might lead to illness.
- it enables earlier intervention and more preventative work⁷⁴.

A number of studies emphasise the special skills that social work can bring to a

⁶⁷ L Ratoff, Barbara Pearson, "Social Case-work in General Practice: An Alternative Approach", *British Medical Journal*, 1970, ii, pp. 475-477 (p. 476).

⁶⁸ *Ibid.*, p. 477.

⁶⁹ J W Evans, T W I Lovel, K K Eaton, "Social Workers and General Practice", *British Medical Journal*, 1969, i, pp. 44-46 (p. 46).

⁷⁰ Ratoff and Pearson, 1970, p. 477.

⁷¹ Corney, 1983, p. 110.

⁷² *Ibid.*, p. 109.

⁷³ Dongray, 1958, p. 1220.

⁷⁴ Corney, 1983, p. 95.

practice, and their counselling skills in particular. Ratoff and colleagues noted in 1974 that "doctors have thus been to a large extent unaware of the functions and skills of social workers. ... General practitioners have tended to interpret the role of social workers in a limited way, mainly in the terms of the provision of financial and practical help. They appear to be largely unaware of the therapeutic skills which social workers see as a significant component of their role."⁷⁵ Thus social worker attachment was sold to GPs in the 1970s as an alternative therapeutic intervention, a means of improving the health of patients and not just their welfare: social work was framed in the medical model of intervention. This could create problems for GPs. Jeffrys and Sachs refer to the unease in one practice because of the absence of a clear distinction between the skills of the doctor and those of the social worker. For one doctor, "psycho-social counselling was one of the most rewarding aspects of his own work which he did not want to lose"⁷⁶. However, the NHS and Community Care Act challenged this perception of the therapeutic role of social workers in general practice by defining the role of social work in terms of assessment and care management.

Some writers offer advice on setting up attachments. Cooper suggests starting with practices who are already enthusiastic and committed, and others will become

⁷⁵ L Ratoff, Anne Rose, Carole Smith, "Social workers and general practitioners - some problems of working together", *Journal of the Royal College of General Practitioners*, 1974, 24, pp. 750-760 (pp. 755-756).

⁷⁶ Margot Jeffrys and HESSIE SACHS, *Rethinking General Practice* (London: Tavistock Publications, 1983) p. 139.

interested when they see the benefits⁷⁷. Corney advocates adequate preparation, and the establishment of clear goals and shared aims⁷⁸. She says that GPs and social workers should be selected carefully⁷⁹. Evans *et al* offer advice on teamwork, saying that "If the doctor is to be the leader of such a team he should qualify by his talents for leadership rather than by his possession of a medical degree."⁸⁰ Rushton and Davies advocate adequate preparation for schemes and discussion with all those involved, the commitment of the GP, the practice already works as a team, a self-reliant and adaptable social worker⁸¹. Goldberg and Neill identify the essence of good collaboration:

it was based on a concept of partnership, equality and respect for each other's expertise and functions, and this kind of professional respect extended to all the non-medical members of the team. The creation of a regular, well-organised channel of communication made it possible to discuss problems in an orderly fashion, to forge a common language and to clarify different approaches and perceptions as an on-going process. Mutual support in face of much uncertainty and of intractable problems led to a release of purposeful energy and to an atmosphere of greater hope which possibly communicated itself to the patients and their families. Frank discussion and fruitful interaction had a cohesive and anxiety-reducing effect, yet the group was never unduly introspective but always strongly oriented towards its purposes and towards the patients and the outside world.⁸²

⁷⁷ Brian Cooper, "Social work in general practice: the Derby scheme", *The Lancet*, 1971, i, pp. 539-542 (p. 542).

⁷⁸ Corney, 1988, p. 30.

⁷⁹ *Ibid.*, p. 120.

⁸⁰ Evans, Lovel, and Eaton, 1969, p. 45.

⁸¹ Andree Rushton and Penny Davies, *Social Work and Health Care* (London: Heinemann Education Books, 1984) p. 77.

⁸² Goldberg and Neill, 1972, p. 170.

These early studies invariably conclude that social worker attachment is a good thing and there should be more of it, though Goldberg and Neill call for more experiments⁸³. Twenty years later, social worker attachment is still seen as an experiment. A recent account reports the success of a project in Cardiff:

The project seems to be a model which can be successfully adopted within primary care ... the director of social services reported ... that the pilot had been a resounding success. ... We now look forward to the widespread implementation of this form of social work which, with the full secondment of health visitors and district nurses to primary care practices, will make the primary healthcare team a reality for the first time in the area.⁸⁴

Doctors are not always clear about their relations with social services. A study of general practice in Manchester in the early 1980s found that 30% of practices claimed to have an attached social worker, even though practice attachment was not the policy of the local Social Services Departments⁸⁵.

The problems of collaboration

In the 1970s, researchers began to acknowledge and explore the difficulties of inter-professional collaboration.

⁸³ *Ibid.*, p. 174.

⁸⁴ Ruddy, 1992, p. 24.

⁸⁵ David Wilkin, Lesley Hallam, Ralph Leavey and David Metcalfe, *Anatomy of Urban General Practice* (London: Tavistock Publications, 1987) p. 49.

Two studies of social workers' attitudes were carried out in the mid-1970s. The first showed that social workers found relations with GPs particularly difficult, because GPs often did not understand their roles, or saw them merely as providers of statutory services, or expected the social workers to carry out their requests without question. Examples of co-operative and understanding doctors were rare⁸⁶. In the second survey, the problems reported by social workers were generally practical, relating to accommodation, support services, lack of adequate preparation for the attachment/liaison or of communication systems: the study suggests solutions and guidance on setting up collaborative projects. Though some problems could be related to differences in culture between medicine and social work, such as different technical languages, incompatible models of practice, professionally unsatisfying referrals, there is no discussion of the implications⁸⁷.

Ratoff and colleagues examine the reasons for difficult relations between the two occupations. These include differences in training, knowledge and skill between the two occupational groups and the lack of understanding between them. Neither occupation understood the pressures the other faces. They comment that "social workers ... do not appreciate the pressures under which doctors work and the calls which they have upon their time and resources"⁸⁸. They work under different time

⁸⁶ DHSS, *Social Service Teams: The Practitioner's View*, 1978, HMSO, § 10.75-10.86.

⁸⁷ Iain C Gilchrist, Jean B Gough, Yvonne R Horsfall-Turner, Eileen M Ineson, Ged Keele, Barnard Marks, Heather J Scott, "Social work in general practice", *Journal of the Royal College of General Practitioners*, 1978, 28, pp. 675-686.

⁸⁸ Ratoff, Rose, and Smith, 1974, p. 756.

constraints, with doctors expecting immediate action and social workers requiring time to make a full assessment. Doctors are independent contractors, while social workers are members of a hierarchy. Ratoff and colleagues recommend shared undergraduate and postgraduate training, shared information and respect for the code of confidentiality⁸⁹.

Dingwall looks at relationships among three members of the Primary Care Team (GPs, health visitors and social workers) and identifies the difficulties in collaboration. For GPs, the problems arise out of their independent contractor status and their hospital training, which teaches them that doctors are supreme. The class and sex differences of members of the Primary Care Team also inhibit collaboration. In addition, Dingwall argues that there is an overlap between the provision of social and health care in the roles of Primary Care Team members which creates an unstable division of labour and can lead to inter-occupational rivalry. He concludes that "teamwork" is "a rhetorical device" which attempts to overcome these problems, and finds it hard to be optimistic about the future of the Primary Care Team.⁹⁰

Other difficulties are mentioned in the literature. There can be a conflict of interests between a social worker's need to work collaboratively and her responsibility to act

⁸⁹ *Ibid.*, pp. 759-760.

⁹⁰ Robert Dingwall, "Problems of Teamwork in Primary Care", in Anthony W Clare and Roslyn H Corney, eds., *Social Work and Primary Health Care* (London: Academic Press; 1982) pp. 81-113 (p. 99), and also in Susan Lonsdale, Adrian Webb and Thomas L Briggs, eds., *Teamwork in the personal social services and health care* (London: Croom Helm, 1980) pp. 111-137 (p. 133).

as an advocate for clients⁹¹. Doctors also report conflicts of interest, usually offered in terms of the issue of confidentiality but relating to the desire to protect the patient's interests in situations where the social worker may play the role of social police⁹². Professional isolation of the social worker can also be a problem. Huntingdon surveys the conceptual knowledge of social work and finds it muddled and confused. She says that the focus, knowledge and skills of social work need to be clarified if social work is to make a significant contribution to primary care⁹³.

The most important study of the problems of collaboration is Huntingdon's analysis of the social and cultural differences between social work and general medical practice⁹⁴. In terms of their occupational structures, social workers tend to be young, often unmarried and female. They are employees of bureaucratic organisations. Social work is a young occupation. Social workers earn about half the salary of the average GP. On the other hand, family doctors are usually older, usually married, men. They are usually self-employed. Medicine as an occupation has a long history, which is accustomed to exercising authority over patients and over other occupational groups. It commands high status and a high salary.

These structural differences between the two occupations contribute to cultural

⁹¹ Mailick and Ashley, 1981, p. 134.

⁹² McKinstry, 1987, p. 222.

⁹³ June Huntingdon, "The Proper Contributions of Social Workers in Health Practice", *Social Science and Medicine*, 1986, 22:11, pp. 1151-1160 (p. 1156).

⁹⁴ June Huntingdon, *Social Work and General Medical Practice: Collaboration or Conflict?* (London: George Allen & Unwin, 1981).

differences. Where general medical practice is clear about its mission, aims and tasks, social workers are unclear, because social work embraces a range of occupational groupings. The aims of general practice are to treat disease, cure the individual patient and save life. The GP needs to act quickly in emergencies. The social worker is concerned about the person, with prevention and with maintaining the quality of life, even if it involves risk. Her focus is on the group. She may use "holding" as a strategy. Medical knowledge has high status, is deemed to be "scientific" and research based, employing "hard" evidence. Social science is seen as "soft" knowledge, low on analysis, imprecise, and riddled with poorly thought out ideas. The doctor can play a virtuoso role, "saving lives". Huntingdon found that practice-based social workers might play this role by intervening in crises. The two occupations speak different languages, and may attach different meanings to the terms they have in common. They have different ways of seeing the world and their role in it. For the doctor, this means using a medical model, in which health is understood as the absence of disease. The social worker uses a social model, which is about the ability to function in society. A doctor's power rests in his profession; for the social worker, power is vested in the bureaucracy which employs her. Medicine enjoys higher status and prestige than social work.

The relationship between a doctor and patient is very different from that between a social worker and client. The doctor has a one-to-one relationship with the patient, with whom he is likely to have ongoing contact over many years. His income is derived from capitation fees, so that it is in his advantage to maintain his list. The doctor is authoritative and may direct the patient. The social worker represents her

agency, so that the relationship with the client is three-sided. Her salary is not dependent on the clients she sees. She has episodic contact with clients. She would usually play a non-directive role; her relationship with the client is based on an expectation of equality. Huntingdon says that the key to the differences between the two occupations is the doctor's legal responsibility for the patients on his list. When it comes to intra-occupational collaboration, doctors are not used to it and it does not always come easily to them. Teamwork is seen as optional⁹⁵. Social workers, on the other hand, are trained to it and are committed to it. Doctors expect to lead the team; they demand feedback, but are worse at giving it.

Huntingdon also found some similarities between the two cultures, and argues that the similarities are as important as the differences:

[in] their sensitivity to the type and status of their knowledge and to the status of their occupations themselves; in their vulnerability to recent and continuing identity crises with their accompanying threats to occupational cohesion, and to feelings of fatigue, depression and despair in the course of their work with patients and clients; and in the almost limitless nature of their missions.⁹⁶

She concludes that any increase in mutual understanding is dependent on structural alterations. The situation is changing and developing all the time. She endorses

⁹⁵ For instance, a survey of GPs in a London borough in the late 1960s found that a third of the doctors rejected the concept of teamwork. See R G Harwin, Brian Cooper, M R Eastwood, D P Goldberg, "Prospects for social work in general practice", *The Lancet*, 1970, ii, pp. 559-561. On the other hand, it would be difficult to fulfil the 1990 GP contract without an effective primary care team.

⁹⁶ Huntingdon, 1981, p. 174.

Kahn's prerequisites for collaboration:

- (1) insight into one's own occupational system;
- (2) effort to gain insight into systems with which we would collaborate;
- (3) clear definition of and agreement about reasons, bases and goals of collaboration.⁹⁷

Questioning Collaboration

Another stream of literature questions the relentless pursuit of inter-professional collaboration. Webb and Hobdell suggest that "the uncritical assumption that better teamwork means better coordination, which in turn means better service for the client, is a naive premise that we are very close to adopting in practice".⁹⁸ They argue that doctors, accustomed to working in hierarchical medical teams, expect to operate the same model of control in inter-professional teams. Modifying these patterns by training and planning may be too costly when set against the benefits. Webb and Hobdell ask if we should "forget the problems of coordination - with the exception of a few especially sensitive issues such as that of children at risk of physical harm - and concentrate on raising the professional standard of social work. The latter course could conceivably do more for collaboration between doctors and

⁹⁷ *Ibid.*, p. 182.

⁹⁸ Adrian L Webb and Martin Hobdell, "Coordination and Teamwork in the Health and Personal Social Services, in Susan Lonsdale, Adrian Webb and Thomas L Briggs, eds., *Teamwork in the Personal Social Services and Health Care* (London, Croom Helm, 1980) p. 108.

social workers than hastily improvised structures and procedures designed to induce the early birth of mutual professional accord and effective communication".⁹⁹

Bywaters argues strongly that social workers should not collaborate with GPs. He finds that the medical model of health is seriously flawed; medicine's impact on health is severely limited; medicine exerts power well beyond its usefulness, a power which devalues the contribution of other health workers, including social work. In this setting, social workers have difficulty in asserting their perceptions of health and the client, so that:

Social work finds itself at odds with medicine in its central belief in a respect for the client's self-knowledge and right to choice, and in its growing recognition of the value of mutual support and exchange. Medical expectations of patient passivity fit uneasily with social work objectives of a self-directed and empowered clientele."¹⁰⁰

While social work has sought "accommodation, compromise [and] influence within the individualistic medical paradigm" collaboration has failed to advance the cause of social work or the health of the population. This stance of "accommodation, compromise or influence" appears in those studies which promoted social work as a therapy, in a manner that would entice GPs, rather than as a means of assessing the needs of vulnerable people and coordinating services to meet their needs. This may have been due to the extension of the role of social work when the service

⁹⁹ *Ibid.*, p. 109.

¹⁰⁰ Paul Bywaters, "Social Work and the Medical Profession - Arguments Against Unconditional Collaboration", *British Journal of Social Work*, 1986, 16, pp. 661-677 (p. 670).

expanded. However, it appears that the social services accommodated themselves to a medical world view in order to extend their influence.

An important dimension in this disaffection with attachment is the struggle by social workers for equality. Some of the early writers speak in terms of the social worker as handmaiden¹⁰¹. Dingwall calls for equality, and is very pessimistic about collaboration because of the lack of equality in relationships¹⁰². This pessimism is justified if the following advice offered by the president of the Royal College of Psychiatrists on multidisciplinary mental health teams is typical:

Consultants are generally regarded as leaders of the multidisciplinary team because their comprehensive biological, psychological and social training in medicine and in psychiatry best fits them for this roles; other professional disciplines, medical referrers and patients will assume and prefer them to be in this roles; remuneration rates imply responsibility; they will be the responsible medical officer at law; and their specialist training in diagnosis and the range of treatment methods which they can prescribe equip them uniquely.¹⁰³

Admittedly, this refers to hospital consultants rather than general practitioners, but as noted earlier, hospitals are the training ground for GPs, and young doctors cannot fail to be influenced by such attitudes.

¹⁰¹ For instance, Dongray, 1958, who reports one of the benefits of attachment as "Help is available on the spot whenever the doctor is puzzled or disturbed by a particular problem ..." (p. 1222). And this was written by a social worker!

¹⁰² Dingwall, 1982, pp. 98-99.

¹⁰³ Andrew Sims and David Sims, "Top Teams", *Health Service Journal*, 24.6.1993, pp. 28-30 (p. 29).

Evans and colleagues call for a "coequal partnership"¹⁰⁴, but do not explain how they expect equality to function. Social workers themselves do not always behave as if they believe in equality. Rushton and Davies comment that "one of the hazards of collaboration in this setting is that the social worker can collude, through her deferential behaviour, with the GP's paternalism."¹⁰⁵ A study of contacts among social workers, general practitioners and community psychiatric nurses found that GPs work with others mainly by referring or delegating work, rather than by any more profound means of collaboration. Sheppard concludes that:

The refusal by GPs to initiate contact ... appears quite profound. It seems to provide others with two alternatives: either to collude with GPs assumption of leadership or to behave in ways which implicitly challenge it, but which reduce communication which may benefit the client.¹⁰⁶

Expecting equality in the near future in all the categories examined by Huntingdon would be naive. She comments that "it is doubtful that social work will ever have the status and prestige of medicine, and it will have to take this difference into account in its relationship with the occupation"¹⁰⁷. Abramson and Mizrahi suggest that social workers should promote their skills as a resource for doctors, rather than striving for egalitarian collaborative relationships, and that they should use the

¹⁰⁴ Evans, Lovel, and Eaton, 1969, p. 45.

¹⁰⁵ Rushton and Davies, 1984, p. 75.

¹⁰⁶ Sheppard, 1992, p. 435.

¹⁰⁷ Huntingdon, 1981, p. 107.

strategies of negotiation, bargaining and exchange¹⁰⁸. We are again faced with the issue of balancing what should be with what is actually possible.

Social workers and community nurses

Though most of the work in this area has concentrated on inter-professional collaboration between social workers and GPs, some studies look at the relationships with other staff groups. Relationships among social workers and two types of community nurses will be considered here: health visitors and district nurses. They are generally regarded as members of the primary care team and are likely to be important players when social workers are attached to primary care teams. All three groups are essentially female occupations struggling to establish a professional identity¹⁰⁹, but where nursing has gone along with its subordination to medicine for the sake of collaboration, social work and health visiting have been more likely to challenge it, albeit unsuccessfully. Nurses and social workers work in different ways. As Trevor Clay puts it,

Social workers are risk-takers with their clients, they peel off the cotton wool and help the client and themselves face the wound and the pain. Nurses operate in a different way, less confrontational, more healing. Nurses do for patients what patients would do for themselves if they were able. As one community nurse described it

¹⁰⁸ Julie Abramson, Terry Mizrahi, "Strategies for Enhancing Collaboration Between Social Workers and Physicians", *Social Work in Health Care*, 1986, 12:1, pp. 1-21 (pp. 17-18).

¹⁰⁹ Pamela Abbott and Claire Wallace, "Social Work and Nursing: A History", in Pamela Abbott and Claire Wallace, eds., *The Sociology of the Caring Professions* (London: The Falmer Press, 1990) pp. 10-28 (pp. 25-27).

to me recently, "Social workers would be prepared to say to the client, 'I can do no more'. The nurse continually says to herself, 'I must do even more'.¹¹⁰

There is considerable overlap between the roles of social workers and health visitors, estimated at 27.5% in one study¹¹¹. Williams and Clare reported that GPs have difficulty distinguishing between the work of health visitors and social workers.¹¹² Corney finds that collaboration between social worker and health visitor is important to save duplication of effort, for mutual support and to develop integrated care packages¹¹³. On the other hand, overlap can lead to conflict. Many accounts refer to difficult relationships between social workers and health visitors¹¹⁴. Child protection work is an area in which relationships can be particularly strained¹¹⁵. However, an account of a project in Brent in which health visitors worked in an multidisciplinary neighbourhood project with social workers found that collaboration was "a continuing, almost taken-for-granted process ... Sharing an office, workers

¹¹⁰ Trevor Clay, "The future for social work and nursing: A Royal College of Nursing view", *Social Work Today*, 16.3.1987, pp. 13-14 (p. 14).

¹¹¹ Forman and Fairbairn, quoted in Roslyn H Corney, "Health Visitors and Social Workers", in Anthony W Clare and Roslyn H Corney, *Social Work and Primary Health Care* (London, Academic Press, 1982) pp. 133-139 (p. 133).

¹¹² Paul Williams and Anthony Clare, "Social Workers in Primary Health Care: the General Practitioner's Viewpoint", in Anthony W Clare and Roslyn H Corney, eds., *Social Work and Primary Health Care* (London, Academic Press, 1982) pp.105-113 (pp. 111-112).

¹¹³ Corney, 1982, p. 133.

¹¹⁴ E.g. Nigel Bruce, *Teamwork for Preventive Care* (Chichester: Research Studies Press, John Wiley & Sons Ltd, 1980) pp. 87-93; Dingwall, 1982, pp. 91-94..

¹¹⁵ Steve Taylor and Nick Tilley, "Ironing out the Conflict", *Community Care*, 14.5.92, pp. 12-14.

continually up-dated one another about developments within families in joint care."¹¹⁶

There are even fewer studies of relationships between district nurses and social workers, though close working between them is most important for the delivery of coordinated care. Bassett describes an inter-professional team approach among district nursing, social work and domiciliary care in order to provide coordinated care and avoid duplication. The key to this approach was clarification of roles and responsibilities and regular meetings to agree packages of care for clients and obtain commitment to the delivery of care.¹¹⁷

At an operational management level, there is an issue about where the boundary of care lies between district nursing and social care, which is either the fuzzy grey area where their roles overlap or the gap between their roles. The issue which symbolises this is the matter of bathing, though making drinks, preparing snacks, collecting prescriptions, regulating heating and securing the home can also come under "extra care"¹¹⁸. Is the Social Services Department responsible for the provision of baths, or District Nursing? What is a health bath and what is a social bath? One SSD manager in Sunderland joked that a health bath has dettol in it.

¹¹⁶ Hessie Sachs, *A brave attempt: Teamwork between health visitors and social workers on an inner city estate* (London: King's Fund Centre, 1990) p. 109.

¹¹⁷ Peggy Bassett, "Team care at work", *Journal of District Nursing*, February 1989, pp. 4-6.

¹¹⁸ Helen Evers, Frances Badger, Elaine Cameron, Steve Arnold, Linda Evitts, "Taking extra care", *The Health Service Journal*, 4 July 1991, p. 27.

With the role of home helps expanding to take on personal care, the role of the District Nursing Auxiliary becomes less clear.

Inter-Professional Collaboration (2): Primary Health Care Teams

Inter-professional collaboration in primary health care is usually described in terms of teamwork. Gregson and colleagues argue that collaboration is not the same as teamworking. Collaboration implies that professionals work together, whereas a feature of teamworking is that its members share common goals. Teamworking involves collaboration, but is a wider concept¹¹⁹. However, the sharing of goals has already been identified as a mark of collaboration. Gilmore, Bruce and Hunt identify four characteristics of teamwork:

1. That the members of a team share a common purpose which binds them together and guides their actions.
2. That each member of the team has a clear understanding of his own functions, appreciates and understands the contribution of the other professions represented on the team and recognises commonness of interest and skill.
3. That the team does the practising by pooling knowledge, skills and resources and that all members share responsibility for the total outcome of their decisions.
4. That the effectiveness of the team is related both to its capabilities to carry out its work and its abilities to manage itself as an interdependent group of people.¹²⁰

¹¹⁹ Barbara A Gregson, Ann Cartlidge, John Bond, *Interprofessional Collaboration in Primary Health Care Organizations* (London: Royal College of General Practitioners, 1991) Occasional Paper 52, p. 2.

¹²⁰ Margaret Gilmore, Nigel Bruce and Maura Hunt, *The Work of the Nursing Team in General Practice* (London: Council for the Education and Training of Health Visitors, 1974) p. 6.

There are certain parallels between the cadre of literature on social workers and general practice and that on Primary Health Care Teams, and a certain amount of overlap between them. There are studies which explore one aspect or another of teamworking in primary health care or the relationship between general practitioners and nurses or other team members. Other pieces of work consider barriers to collaboration. Some explore the practical difficulties and ways of overcoming them. Other problems are more deep-rooted and much more difficult to address. However, these distinctions between the types of work are less rigid in the literature on primary health care teams, and fall less neatly into a chronological pattern. This is further complicated by the presence of the "handbook" type of literature, instructing doctors, nurses and others on how to do teamwork.

Gilmore, Bruce and Hunt define the primary health care team as "a group of people who made different contributions towards the achievement of common goals through participation in the planning of policies and the coordination of their efforts to implement them"¹²¹ Armitage speaks of "The exchange of information between individuals involved in the delivery of primary health care, which has the potential for action or joint working in the interests of a common purpose"¹²².

The Harding Report defined the primary health care team as

¹²¹ *Ibid.*, p.150.

¹²² P Armitage, "Joint working in primary health care", *Nursing Times Occasional Paper*, 79 (28), 1983, pp 75-8 (p. 75).

an interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service¹²³.

More than a decade later, the list of team members could be extended considerably to include practice nurses, practice managers, and all other health and social professionals who can cooperate in the provision of a community service to the patients registered with the GPs.

There are different ways of describing the typology of teams. Some writers¹²⁴ distinguish between the "core team" which shares the same accommodation, and the wider team, which includes those specialists who provide a service on an occasional or sessional basis, such as dietitians, physiotherapists, community psychiatric nurses, midwives, counsellors. This is a typology based on the organisation of the service. An alternative typology is centred on the client. Pritchard identifies three types of teams in primary care. Firstly, there are "intrinsic" teams, which are the teams around the patient, and include the patient, carer, GP, nurse and any other caring professionals involved in the case. These are "the basic unit of teamworking in general practice"¹²⁵. They are characterised by being flexible and responsive to

¹²³ Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee, *The Primary Health Care Team*, (DHSS, 1981) p. 2.

¹²⁴ E.g. Denis Pereira Gray, "The Primary Health Care Team" in Brian Jarman, ed., *Primary Care* (Oxford: Heinemann Medical, 1988) pp. 82-94 (p. 85).

¹²⁵ Peter Pritchard, *Manual of Primary Health Care* (1981) p. 49.

needs, task-oriented, patient-centred, and disperse when the task is completed. The second type of team is the functional team, which focuses on a particular project or function within primary care, like administration, home nursing, social care, or prevention and health education. Thirdly, there is the full team, which may never meet in some practices, and should only meet when the agenda is of interest to everyone.

Teamworking in Primary Care

The early studies of Primary Health Care Teams concentrated on structure. Jeffreys and Sachs examined the effect on two practices of moving into a Health Centre. They found that inter-professional collaboration improved in one practice and remained at the same level in the other¹²⁶. Marsh and Kaim-Caudle found a high degree of satisfaction among the patients of an active primary care team in which care was delegated to the member best able to provide it¹²⁷. Bowling, on the other hand, found doctors reluctant to delegate work to nurses because this threatened their independence and clinical freedom¹²⁸. However, this attitude is changing as a result of the 1990 GP Contract and the growing interest in prevention and the management

¹²⁶ Jeffreys and Sachs, 1983, p. 190.

¹²⁷ Marsh and Kaim-Caudle, *Team Care in General Practice* (London: Croom Helm, 1976).

¹²⁸ Ann Bowling, "Team work in primary health care", *Nursing Times*, 30 November 1983, pp. 56-59.

of chronic diseases in primary care.¹²⁹

The 1980s saw attempts to define measures of teamworking, or proxies for teamworking. Armitage defined five levels of collaboration¹³⁰:

1. Isolation	Agents who never meet, talk or write to one another.
2. Encounter	Agents who encounter or correspond with others but do not interact meaningfully.
3. Communication	Agents whose encounters or correspondence include the transference of information.
4. Collaboration between two agents	Agents who act on that information sympathetically; participate in matters of joint working; subscribe to the same general objectives others on a one to one basis in the same organisation.
5. Collaboration throughout the organisation	Organisations in which the work of all members is fully integrated.

This taxonomy of collaboration was used by a study in Newcastle which examined collaboration between pairs of primary health care professionals. From this they developed a tool for measuring inter-professional collaboration¹³¹, which was correlated with data about how the respondents worked and communicated. From this the study identified the significant factors in collaborative and non-collaborative pairings of GPs and district nurses and GPs and health visitors. Collaboration was higher where:

¹²⁹ See, for example, John Hasler, "The primary health care team: history and contractual forces", *British Medical Journal*, 1992, 305, pp. 232-234.

¹³⁰ Armitage, 1983, p. 76.

¹³¹ J Bond, A M Cartlidge, B A Gregson, P R Philips, F Bolam & K M Gill, *A study of interprofessional collaboration in primary health care organisations* (Newcastle: University of Newcastle upon Tyne, Health Care Research Unit, 1985) Report No. 27.

- community nurses (i.e. district nurses and health visitors) were attached to practices
- community nurses related only to one or two practices
- community nurses were accommodated in the same building as the practice
- community nurses were in the building at the same time as the doctors
- the professionals met by chance as well as at meetings
- members consulted one another and referred cases to each other
- members consulted each other's records
- community nurses wrote in practice records
- community nurses felt that the doctors understood their role
- there was a friendly, informal atmosphere
- reciprocal use of first names
- members commented on one another's role¹³²

Overcoming the barriers to working in teams

There is a great deal of discussion in the literature about the barriers to effective teamworking and ways of overcoming them. At one end of the spectrum, Mackichan offers what is very much a technical handbook on who does what. He insists that knowledge must be kept up-dated and says that members must get to know each other's skills and limitations. He advocates drive and commitment from the team members and good communication, which must not "be allowed to degenerate into superficialities"¹³³. He recognises that there are problems with team work, but hopes that "time will provide the answers"¹³⁴.

Time did generate a great many suggestions. Some were very directive, on the lines

¹³² *Ibid.*, vol 2, chapter 12, pp. 140-148. See also Gregson, Cartlidge and Bond, 1991, pp 17-26.

¹³³ N D Mackichan, *The GP and the Primary Health Care Team* (Pitman Medical, 1976) p. 329.

¹³⁴ *Ibid.*, p. 329.

of "if only you do such and such, good teamwork will emerge". The language is very much in terms of "should" and "ought". This approach was taken by several studies, which produced numerous recommendations, and led to further disappointments and counter suggestions.

Thus, in the 1960s and '70s there was a growing emphasis on the need to bring care workers together in the same location in order to promote efficient, effective and coordinated care. The drive towards group practice, the development of health centres and attachment schemes is indicative of this. The literature reflects this. Health workers are more likely to collaborate if they are based in the same building¹³⁵. Premises need to be suitable¹³⁶. Teams need space for offices and meetings. However, there was also recognition that "physical proximity was ... no guarantee of cooperation unless agencies were positively motivated to make use of it"¹³⁷. This is illustrated most graphically in Beales' account of health centres, and the impact they have on facilitating or, more often, hampering team work. He argued that "it does not always apply that because contact is easier, more contact occurs, but sometimes it does"¹³⁸, and concluded:

It has too often been taken for granted that simply putting as many

¹³⁵ John Ovretveit, *Cooperation in Primary Health Care* (Brunel Institute of Organisation and Social Studies, 1990) § 4.

¹³⁶ Gregson, Cartlidge and Bond, 1991, p. 25.

¹³⁷ Bruce, 1980, p. 70.

¹³⁸ J Gerald Beales, *Sick Health Centres and How to Make Them Better* (Pitman Medical Publishing Co., 1978) p. 69.

people as possible under the one roof would inevitably lead to more contact and communication amongst them; that there would, as a result, be more appreciation of each other's skills and role, more frequent and more speedy referral of patients, better feedback of information, less unnecessary replication. It has too often been taken for granted that health centres are inevitably good for the patient because they not only provide a variety of people to work for him, they ensure that those people will work *together* for him. But few health centres, in practice, have displayed a great deal of togetherness, and it is more usual to find individuals operating in as much isolation as they did before the centre was built.¹³⁹

Advice was offered about other practical issues. On access to records, some advocated the sharing of records¹⁴⁰, while others argued for mutual access to individual records¹⁴¹. Several writers recommend that team members should meet together regularly to share information about patients, pass on referrals, discuss problems, agree practice policy and protocols and learn about developments in clinical practice¹⁴². The selection of staff to be attached to practices is another issue discussed, and the ability of attached nurses and health visitors to choose which practices they work with.¹⁴³

¹³⁹ *Ibid.*, pp. 137-138.

¹⁴⁰ Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee, 1981, § 2.26, p. 20; Marsh, 1991, p. 23.

¹⁴¹ David N H Greig, *Team-work in General Practice* (Tunbridge Wells: Castle House Publications, 1988) pp. 59-60.

¹⁴² Marsh, 1991, p. 24; Rosemary Pratt, "Improving teamwork in general practice", *RCGP Connection*, December 1990, pp. 10-11; Leicestershire Family Practitioner Committee and Leicestershire Health Authority, *Study into the delivery of the primary health care services in Loughborough, Barrow-upon-Soar, Quorndon and Shepshed, Leicestershire*, 1988, recommendation 13.29, p. 75.

¹⁴³ Gilmore, Bruce, and Hunt, 1974, pp. 80 ff; Joint Working Group, 1981, § 3.10.

There is often an assumption that personalities, or the "People Factor" is a barrier to teamwork. Teams may not work well because members do not like one another or find they cannot work together. However, the Edwards Report points out that personal conflict may be manifestations of inter-professional or inter-organisational tensions¹⁴⁴. It might also arise out of tensions between class, gender or status divisions.

Another consideration is the interaction between different professional groups. Professional and status differences can interfere with collaboration. This is as true within the health service as between it and the social services. Professionalization is about the control of expert knowledge as it is applied to specialised tasks¹⁴⁵. This control gives power and status to the work group. Medicine is a long-established profession, whereas nursing and health visiting are regarded as semi-professions which traditionally serve and are subservient to the full profession of medicine¹⁴⁶. There is a gender dimension here: medicine is still predominantly a male occupation, while nursing, health visiting and social work are predominantly female. The semi-professions have become more professionalised in recent years by developing professional codes and raising entry and training requirements. Nursing, health visiting and social work are all moving towards degree-level entry. This increases

¹⁴⁴ DHSS, *Nursing in the Community: A Team Approach for Wales* (Edwards Report), 1987, para 9.9.

¹⁴⁵ Philip Elliott, *The Sociology of the Professions* (London: Macmillan Press, 1972) p. 11.

¹⁴⁶ Jeff Hearn, "Notes on Patriarchy, Professionalization and the Semi-Professions", *Sociology*, 1982, 16:2, pp. 184-202 (p. 192).

status and occupational advancement and the number of men entering these professions. If professionalization is patriarchal, as Hearn suggests¹⁴⁷, and characterised by "masculine" forms of behaviour such as authority and self-control, this is likely to lead to male domination of the professions. Increasing professionalization also makes the professions more exclusive, more autonomous, and is, therefore, divisive, defining marked boundaries around the sphere of knowledge and practice and creating a professional identity and perspective. This may make joint working ever more difficult, though the appropriateness of joint working when female nurses and social workers provide support to male doctors in a subordinate role must be questioned. This all makes the Chief Medical Officer seem extraordinarily naive when he said that "Progressively, teams are becoming alliances in which professional boundaries are dissolved by better communication and the development of shared guidelines on care"¹⁴⁸

Another characteristic of the increased professionalization of nursing and social work is the growth of specialisms. Health Visitors originated separately from the nursing profession, and though the modern health visitor is a trained nurse, she would regard herself as belonging to a different and distinct profession. Within nursing, midwives, district nurses, Community Psychiatric Nurses (CPNs) and Community Nurses in Learning Disabilities (CNLDs) all have their own training programmes which identify their specialisation. Practice Nurses are a relatively recent breed who

¹⁴⁷ *Ibid.*, pp. 195-196.

¹⁴⁸ Department of Health, *On the State of the Public Health 1991: the Annual Report of the Chief Medical Officer of the Department of Health* (HMSO, 1982) p. 109.

have not yet established separate mandatory training, though this is being developed. Despite the generic role promoted following Seebom, social work has its own specialisms in child care, mental health, care of older people and people with disabilities. There has also been an increasing tendency to differentiate work undertaken by qualified and unqualified labour¹⁴⁹. Thus, divisions have developed even within occupational groups.

There is a further dimension to professional tensions, the difference in employment status. Social workers, health visitors and district nurses are all employees of large organisations. GPs, on the other hand, are independent contractors. Every practice is a separate organisation. The only control over GP activity is through the contract for their services, which is determined nationally but managed locally by the Family Health Services Authority. The independent status of GPs makes collaborative activity very difficult, because they can not be required to work jointly with other professionals. They will only do it if they want to, because they see collaboration as being of value to their patients and to the way they work.

The lack of mutual understanding among team members about roles and responsibilities¹⁵⁰ is another possible problem. This could be addressed through the induction of new team members, or through regular meetings, either formal or

¹⁴⁹ Abbott and Wallace, 1990, p. 26.

¹⁵⁰ Ovretveit, 1990, § 4; DHSS, 1987, para 9.5.

informal. Joint training and education are often advocated¹⁵¹. There are three ways in which training and education could be multidisciplinary: making elements of basic (pre-qualifying) training to students from different disciplines; providing in-service training on topics of common interest; training in teamwork. This would help people from different professional backgrounds to understand one another's roles and responsibilities, and to see how their different skills and approaches might complement each other.

It is also argued that team members should be committed to making teams work.¹⁵² This commitment is more likely to be present where members see that effective teamworking is to their own advantage as well as to patients'¹⁵³.

By the end of the 1980s and early 1990s, there was evidence that PHCTs had not taken these lessons on board¹⁵⁴. Making a team work effectively is a complex business, with many practical problems to take into account. However, overcoming these barriers has not necessarily resulted in good teamwork. This could imply

¹⁵¹ Gilmore, Bruce and Hunt, 1974, pp. 160-163; B L E C Reedy, "The Health Team" in Royal College of General Practitioners, *Trends in General Practice 1979*, pp. 111-141; J H Barber and Charlotte R Kratz, eds, *Towards Team Care* (Churchill Livingstone, 1980) p. 15; Joint Working Group, 1981, § 3.4 iii - 3.8; David Brooks, Anne Hendy, and Alan Parsonage, "Towards the reality of the primary health care team: an educational approach", *Journal of the Royal College of General Practitioners*, 1981, 31, pp. 491-495.

¹⁵² Joint Working Group, 1981, § 4.42.

¹⁵³ Ovretveit, 1990, § 1.

¹⁵⁴ Allen Hutchinson and Sue Gordon, "Primary care teamwork - making it a reality", *Journal of Interprofessional Care*, 1992, 6:1, pp. 31-42 (p. 36).

inertia or lack of interest, the failure of the measures proposed, or that the factors which inhibit teamwork are more fundamental. Some studies go beyond the practical difficulties of teamwork to look at the sociological, cultural and structural dimensions, which are less easily addressed by individual teams.

Fundamental problems in teamwork

These appear in the debate about leadership. Recent management text books are clear about the need for leadership within teams. Hastings and colleagues argue that the Team Leader's role is to create the environment which stimulates team members to perform outstandingly. Leaders plan and provide direction for the team; secure resources; build up the credibility of the team outside; appraise performance of its members; act as guardian of the standards the team has jointly agreed¹⁵⁵. The question in primary health care teams is who takes on the role of leader, and how this role is interpreted.

Hicks clearly sees general practitioners as leaders of the team, "not only because of their all-round clinical skills but also because they have accepted the full responsibility for the continuing care of the patients who have registered with them. This responsibility cannot be accepted or indeed assumed by any other member of

¹⁵⁵ Colin Hastings, Peter Bixby and Rani Chaudhry-Lawton, *The Superteam Solution* (Aldershot: Gower, 1986) chapter 8.

the team."¹⁵⁶ Certainly, the British system of registration with a general practitioner is unique, and means that almost every person in the country is under the care of a doctor who has 24-hour responsibility for the patients on her list. This means that doctors feel that, in the end, they are ultimately responsible for the patients' care. Other health professionals are also professionally accountable for the work they do, but none of them is charged in law with the continuing care of the patient. There is also a need for someone to coordinate the care.

The Harding Report makes a distinction between clinical responsibility for the registered patient and leadership of the team, and suggests that any member of the team who has the skills can be leader.¹⁵⁷ Greig, a doctor himself, points out that as practice profits are dependent on what some members of the primary care team do, the GP should retain control of these people¹⁵⁸. On the other hand, this control might tend towards encouraging interventions that maximise profits rather than provide the best care for the patient.

Doctors often own the premises from which the primary care team works. Even when they rent accommodation, they have territorial rights over the premises that other members of the primary health care team do not have. This may reinforce their leadership role.

¹⁵⁶ Donald Hicks, *Primary Health Care: a review*, DHSS (London: HMSO, 1976) § 1022, p. 526.

¹⁵⁷ Joint Working Group, 1981, § 4.21.

¹⁵⁸ Greig, 1988, p. 123.

There are, however, problems in assuming that doctors will be leaders in primary health care teams. In a group practice, it may not be clear whether one or all of the doctors is leader. However, fund-holding, with its designation of a lead doctor who is not necessarily the senior partner, has now set the precedent for a lead team-coordinator. Doctors do not always make the best leaders, though they have tended to assume the role. Some reasons for this have already been mentioned, but they also include expectations within the team that they should be the leader, because medicine has a higher status than nursing, and because a predominantly male profession tends to dominate a mainly female one.

If other professionals, such as social workers, are to be encouraged to join the primary health care team, the dilemma becomes more acute. There can be no automatic assumption that doctors will lead social workers.

If care is to be patient-centred rather than service-centred, the doctor may not be the key worker in an individual patient's care. Barber and Kratz argue that "leadership should be fluid, passing from one member to another, depending on the needs of the patient and the importance of each individual discipline's contribution to the care of the individual patient".¹⁵⁹ Marsh agrees: "It is the problem that the patient presents which leads the team, and those primarily responsible for that problem will, for a period, lead the team in dealing with it"¹⁶⁰. Different writers have different perceptions of what the "team" means (see Pritchard's typology above). Different

¹⁵⁹ Barber and Kratz, 1980, p. 156.

¹⁶⁰ Marsh, 1991, p. 26.

types of teams require leadership of different kinds. The "key worker" role in relation to a particular patient is very different from the strategic and managerial leadership of the whole team. A primary care organization is likely to have many key workers, but will still need a leader.

The discussion about leadership raises a number of issues. Firstly, there are different types of leadership, exercising different types of control¹⁶¹. Secondly, leadership is not necessarily the same as line or operational management. The role of the team leader could be to manage the way the team itself works rather than its individual members. Thirdly, there is some confusion between the role of team leader and that of key worker, who takes the lead in delivering the service to each patient.

As in discussions about social worker attachments, the principle of equality, or the lack of it, is a notion which underlies many of these issues. Doctors, nurses and therapists have all worked in hospitals at earlier stages of their careers, where the methods of working are very hierarchical and nurses are subordinate to doctors. There is a tendency to replicate these relationships in primary care. Nurses aspire to equality in the team, as the following examples show, even if they do not experience it:

¹⁶¹ John Ovretveit, *Coordinating Community Care: Multidisciplinary Teams and Care Management* (Milton Keynes: Open University Press, 1993) pp. 123 ff.

a team approach suggests that all members have an equal voice¹⁶²

the doctor remains, in all too many cases, the leader and not an equal member of the team; ... How can we have a genuine primary health care team if one member (the GP) remains 'beyond the pale'?¹⁶³

McIntosh and Dingwall, in the 1970s, show that though community nurses expect equality in teams, and health visitors in particular have been trained to assume equality, in practice they are expected to serve under the doctors¹⁶⁴. Similarly, doctors may speak of equality, but underlying their behaviour and practice is an assumption of dominance. Though there may be good communication regarding the care of individual patients, community nurses may be excluded from discussions on policy within the practice. McIntosh and Dingwall observe that

the status of many nurses and health visitors in practice attachments is equivocal. On the one hand they are superficially a member of the team, they have direct contact with doctors and their advice is sought. However, they do suffer a certain subtle but no less potent undermining of any aspirations to partnership that they might have.¹⁶⁵

The situation is compounded by the expectations of patients, administrative staff in

¹⁶² Sue Seidel, "Part of the team?", *Nursing Times*, 1986, 82:28, p. 84.

¹⁶³ Editorial, "How can we have a genuine primary health care team in one member remains 'beyond the pale'?", *Nursing Times*, 1985, 81:32, p. 3.

¹⁶⁴ Jean McIntosh and Robert Dingwall, "Teamwork in theory and practice", in Robert Dingwall and Jean McIntosh, eds., *Readings in the Sociology of Nursing* (Churchill Livingstone, 1978) pp. 118-134 (p. 127).

¹⁶⁵ *Ibid.*, pp. 130-131.

the practice and nurse managers alike. McIntosh and Dingwall conclude that

a triumvirate of doctors, ancillary workers and patients share common models of the proper structure of the organisation. This grouping controls all the significant resources of the practice: time, space, information, finance and access to patients. Hence the activities of the district nurses and health visitors are limited by this context and by their previous training in hospital which offers them a whole array of strategies for managing this situation. In consequence, they tend to be squeezed back into traditional nurse roles. This is accentuated by the reluctance of their own administrative superiors to support their field staff. They tend to regard practice attachment and teamwork as synonymous and to see difficulties as personal problems of particular individuals rather than as the outcome of structural processes. This reflects the administrators' intense commitment to attachment as part of a drive to enhance the independence and, in their view, the professional status of nursing. When dealing with the public, health visitors and district nurses are restricted by their traditional sense of loyalty to doctors, by the desire to maintain a facade of egalitarianism through suppressing overt criticism and its implications of inequality, and by their desire to avoid trouble from their own management.¹⁶⁶

There does seem to be a difference in the way doctors and nurses have approached teamwork. Nurses are trained to hold a holistic view of health concerned with the care of the whole person (rather than the treatment of the diseased part). Primary health care teams are about pooling skills and sharing care so that all the patient's needs are addressed. Teamworking is marked by cooperation.

On the other hand, the General Medical Services Committee of the BMA in its 1983 document *General Practice: A British Success* talks of teamwork in the same breath as new technology:

¹⁶⁶ *Ibid.*, pp. 133-134.

The strength of the NHS as a whole depends on its cohesion and the same is true at the level of patient care. The changing shape of partnerships, the modern design of many premises and the improving patterns of staffing, team work and equipment are evidence of the continuing evolution of general practice. They show the profession's willingness to invest in order to improve services to patients. Very few general practitioners would disagree that supporting staff and primary health care teams are now an integral part of general practice. We feel that these developments should be enhanced by making maximum use of the new technology that is revolutionising communications and the collection and recall of data. This information technology, the improved opportunities for carrying out clinical investigations on surgery premises, and the wider deployment of teams will all enable general practitioners to provide improved care for patients in the surgery. This will reduce the occasions on which they have to be referred to hospitals¹⁶⁷.

The Committee recommended that:

Further development of the team work and technological support already present in general practice will improve and extend the economical care that family doctors can provide.

The implication is that the primary health care team is another piece of kit, like a computer, which all good practices have. There is no indication that the primary health care team needs time or nurturing, nor any understanding of how teams promote good practice. An American study found that "when doctors talk about teamwork they're talking about nurses doing what they want done more quickly"¹⁶⁸. On the other hand, the Edwards Report, published just four years after the BMA report, has a different perception of primary health care teams working together for

¹⁶⁷ General Medical Services Committee, *General Practice: A British Success* (British Medical Association, 1983) p 32.

¹⁶⁸ "Shades of Collaboration", *American Journal of Nursing*, April 1992, pp. 14, 17.

a purpose: "Teamwork is not just a matter of avoiding obstruction of one another whilst pursuing different goals: it is a positive collaboration to agree what the problems are, and to tackle them jointly in accordance with agreed objectives and priorities"¹⁶⁹.

This difference in perception seems to arise from where the professions stand on the continuum of the medical - social model of health. Doctors as a profession tend to a medical model of health in which they are experts concerned with treating the malfunctioning body. Within this model, the primary health care team is a means for delivering a technical service in which different professionals have varying roles. Teamworking is, therefore, about ensuring that the different experts have the right knowledge and information to carry out their tasks. Writers on primary health care teams in medical text books tend to talk about membership of teams as resources, rather than as relationships. For instance, the purpose of the primary health team for Morrell is to widen the skills available and ensure enough staff to do the work:

Primary medical, or health, care is concerned with providing health education, prevention, an appropriate response to new symptoms of illness, and the continuing care of chronic disease. It is difficult to see how one health professional can fulfil all these roles; no one person can be expected to have all the requisite knowledge and skills. In addition, if accessible to a defined community of patients they cannot be expected to have the time to provide all these services.¹⁷⁰

¹⁶⁹ DHSS, 1987 (Edwards Report) para 9.8.

¹⁷⁰ David Morrell, *The Art of General Practice* (Oxford: Oxford University Press, 1991) p. 115. See also Gray, 1988, p. 88.

He suggests that practice managers and practice nurses could be made partners in the practice.

Underlying Greig's book, *Team-work in General Practice*, is a perception of the team that is almost entirely task- and treatment-orientated. He says that "it is the job of the primary health care team to make sure that *medical* care reaches those who need it"¹⁷¹ (my italics).

There are signs that attitudes among doctors, or at least doctors who write about teams, are changing. Pringle remarks that

The perceived and tangible hierarchy in general practice perpetuates the status of nurses, practice managers, and attached staff as co-workers rather than team members.¹⁷²

Marsh offers a view of a very efficient team in which a lot of care is delegated. He talks of "sharing care" and democratically functioning teams, and makes the patient the centre of the team. Efficiency means that the work is carried out by members of the team who are best able to do it, thus freeing GPs to concentrate on diagnosis and treatment, which is what they are trained for¹⁷³.

¹⁷¹ Greig, 1988, p. 1.

¹⁷² Mike Pringle, "The developing primary care partnership", *British Medical Journal*, 1992, 305, pp. 624-626 (p. 625).

¹⁷³ Marsh, 1991, p. 2.

INTER-AGENCY AND INTER-PROFESSIONAL COLLABORATION :

DISCUSSION

This chapter began by addressing abstract concepts of collaboration, moved on to look at studies of joint planning, social worker attachments to general practice and primary health care teams, and ended by looking at the practical difficulties of inter-professional working. All of these are aspects of one issue, the problem of how groups of public servants work together to provide better care. The bodies of literature are all quite discrete, taking different approaches and using different terminology, but in the end, many of the themes are similar, whether the subject is agencies working to plan services or practitioners in the field.

In order to bring these separate streams together into a form that provides a basis for analysing collaboration in Sunderland, a framework has been created which recognises the complexity of joint working at different levels of the organisation, and in which many factors are in play. The framework is based on one proposed by Davidson¹⁷⁴, though it has been adapted considerably and extended to take account of collaborative activity at different levels. Davidson's framework sets out the matters that have to be addressed in the environment, the nature of the organisations themselves and the mechanisms for joint working. To this, a fourth category has been added, that of the personal attitudes of the individuals involved.

These categories have been set against the three levels of collaboration: strategic,

¹⁷⁴ Davidson, 1976, pp. 122-135.

operational and practitioner. This thesis concentrates on two levels, but the third, the operational or joint management level, has been included for completeness, though the available literature does not provide sufficient information to complete the table. Looking at the three levels together does create one difficulty. At the strategic level, we are considering the representatives of agencies who come together to plan services. Though various joint committees act as a mechanism for this collaboration, the agencies remain quite separate. At the operational and practitioner levels, the subject is the creation of a project or team around which or within which joint working takes place, an organisation arising out of other organisations. It is even more complex when one takes account of the fact that GPs are independent providers of health care, so that each general practice is a little organisation in its own right. So the means of working together, the team or the joint project, becomes a separate and identifiable entity. Members of the new organisation may also retain membership of the parent body, such as social workers or district nurses attached to PHCTs, which can lead to a conflict of interests, especially when other members, such as GPs and their employed staff in this example, are only members of that team.

Within the resulting framework, the key issues addressed in the literature have been set out. The issues in the first category, the environment, start as more or less the same for all three levels: the level of turbulence and the demand on services affect the agencies all the way through, though some aspects of the environment will have more immediate impact on some levels than others. Though a district nurse in a PHCT may be aware of the political pressure to collaborate or the economic

pressures on the provision of services, these factors will have been filtered through many layers by the time they reach her. But other factors will have a more direct impact, such as the level of demand for the services she provides. In addition, the environment for each level includes the other two levels: the strategic level works to produce policies that the other two levels implement and operate. The operational management level is working with the strategies established by the senior managers and planners, and managing the staff who will deliver services. The field workers are working in the context of the policies and procedures set by the other two levels, though they are likely to be interpreting these to suit their own perceptions of the job and enable them to cope with the pressures as they see them.¹⁷⁵

The second category, characteristics of the organisation, project or team, is where we see the greatest differences between the levels. At the strategic level, the issues are about the compatibility of the structures of, in this case, the Health Authorities and the Local Authority, the nature and pressures on funding, the mutual understanding about their areas of responsibility. At the joint management and joint working levels, the issues are about the internal features of the demi-organisation, agreements about the way things will work or be managed.

The third category, collaborative mechanisms, appears to be very similar for the different levels, though this has to be assumed for the joint management level, as the literature for this level is limited, and I have not used it systematically. The

¹⁷⁵ Michael Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (New York: Russell Sage Foundation, 1980).

issues here are about formal and informal processes for coming together between the organisations or within the team. Again, in the fourth category, when the literature speaks of the attitudes of individual players, they are much the same for those involved in strategic planning as for those providing care to clients and patients.

This framework will be used to measure joint planning activity and joint working in two projects in Sunderland described in this thesis. This will create a basis for addressing a number of questions about collaboration, about the framework, and about the nature of collaborative working in Sunderland. The issues at stake are:

- Does the framework provide a helpful model for assessing inter-agency coordination and collaboration?
- Does looking at collaboration at different levels of the organisation lead to a better understanding of the nature of collaboration?
- How effective was inter-agency and intra-agency coordination among the health and social services in Sunderland in 1990-1994?
- The literature points to the optimum requirements to facilitate collaboration; what can we learn about the requirements for pragmatic collaborative activity, recognising that the real world is messy and that ideal circumstances often do not pertain? If pragmatic collaboration is not perfect, is it still collaboration?
- What impact has the implementation of the NHS and Community Care Act 1990 had on the prospects for collaboration?
- Which matters more for outcomes for clients: effective coordination of planning, or professionals who provide an integrated or coordinated service?

FRAMEWORK FOR COLLABORATION

	ENVIRONMENT	CHARACTERISTICS OF THE ORGANISATION / PROJECT / TEAM	COLLABORATIVE MECHANISMS	COLLABORATIVE ATTITUDES
STRATEGIC	<p>Level of turbulence</p> <p>Legislation</p> <p>Policy coordination</p> <p>Political pressure to collaborate</p> <p>Economic forces</p> <p>Level of demand on services</p>	<p>Compatible structures</p> <p>Accountability framework</p> <p>Domain</p> <p>Funding: (i) pressures, (ii) earmarked for collaborative enterprise</p> <p>Culture in which coordination / collaboration is valued</p> <p>Geographical boundaries</p>	<p>Formal processes for joint working</p> <p>Informal processes</p> <p>Authority</p> <p>Funding</p> <p>Perceived benefits to the organisations</p> <p>Perceived benefits for clients</p> <p>Costs of collaboration</p>	<p>Commitment.</p> <p>Understanding and willingness to learn.</p> <p>Trust.</p>
OPERATIONAL	<p>Level of turbulence</p> <p>Legislation</p> <p>Policy coordination</p> <p>Political pressure to collaborate</p> <p>Economic forces</p> <p>Level of demand on services</p>	<p>Clarity of Purpose:</p> <p>Collective aims and objectives</p> <p>Separate aims and objectives</p> <p>Focus and ambition</p> <p>Commitment from the agencies:</p> <p>Stable representation</p> <p>Appropriate and commensurate rank</p> <p>Shared ownership by the agencies</p> <p>Equal legitimacy of participating authorities is fostered and recognised.</p> <p>Explicit and detailed agreements on funding, personnel and administrative issues.</p> <p>Clear and explicit understanding of areas of responsibility and lines of accountability.</p> <p>Agreed systems for monitoring and evaluation.</p> <p>Common fund.</p>		<p>Entrepreneurial and networking skills.</p>
PRACTITIONER	<p>Level of turbulence</p> <p>Legislation</p> <p>Policy coordination</p> <p>Political pressure to collaborate</p> <p>Economic forces</p> <p>Level of demand on services</p>	<p>Leadership.</p> <p>Nature of membership, e.g. attachment.</p> <p>Clear, explicit agreements about how the team will work.</p> <p>Shared goals.</p> <p>Shared understanding of roles and responsibilities.</p> <p>Culture in which coordination / collaboration is valued</p>	<p>Joint learning / training.</p> <p>Shared records / access to records.</p> <p>Formal meetings.</p> <p>Informal encounters.</p> <p>Shared accommodation</p> <p>Methods of communication.</p> <p>Time for the team</p>	<p>Commitment.</p> <p>Trust.</p> <p>Understanding / Insight into systems of others.</p> <p>Insights into one's own occupational system.</p> <p>Equality.</p>

CHAPTER FIVE

SUNDERLAND

INTRODUCTION

This chapter has two purposes. The first is to describe Sunderland in terms of a profile of the health and social status of the city, the health and social care services available and an overview of the way in which services were coordinated. The second is to assess the factors in the first category of the framework set out in Chapter Four, namely the issues that influenced the environment in which the health and social services attempted to work together.

Sunderland straddles the mouth of the River Wear in the metropolitan county of Tyne and Wear in north-east England. Heavy industry once predominated, mainly coal mining and ship building, but by 1990 the shipyards had closed and only one pit was operating. This closed in 1994. The Nissan car factory in Washington is a major employer, but unemployment rates are high, and the city suffers from economic depression. There was some good news. In 1992, Sunderland became Britain's newest

city, the football team reached the finals of the FA Cup, the polytechnic became a university, and the new city won a bid for City Challenge money, a scheme for targetting more effectively money formerly available through the Urban Programme.

POPULATION: SIZE AND STRUCTURE

The resident population of Sunderland at the 1991 Census was 289,040, of whom 139,461 are male and 149,579 are female. The population is skewed towards the younger age groups, with a high proportion of children (aged under 16) and young adults (aged 16-24) and a low percentage of older people.

TABLE 5.i: POPULATION STRUCTURE: PERCENTAGE IN EACH AGE-GROUP: COMPARISON WITH THE NORTHERN REGION AND ENGLAND

AGE-GROUP	SUNDERLAND ¹	NORTHERN REGION ²	ENGLAND ³
0 - 4	7.0	6.5	6.7
5 - 15	14.8	13.9	13.6
16 - 17	2.6	2.5	2.5
18 - 29	18.2	17.4	18.2
30 - 44	21.5	21.3	21.5
45 - 64	22.1	22.7	22.0
65 - 74	8.6	9.5	9.0
75 - 84	4.3	4.9	5.3
85 and over	0.9	1.0	1.2

¹ OPCS, 1992, Part 1, Table 35.

² OPCS, 1993a, Part 1, Vol. 2, Table 35.

³ *Ibid.*

Tyne and Wear is one of the more densely populated parts of the UK. Sunderland had 21.3 persons per hectare, compared with 2.0 persons per hectare in the Northern Region and 3.6 in England⁴.

SOCIAL AND ECONOMIC INDICATORS

Indices of Deprivation

Whichever the indicator of social and economic circumstances, Sunderland is deprived. The index of deprivation developed by Townsend, Phillimore and Beattie used a combination of data from the 1981 census⁵. According to this index, sixteen of the twenty-five Sunderland wards were placed among the 40% most deprived wards in the Northern Region, with ten ranking among the 20% of the wards with the highest deprivation. Only two wards ranked among the 40% least deprived wards. When the Townsend Index is applied to the districts of England, using 1991 census data, Sunderland is ranked as the 29th most deprived area out of 366 districts,⁶ takes 18th place in an analysis of poverty in England⁷, and 356th in an analysis of wealth⁸.

⁴ OPCS, 1991 *Census: Great Britain. Health Area Monitor* CEN91 HAM16, (London: HMSO, 1993b) Table A.

⁵ Peter Townsend, Peter Phillimore & Alistair Beattie, *Inequalities in Health in the Northern Region* (Northern Regional Health Authority and the University of Bristol, 1986).

⁶ David Gordon and Ray Forrest, *People and Places 2: Social and economic distinctions in England* (School for Advanced Urban Studies, 1995) pp. 78-79.

⁷ *Ibid.*, pp. 82-83.

⁸ *Ibid.*, pp. 84-85.

The Department of the Environment's composite deprivation index can be used at district, ward or enumeration district (ED) level⁹. The Index is composed of a number of census and non-census indicators to show the degree, the spatial extent and the intensity of deprivation. Using this methods, Sunderland has an overall deprivation score of 21.15, and is ranked 34th most deprived district in England. This Index shows more deprivation in the north and midlands relative to the south of England, because of its use of a wider set of indicators than those used in other indices (for example, the Jarman Index) which concentrate on factors of particular concern in the south, such as ethnicity.

Housing

After the war, Sunderland engaged in an impressive building programme of council housing. Slum housing in the centre of Sunderland was cleared, and replaced with council housing estates round the edge of the town. Most of this was constructed during the 1950s and 60s. More than three-quarters of local authority property is in the form of 1-4 bedroom houses and bungalows, and 85% of these have 2-3 bedrooms. These post-war council housing estates have most of the problems of deprivation and ill-health. There is very little high-rise housing in Sunderland compared with other local towns and cities, such as Gateshead and Newcastle-upon-Tyne. In 1996, 4.8% of local authority housing units were in multi-storey properties¹⁰.

⁹ Department of Environment, *1991 Deprivation Index: A Review of Approaches and a Matrix of Results* (London: HMSO, 1995).

¹⁰ City of Sunderland, Housing Department, personal communication, 1996.

The proportion of large homes, with seven rooms or more, is low in Sunderland, at 8.9%. Only 33 districts in England of 366 have fewer.¹¹

Between 1981 and 1991, there was a marked shift in the balance of owner-occupied homes and those rented from the Local Authority (Table 5.ii), due mainly to new building and to the government's Right to Buy policy. About a third of the increase in the number of owner-occupied households was due to the government's Right to Buy policy.

TABLE 5.ii: HOUSING TENURE IN SUNDERLAND
(1981 AND 1991 Census Data)

	1981 CENSUS DATA ¹²		1991 CENSUS DATA ¹³	
	NUMBERS	% TOTAL	NUMBERS	% TOTAL
Owner Occupied	40,011	38%	60,572	53.3%
Local Authority	56,923	54%	43,996	38.6%
Housing Association	2,551	2%	4,113	3.6%
Privately rented	5,530	5%	5,133	4.5%
Other	99	0.1%	90	0.1%
TOTAL	105,114		113,814	

The percentage of homes in Sunderland which are owner-occupied is much lower than the percentage for the country as a whole or for the Northern Region (Table 5.iii)

¹¹ Gordon and Forrest, 1995, pp. 62-63.

¹² OPCS, *Census 1981. County Report: Tyne and Wear*, CEN81 CR41 (London: HMSO, 1982) Part 1, Table 25.

¹³ OPCS, 1992, Part 1, Table 62.

TABLE 5.iii: OWNER-OCCUPATION: COMPARISONS
(1981 and 1991 Census Data)

	1981 ¹⁴	1991 ¹⁵
UNITED KINGDOM	55%	66%
NORTHERN REGION	47%	61%
SUNDERLAND	38%	53%

In Sunderland in 1991, 42% of council tenants had rent arrears, though arrears of less than £100 were probably due to tenants choosing to pay rents fortnightly in arrears. 12% of council tenants had rent arrears of over £100, which is probably a more accurate picture of the dimensions of the financial problem.¹⁶ A high proportion of Sunderland council tenants (61%) received housing benefit.¹⁷

Employment and Income

Unemployment statistics are based on the number of people claiming benefit. Changes in the way benefits are allocated have changed the way in which unemployment statistics are calculated. Young people under 18 who are out of work have not, on the whole, been eligible for income support since September 1988, and therefore do not

¹⁴ OPCS, 1982, Part 1, Table 25; OPCS, *Census 1982 National Report: Great Britain*, CEN81 NR(1) (London:HMSO, 1983) Part 1, Table 25.

¹⁵ OPCS, 1992, Part 1, Table 62; OPCS, 1993a, Part 1, Volume 2, Table 62.

¹⁶ Figures supplied by Borough of Sunderland, Housing Department.

¹⁷ Borough of Sunderland, Marketing and Policy Unit, "Urban Programme 1992-1993" (1991).

appear in the unemployment statistics. In January 1991, 11.4% of the estimated economically active population of Sunderland were unemployed, when the proportion of unemployed people nationally was 6.7%¹⁸. Half of the unemployed people in the borough had been seeking work for over six months. Sunderland has a high proportion of unemployed 16 and 17 year olds¹⁹ and also of "men on the scrap heap", defined as men aged 55-64 who are unemployed, on a government scheme or otherwise inactive, but not retired.²⁰ Only three districts have more men in this position. In the 1991 census, based on a 10% sample, 14.8% of respondents described themselves as unemployed²¹. This includes people who regard themselves as unemployed who do not fall within the official definition.

An analysis of income by area ranks Sunderland at 358, with only 8 poorer districts in England.²² The same study ranks Sunderland at 330 out of 366 districts on an analysis of households with more than one earned income,²³ so that only 36 districts have fewer households with only one earned income.

A comparison of socio-economic groups shows a much smaller proportion (12%) of households in Sunderland headed by someone in social classes I and II when compared

¹⁸ Quoted in Borough of Sunderland, Marketing and Policy Unit, 1991.

¹⁹ Gordon and Forrest, 1995, pp. 36-37.

²⁰ *Ibid.*, pp. 34-35.

²¹ OPCS, *1991 Census. County Report: Tyne and Wear* CEN91 CR41, part 2 (London: HMSO, 1992) Part 2, Table 72.

²² Gordon and Forrest, 1995, pp. 74-77.

²³ *Ibid.*, pp. 32-33.

with England, and more households headed by someone in a manual occupation (see Table 5.iv.

TABLE 5.iv: COMPARISON OF SOCIO-ECONOMIC GROUPS: HOUSEHOLDS BY HEAD OF HOUSEHOLD (1991 CENSUS)²⁴

	Sunderland	Northern Region	England
I - Professional, etc, occupations	3.9%	5.5%	6.7%
II - Managerial and technical	21.6%	25.0%	31.0%
III N - Skilled occupations - non-manual	13.5%	12.5%	13.6%
III M - Skilled occupations - manual	32.2%	30.3%	26.4%
IV - Partly skilled occupations	15.8%	15.7%	13.4%
V - Unskilled occupations	5.3%	5.8%	4.5%
Armed forces, on a government scheme, occupation inadequately described	3.1%	2.4%	2.5%

Education

Entitlement to free school meals is dependent upon the receipt of income support or family credit. The benefit is taken up by only the poorest families. In 1990, 12% pupils in the United Kingdom claimed free school meals²⁵. In January 1991, 26.3% pupils at all Sunderland secondary schools were entitled to free school meals, and 30.9% pupils at primary schools. By the end of the research period, the proportions

²⁴ Office of Population Censuses and Surveys, *1991 Census Report for England. Regional Health Authorities*, CEN91 RERHA, Part 2 (London: HMSO, 1993) Table 90.

²⁵ Central Statistical Office, *Social Trends 22* (London: HMSO, 1992) table 3.11, p 55.

increased slightly to 27.7% and 32.8% respectively²⁶. The percentage of pupils claiming free school meals, and therefore experiencing poverty, is appreciably greater in Sunderland than for the United Kingdom.

The proportion of pupils in Sunderland remaining in education after the age of 16 is low. In 1990, 38% of pupils stayed on in education²⁷. This was substantially less than the figures for the Northern Region (61%) and Great Britain (65%)²⁸. There were 13 other districts in England (out of 366) with a worse record on this indicator²⁹. A low proportion, 3.2%, of the population of Sunderland was educated to degree level. Only 29 districts had fewer highly educated citizens.³⁰

Ethnic Minorities

The black and ethnic minorities comprise only a small percentage of the population of Sunderland. The 1991 census reported that 98.9% of the population of Sunderland was white. In contrast, a significantly greater proportion of Sunderland doctors was born on the Indian subcontinent or in Commonwealth countries (36%) than in the Northern

²⁶ City of Sunderland, Education and Community Services, *Fact Card 1995*.

²⁷ Borough of Sunderland, Education Department, letter of 10 September 1991, enclosing 1990 post-16 destinations.

²⁸ Central Statistical Office, *Regional Trends 27* (London, HMSO, 1992) p. 59, table 5.4.

²⁹ Gordon and Forrest, 1995, pp. 40-41.

³⁰ *Ibid.*, pp. 68-69.

Region (15%) or England (19%)³¹.

The three main ethnic groups, Indians (709), Bangladeshis (661) and Chinese (620), each accounted for 0.2% of the population, according to the 1991 census. The Commission for Racial Equality funded a study of the needs of ethnic minorities in Sunderland, which was completed in 1990³². The project concentrated on the needs of the Bangladeshi community in Sunderland, as it was the fastest-growing ethnic minority group in Sunderland and the most deprived, facing more problems than other groups. As a result of the study, the Health Authority arranged for one health visitor to work solely with the Bangladeshi community and appointed two link-workers. The project ran a baby clinic, family planning, health screening and health promotion.

ILL-HEALTH IN SUNDERLAND

There is considerable evidence to show a link between social and economic deprivation and ill-health³³, even though the precise nature of this link is difficult to determine. The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". There are several problems in attempting to describe health. Firstly, it is not possible to measure health

³¹ Department of Health, *General Medical Services : Basic Statistics, 1 October 1992, Northern Region*.

³² Andrew Field, "'We're here too!': The results of a research project into the needs of the Bangladeshi community in Sunderland" (1990).

³³ See, for example, Douglas Black, J N Morris, Cyril Smith, Peter Townsend, *Inequalities in Health: The Black Report* (Penguin, 1982).

directly, as no measure exists. Various indicators can be used as a proxy, but they are measures of ill-health, rather than a positive state of health. Secondly, there is a dearth of data available, particularly for small areas.

Indicators of health for the Northern Region are, generally speaking, poorer than those for the country as a whole, and those for Sunderland are usually at the worse end of indicators for the Region.

The Health of Infants and Children

The number of births in Sunderland had remained steady for some time at around 4,000 a year, and the Standardised Fertility Ratio was only slightly higher than the national rate³⁴, though by 1994, the number of births started to fall. The proportion of babies born outside marriage period was consistently higher than that for the Northern Region and for England and Wales, and the gap was widening³⁵. Data to indicate the number of babies born to a stable relationship outside marriage was not available until 1994. In that year, 45% of births in Sunderland were outside marriage, though 73% of these were registered in the joint names of both parents.

The rate of births to very young mothers was high. At the start of the research there were 3.7 pregnancies (deliveries and terminations) to every 1,000 girls aged 10-15, well

³⁴ OPCS Vital Statistics, VS1 series.

³⁵ *Ibid.*

above the national mean of 2.7³⁶. Only 15% of districts in England and Wales had a higher rate of pregnancies to very young girls. Campbell interviewed teenage mothers in Sunderland in her journey through the working classes in the early 1980s:

... in the eighties, unemployed girls who've never experienced economic independence are doing the only thing they can - having babies, either getting married or not, but often staying with their mam and dad, and quite soon getting a council house. They never consider an abortion, often don't use contraception. They want children. Of course they do. There isn't anything else. Being a mother has a certain status after all, it makes you feel grown up³⁷

In 1989, 7.5% of babies born in Sunderland weighed less than 2500g, above the national mean of 6.8%. Only twenty per cent of districts were in a worse position³⁸. This means that in Sunderland around 28 babies in excess of the national average were born weighing less than 2500g, and therefore had a less propitious start in life. However, Sunderland had very few births under 1000g and is ranked among the "better" districts for this indicator.

Sunderland's record for perinatal mortality and infant mortality (deaths under one year) had improved throughout the 1980s. In the past, it had a poor record in comparison with the Northern Region and England and Wales, but the 1992 figures were closer to the regional and national norms. The numbers involved are so small that it is not

³⁶ Department of Health, *Health Service Indicators 1989-90*, computer package,

³⁷ Beatrix Campbell, *Wigan Pier Revisited: Poverty and Politics in the 80s* (Virago, 1984) p. 63.

³⁸ Department of Health, *Health Service Indicators 1989-90*, computer package, NB45.

possible to tell whether this is part of a trend.

The levels of take up of immunisation against childhood illnesses improved markedly in Sunderland in the late 1980s and early 1990s, so that Sunderland compared well with regional and national norms. Improvements were due to targetted efforts, and to changes in the payment structure in the 1990 contract, which gave financial incentives to GPs to improve rates.

The protection of children and young people from abuse is important to safeguard the health and wellbeing of the young, and is required by statute. The number of children in Sunderland on the Child Protection Register at 31 March 1994 was 369³⁹. The numbers on the register can vary markedly, but appear to be increasing. The rate of registration per 1,000 young people under 18 for the year ending on 31 March 1994 was 5.3. This was a marked increase on the 1993 rate (3.6), which was higher than that of the Northern Region (3.4) and the national figure (3.0).

Mortality

In the absence of other indicators, mortality statistics have often been used as a proxy indicator of the level of ill-health. The Standardised Mortality Ratio (SMR) is the mortality rate standardised for the age and sex of the population, and allows comparison of the death rates of different areas and over time. Sunderland ranked among the worst

³⁹ City of Sunderland Area Child Protection Committee, *Annual Report, 1993 - 94*, p. 14.

10% of districts for indicators of mortality from all causes at all ages in 1989, apart from child mortality⁴⁰. The standardised mortality ratio for the 15-64 age was 128.3, and for all ages was 120.5, that is 28% and 21% respectively above the national average. Heart disease was the biggest single cause of death, accounting for 31% of deaths in the period 1985-89. Strokes accounted for a further 11%, lung cancer for 7%, and other cancers for 19%⁴¹.

Over time, Sunderland's SMR for all ages and all causes of death was consistently above that for England and Wales and was the same or higher than that for the Northern Region (see figure 5.a)⁴², which was also well above that for England and Wales. A report on the geographical pattern of mortality confirmed the familiar pattern of higher mortality in the north and west and lower mortality in the south and east and concludes that the mortality of the north in relation to that of the south has worsened⁴³.

Permanent Sickness

The percentage of people reporting permanent sickness in response to questions about employment status at the 1981 census in Great Britain was 2.1%. The figure for the Northern Region was a little higher at 2.8%, but in Sunderland, 3.1% of the population

⁴⁰ Department of Health, *Health Service Indicators 1989-90*, computer package, ML61.

⁴¹ Sunderland Health Authority, *Annual Report 1990: The Health of Sunderland*, p.13.

⁴² OPCS Vital Statistics, VS1 series.

⁴³ M Britton, ed., *Mortality and Geography*, OPCS (London: HMSO, 1990).

SMRs: Sunderland, Northern Region and England & Wales, 1984-1994

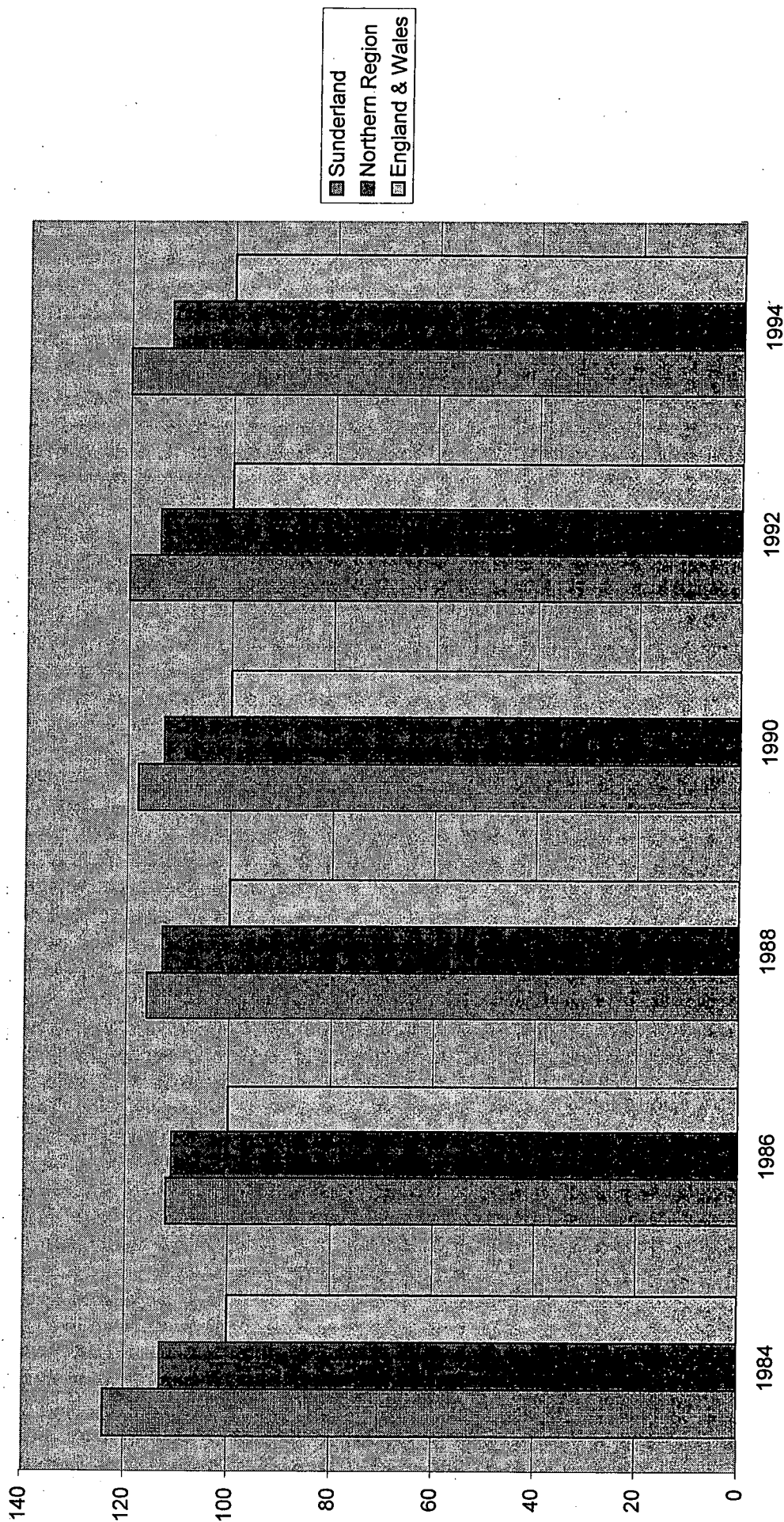


Figure 5.a

reported that they were permanently sick. The percentage of people in Sunderland who reported a long-term limiting illness at the 1991 Census was 17.4%, with one-third of households in Sunderland containing at least one member with a long-term limiting illness. Sunderland had a ratio of 99 residents with long-term limiting illnesses to each health care professional, and was ranked 44th in England (out of 366) on this score.⁴⁴

ILL-HEALTH IN SUNDERLAND WARDS

Though the health of Sunderland was poor, the health of some areas within Sunderland was even poorer. On the number of people reporting permanently sick at the 1981 census, the discrepancies between the Sunderland wards are marked, with the proportions ranging from 1.5% to 4.3%. Of the 25 Sunderland wards, 17 were among the 40% of wards with the poorest health in the Northern Region, with seven wards ranked among the 20% most unhealthy wards⁴⁵. Only one ward in Sunderland, Fulwell, was grouped with the 20% of wards in the northern region with the best record of good health.

A comparison of premature mortality on certain estates in Sunderland with that of parts of Middlesbrough for the period 1975-1986 showed that though the two areas experienced similar levels of deprivation, the premature mortality in Middlesbrough was

⁴⁴ Gordon and Forrest, 1995, pp. 70-71.

⁴⁵ Townsend, Phillimore and Beattie, 1986, pp. 227-240.

much greater than that of Sunderland⁴⁶. However, the mortality of Sunderland was still poor, with a combined SMR of 124 for all causes of death for eight wards⁴⁷, and an SMR of 156 for the estates identified as experiencing particularly high mortality⁴⁸. The most significant causes of premature death in Sunderland during the period 1978-1983 were lung cancer, chronic obstructive airways disease, and cerebrovascular disease for men and women, with the addition of diseases of the genitourinary system for men⁴⁹.

LIFESTYLE RELATED TO HEALTH

Sunderland's record of behaviour that influences health is poor. The population of Sunderland smokes more than the general population, and this is as true of young people⁵⁰ as of adults⁵¹. It is estimated that in 1990, 640 deaths in Sunderland from lung cancer, chronic obstructive airways disease and coronary heart disease were related to smoking. One quarter of these deaths were people aged under 65⁵². The diet of people

⁴⁶ Peter R Phillimore and David Morris, "Discrepant Legacies: Premature Mortality in two Industrial Towns", *Social Science and Medicine*, 33:2, 1991, pp. 139-152 (p. 143).

⁴⁷ Castletown, Central, Colliery, Grindon, South Hylton, Southwick, Thorney Close, Town End Farm.

⁴⁸ Downhill, Hylton Red House, Marley Pots, The Squares, Town End Farm.

⁴⁹ Phillimore and Morris, 1991, p. 146.

⁵⁰ Sunderland Health Promotion and Education Services, *Smoking in Sunderland: Survey of Smoking Behaviour among Adolescents (13-15 years) in the Borough of Sunderland, 1991*.

⁵¹ See Sunderland Health Authority, 1990, pp 21-22.

⁵² Sunderland Health Authority, *The Health of Sunderland*, Annual Report 1991, p. 20.

in the north is less healthy than that of the general population⁵³; there is no evidence to suggest that the people of Sunderland eat a more healthy diet than other northerners. Consumption of alcohol was also high.

Accurate information on the use of illicit drugs is not readily available. It was thought to be fairly limited in the early part of the research period⁵⁴. Referrals of illicit drug users to the Community Addiction Team rose from an average of 19 per month for the period April 1986 - August 1991 to an average of 44 per month for the year to March 1994.

THE NEED FOR CO-ORDINATED CARE IN SUNDERLAND

Sunderland is a deprived area which experiences poor levels of health as expressed in terms of high mortality and morbidity. The causes of these problems are beyond the control of the health and welfare services, and arise from the structure of society. The problems are economic in origin and can only be resolved by a coordinated package of employment, income and welfare policies. However, the health and social services have to deal with the effects of ill-health and economic and social deprivation. If, as shown, there is more ill-health in deprived areas, it is likely that there will be a greater need for the health and social care services in a deprived area like Sunderland.

⁵³ Central Statistical Office (1991) p. 171.

⁵⁴ Tony Machin, "An investigation into the nature and level of illicit drug use in the Sunderland Health Authority Catchment Area", Sunderland Community Addiction Team, September 1991.

A study carried out in a general practice in Stockton in 1984 demonstrated the need for additional health services in a deprived area. A comparison of people living on a deprived estate with those living in better-off areas revealed a number of significant differences⁵⁵: patients from the deprived estates suffered significantly more serious mental illness; more of them attended the hospital accident and emergency department; more of them were admitted to hospital; the immunisation rates among deprived children were much lower; the women had more children; mothers were more likely to be unmarried, and there were more very young mothers among the deprived women; fewer women in the 46-69 age group had had a cervical smear; the prevalence of smoking was greater among the deprived patients; and there was a greater failure to attend medical appointments, both for sickness and prevention, suggesting that deprived patients are less likely to receive medical attention.

Though deprived areas have greater need for primary care than affluent areas, they tend to get less care than better off areas. This was identified by Tudor Hart in 1971 as "the inverse care law". He stated that "the availability of good medical care tends to vary inversely with the need of the population served"⁵⁶. Twenty years later, the inverse care law still held. A study of health promotion clinics in Bedfordshire shows that practices in wards with a high standardised mortality ratio and those in wards attracting

⁵⁵ G N Marsh and D M Channing, "Deprivation and health in one general practice", *British Medical Journal*, 92:3, May 1986, pp. 1173-1176.

⁵⁶ Julian Tudor Hart, "The Inverse Care Law", *The Lancet*, 27 February 1971, pp 405-412 (p. 405).

deprivation payments are less likely to offer health promotion clinics⁵⁷. Similarly, a study of services provided by GPs showed that GPs practising in inner cities were less likely to provide services such as health education, screening, and minor surgery⁵⁸.

Bolden also confirms the additional workload for general practitioners generated by deprivation, observing that high workloads "are a major feature of inner city practices, ... not normally related to the inability of doctors to organize themselves properly, but to the high demand of the socially deprived population which they serve"⁵⁹. A study of out of hours workload in a deprived area of east London found a high rate of consultations outside normal working hours⁶⁰.

The 1986 green paper on primary health care, *Primary Health Care: An Agenda for Discussion*, stated that "the quality of primary health care services in many inner city areas is almost certainly poorer than elsewhere"⁶¹. Although one feels instinctively that this is true, the quality of services is very difficult to measure. A study in Manchester found no systematic evidence that general practice provided in deprived areas was

⁵⁷ S J Gillam, "Provision of health promotion clinics in relation to population need: another example of the inverse care law?", *British Journal of General Practice* 42, 1992, pp. 54-56.

⁵⁸ Michael Calnan, "Variations in the range of services provided by general practitioners", *Family Practice*, 5:2, 1988, pp. 94-104.

⁵⁹ K J Bolden, *Inner Cities* (London: Royal College of General Practitioners, 1981) Occasional Paper 19, p. 11.

⁶⁰ Anna Eleri Livingstone, John Anthony Jewell, John Robson, "Twenty four hour care in inner cities: two years' out of hours workload in east London general practice", *British Medical Journal*, 299, 1989, pp. 368-370.

⁶¹ DHSS, *Primary Health Care: An Agenda for Discussion*, HMSO, 1986, p. 43.

worse, in terms of the structural features of the practice or the patterns of care provided, than in more affluent areas⁶².

People living in deprived areas are also more likely to have multiple problems, for which many helping agencies exist. There is a considerable overlap between health and social needs. There is an assumption in the literature that there is, therefore, a greater need for effective coordination between agencies in the planning and delivery of services, though there is a need to demonstrate that effective coordination would contribute to ameliorating these problems.

PRIMARY AND COMMUNITY CARE SERVICES

The purpose of this section is to take a broad look at the health and social services in the community in Sunderland in 1994. It describes the agencies that commission the services, those that provide them, the services themselves and the links and relationships between the different players at fieldworker and operational management levels.

Between 1990 and 1994, there were considerable changes in the organisation of services and in the relationships between practitioners and their managers. In the health service, the introduction of the purchaser and provider functions led to the setting up of two NHS Trusts independent of the District Health Authority, and this Authority and the Family Health Services Authority were brought together under one umbrella, as Sunderland Health Commission. The Social Services Department was also restructured

⁶² Wilkin, Hallam, Leavey and Metcalfe, 1987, p. 167.

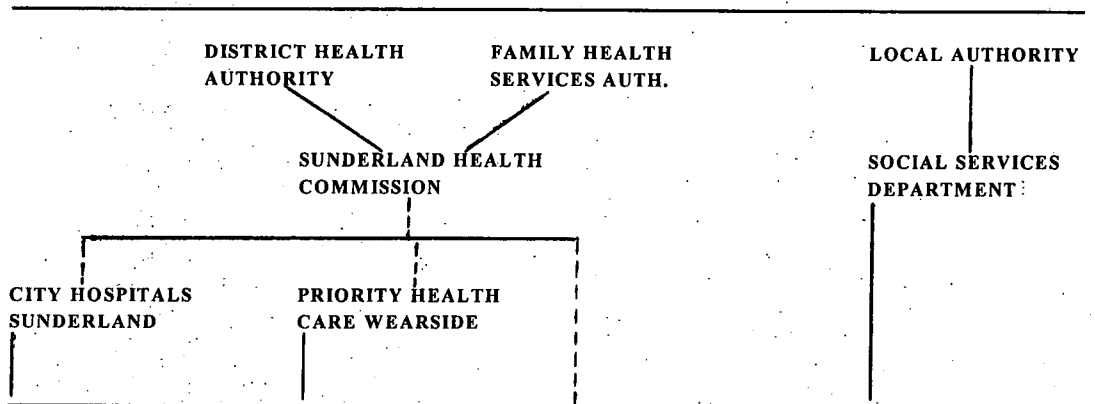
throughout, and was assigned new responsibilities with the implementation of the Children Act and the community care element of the 1990 NHS and Community Care Act.

The Agencies

The three statutory health and social care agencies were all very different, and each changed considerably over the period 1990-1994. Figure 5.b shows the links and relationships between the agencies and the services they commission or provide in Sunderland. It does not show all the services provided by the Trusts, but concentrates on services in the community.

The Family Practitioner Committee (FPC) was the first of the agencies to feel the transforming weight of the NHS and Community Care Act, when the Family Health Services Authority was created in October 1990 as a result of applying Griffiths managerialist theory to the FPC. Its main responsibility was formerly the "pay and rations" of the family practitioners, though it had also contributed to joint planning since 1988. From 1990, it acquired a chief executive and responsibility for introducing and supporting GP fundholding and medical audit, oversight of indicative prescribing budgets, supporting greater use of computers, and cash limited budgets for GP premises and staffing. The new Authority itself was a third of the size of the former FPC. The officers were accountable to the Authority, which became accountable under the reforms to the RHA instead of the DoH. The Authority chair was appointed by the Secretary of State, and other members by the RHA. It was a relatively small organisation, and

PRIMARY AND COMMUNITY CARE LINKS AND RELATIONSHIPS



PRIMARY AND COMMUNITY CARE SERVICES

School Nurses	District Nurses	GENERAL DENTAL PRACTITIONERS	Children & Families
Community Midwives	Evening Nurses	PHARMACISTS	Assessment
Chiropodists	CNLDs	OPTICIANS	Direct Services: Family support, fostering & adoption, residential care, after care, day nursery, support for children with disabilities
Speech Therapists	CPNs	GENERAL MEDICAL PRACTITIONERS	Special Needs & Disabilities
Physio-therapists	Health Visitors	Practice Nurses	Assessment
Dietitians	Marie Curie Nurses	Practice Managers	Direct Services: home support, equipment, day care, short breaks, sheltered accommodation, residential care, services for sensory disabilities, services for people with AIDS.
Stoma Therapist	Community Support Team	Clerical/Secretarial Staff	Older People
Family Planning Nurses	Incontinence Adviser		Assessment
Child Protection Adviser	Clinical Psychology		Direct Services: home support, equipment, day care, short breaks, sheltered accommodation, residential care.
Community Dental Service	Wheelchairs		
	Home Loans		

Figure 5.b

only three of its officers were active in the events described in this thesis: (i) the Chief Executive sat on the Joint Officer Group (JOG) and Joint Consultative Committee (JCC), and (ii) the Independent Medical Adviser and (iii) Planning Officer were very active in preparations for the implementation of community care policies and in setting up the social worker attachment and the community nursing project.

In 1990, the FHSA had little in common with, and little to do with, the DHA, apart from the fact that they were both health authorities serving the same area. Their remits were separate, one working with primary care and the other with secondary and community health care, and they had very different cultures and ways of working. The District Health Authority was managerially responsible for the three service units, which provided acute, priority and community health services, for planning services and for the public health function. At the start of the research period, the DHA had a planning department with four senior managers and supporting staff, which became the contracting department when the NHS reforms took hold. The DHA's change of role, from managing services to contracting for services, represented an enormous shift in the way the organisation understood itself. This was not helped by the double role it had to play for several years, both providing and purchasing services, before the provider units became NHS Trusts.

The District Health Authority (DHA) and Family Health Services Authority (FHSA) established an integrated working relationship in 1993, in the form of Sunderland Health Commission. This was comprised of three non-executive members of each of the Authorities, the joint Chief Executive, and the Directors of Finance and Public Health.

The staff of the two Authorities were integrated into a shared management structure in shared headquarters. The effect of this was to simplify inter-agency coordination, in that there were fewer agencies to coordinate. As statutory bodies, the Authorities themselves could not be amalgamated without a change in the law, which was not implemented until April 1996. Until then, the Health Commission reported to both Authorities. The Health Commission was responsible for purchasing health care services worth £156 million in 1993/94, or about £522 per person.

At the General Election in April 1992, the Conservative Party was elected to its fourth successive term of office. This meant that those Authorities which had been holding back developments in the expectation of a change of government had to resign themselves to implementing plans already in hand. Recent changes introduced by the government, including GP Fundholding, NHS Trusts and the separation of the purchasing from the provision of services in health and social care were there to stay, at least for another term of office.

After the election, 143 health service provider units throughout the country initiated applications for fourth-wave Trust status. In Sunderland, plans to apply for Trust status for one unit comprising all the hospitals and community services were not encouraged by the RHA. The DoH brought out guidance advocating the separation of priority⁶³ and community services from acute hospital services⁶⁴. Sunderland, therefore, applied for

⁶³ Priority services are services for people with mental illness or learning disabilities.

⁶⁴ Department of Health, EL (92) 56, 20 August 1992.

Trust status for two units: one based on the acute hospital services and the other made up of priority and some community services. In April 1993, the existing three health service provider units were replaced by two, as community health services were absorbed into the other two units in preparation for seeking NHS Trust status. The Secretary of State announced in October 1993 the 99 units which would become NHS Trusts in April 1994, including the two Sunderland provider units, City Hospitals Sunderland and Priority Healthcare Wearside. From that point, they were independent bodies and no longer directly managed by the District Health Authority.

The Social Services Department was part of the Local Authority, and was accountable to the elected councillors. There were, then, important differences in the lines of accountability between the health and social services. The relationship between officers of the SSD and the councillors was unlike the relationship between officers of either health authority and their members. The councillors were more closely involved in the daily workings of the SSD than the DHA members. All policy decisions were made by the Social Services Committee, and they sometimes challenged decisions about individual clients made by social workers.

In 1990, the bulk of statutory social services in Sunderland was delivered through a system based on the functional groupings of residential services, day care and fieldwork. These were replaced in 1993 by a central services division and three client-group divisions classified according to age and needs: services for (i) children and families, (ii) people with special needs and disabilities, (iii) older people. Within these divisions, the major functions of the Social Services Department were undertaken: the assessment

and management and purchasing of care, and the direct provision of social services (including social work services, the supply of aids and equipment, domiciliary care, residential care, day care). The NHS and Community Care Act 1990 also introduced a split between purchasing and provision into social services, but the split was between different arms of the service, rather than separating the functions into different agencies, as in the health service. Provision was already via a mixed economy and planned to be more so. The Social Services Department was responsible for purchasing social care services worth around £50 million, or about £167 per person.

Though this thesis concentrates mainly on collaboration between health and social services, it has to be borne in mind that the health service is not one integrated organisation, but a federation of organisations, and that the NHS and Community Care Act created more barriers within the health service than existed before. As a result of the 1990 reforms, the two local health authorities, the DHA and the FHSA were brought closer together towards merger, but the separation of the purchaser and provider functions introduced new splits. Furthermore, the independent contractor status of GPs made every GP practice a separate organisation. There was as much need for the Health Authority to integrate the planning and delivery of services between the various health care organisations as there was with other related services provided by the Local Authority.

The purchaser/provider split was intended to give Health Authorities greater control over the providers through contracts, and it should have been possible for Health Authorities to enforce compliance with policies and services that were jointly agreed

with the SSDs. However, NHS Trusts, in practice, tended to work relatively autonomously. After all, the contracts were not legal documents, and were fairly unsophisticated when it came to describing the nature, quantity and quality of the procedures that were being purchased. Though the Health Authority could in theory switch contracts to alternative providers, this would tend to increase overall costs by increasing overheads on other services purchased from that provider. This meant that the Trusts needed to be included in strategic planning so that they had ownership of developments from an early stage.

Social Services Departments were also divided into purchaser and provider camps, but within the same organisation. This meant that the Director of Social Services still had control over both wings and could make his influence felt. SSDs also contracted for services with the independent and voluntary sector, but their contracts were very different from health service contracts, with much greater detail in the content and more sanctions if contracts were breached.

This had a number of implications. Firstly, though health authorities and social services departments were always very different organisations, the differences were multiplied, making it ever more difficult for the various agencies to understand one another. Secondly, where the SSD had to work with two health authorities in the past, the DHA and FHSA, it now had to work with more health care organisations. Though the formation of the Health Commission meant the SSD only had to work with one group of health authority officers, there were also the two NHS Trusts. There was in addition much more emphasis on consulting GPs and GP fundholders. Not only were there more

health service organisations to work with, but the SSD was expected to work with a great number of other bodies, such as the education department, housing authority, the independent and voluntary sectors and user and carer groups. Where working with the Health Authority had been the chief focus of collaborative activity before the introduction of the 1990 Act, it was now only one among many.

During the early 1990s, the independent sector became increasingly important in the provision of services in the community. Like the statutory agencies, the independent sector was not a single entity, and was made up of a large number of private and voluntary organisations, but was even more diffuse than the statutory sector, with even less cohesion.

There were over 400 voluntary organisations in Sunderland⁶⁵. Some were local societies, often branches of national organisations. Organisations existed for different purposes: to provide services or support, to promote the interests of the client group, or to raise funds. The Council for Voluntary Services (CVS) played a co-ordinating role and provided an information service direct to the public about the services available. An umbrella group represented organisations interested in mental illness. The Council for the Disabled brought together organisations with an interest in people with disabilities. Some voluntary organisations provided services through paid employees, on a not-for-profit basis. Funding for these had come from grants before the implementation of the 1990 Act, but by 1994, these services were funded through

⁶⁵ Sunderland Council for Voluntary Service, *Directory of Voluntary Organisations and Self Help Groups*, 1994.

contracts with the Local Authority.

The private sector was comprised of organisations which provided services for profit. The largest segment of the private sector in Sunderland was made up of the residential care homes and nursing homes which abounded in the city. Boundaries between the private and voluntary sectors could be somewhat blurred as residential care was also provided by voluntary or charitable organisations.

The Services

A full description of community health and social services is provided at Appendix C. The services have been grouped according to the sources of funding and where the contracts for the services are held: family health services, community health services, social services, independent sector. This does have the effect, however, of separating similar or complementary services: dental care is provided by the general dental service and the community dental service, and several community health services work alongside general medical practice. An account of general practice is contained in the main text for a number of reasons. Firstly, the other services are described, but little data is available to offer comparisons or analyses. This is possible, to some extent, for general practice, and helps the overall picture of Sunderland. Secondly, it is particularly important to understand the nature of general practice in Sunderland for two parts of the case study.

General Medical Practice

General Medical Practitioners straddle the boundary between agencies and services. Fundholders act as an agency, purchasing secondary and community services for their patients, as well as providing medical services. Fundholding developed very slowly in Sunderland. By April 1994, only four (8%) of practices were fundholding, compared to 18% in the Northern Region⁶⁶, and 33% throughout the country.

The services provided by GPs are described in Appendix C. Though there were practices in Sunderland which would be regarded as "good" anywhere in the country, the general picture was poor, with a history of high list sizes, smaller practices, older doctors, fewer female doctors and low numbers of GP trainers. Taken on their own, none of these indicators would necessarily indicate a poor level of service. The problem in Sunderland was that so many measures represent what was regarded as the poorer end of the spectrum of an acceptable general practitioner service. There were signs of recent improvement, as demonstrated by the increasing range of services offered in general practice in Sunderland and the increase in practice-employed staff. This was probably due to a number of reasons, including vocational training and the new GP Contract.

ASSESSING THE FRAMEWORK FOR COLLABORATION

This section measures the situation in Sunderland against the framework for

⁶⁶ Northern Regional Health Authority GPFH Statistics (as at 1 December 1993).

collaboration developed in Chapter Four.

The Environment

The political, economic and organisational issues in the national context have already been described (Chapter Three). There is now a need to assess whether this created an environment conducive to the development of collaborative working and inter-agency coordination. The framework identifies six environmental factors likely to have an impact on joint working at all three levels, strategic, operational and practitioner, though some of these will be felt in different ways at the various levels.

The first factor in the framework was the level of turbulence. There was political stability, as the same government had been in power for well over a decade. However, for the health and social services, there was considerable turbulence created as a result of new legislation, namely the NHS and Community Care Act 1990, which led to major reorganisations of all agencies involved. This meant that the agencies had to invest a great deal of time and energy in reorganisation, which was likely to hinder working together.

At the strategic level of the health service, the turmoil created by the NHS and Community Care Act was felt in terms of the separation of the purchaser and provider functions, the setting up of NHS Trusts, the merger of the DHA and FHSA management arrangements, the nurturing of fundholding. At the practitioner level it felt, as a district nurse put it, like "yet another reorganisation", with a new management structure, new

managers with new headquarters and a new logo on the letterhead, while the service still had to be delivered.

The different aspects of the NHS and Community Care Act were not coordinated: *Caring for People* showed no awareness of *Working for Patients*. As the discussion of central/local relations showed, government policy was not aligned to the structures set up to implement it.

There was a great deal of pressure to collaborate. As Webb observes, "exhortations to organisations, professions, and other producer interests to work together more closely and effectively litter the policy landscape"⁶⁷. Community Care policy was heavily laden with reminders to work jointly. However, the means for achieving collaboration were left to local determination. Pressure to collaborate is insufficient unless the means are made available. There needs to be a balance among costs, resources and benefits of collaboration.

Economic pressures meant that the government was keen to control spending in the public sector. This was felt particularly keenly by the Local Authorities, but the NHS was also unable to expand as fast as increasing demand. Though the SSDs acquired additional funding through the Special Transitional Grant after 1993, they also had many extra responsibilities. Problems became more severe in Sunderland after the research period, in 1995, when standard spending assessments were reduced. Financial

⁶⁷ Adrian Webb, "Coordination: A problem in public sector management", in *Policy and Politics*, 19:4, 1991, pp. 229-241 (p. 229).

strictures meant that organisations tended to draw in their boundaries and disperse costs where possible. This was not conducive to collaboration. This might be a different matter if collaboration could be shown to lead to cost savings, but this view was not held in Sunderland.

Demands on services were increasing because of changes in demographic trends and patterns of family life. Demand was likely to be higher in a deprived area like Sunderland, where there was a high level of illness and social need. There was also a greater need for services to be coordinated

Overall, therefore, apart from the pressure to collaborate, environmental factors in the national context were not likely to promote joint working. This was also very much the case locally in Sunderland, where these factors were played out at a much more personal level. Reorganisation meant changes for real people, real jobs and brought anxiety and uncertainty. The legislation brought a new emphasis on meeting the needs of clients rather than on providing services and increasing pressure on the agencies to work together to achieve this, which were positive influences for collaboration. However, the organisational changes made joint working more difficult.

Characteristics of the Organisations

This chapter has introduced the organisations that were involved in implementing community care policies in the early 1990s, which enables us to assess some of the factors in another part of the framework, namely the characteristics of the organisations

at the strategic level.

There was one important advantage for joint working in Sunderland, and that was the coterminous boundaries shared by the health authorities and local authority. This meant that the agencies did not have to coordinate their activities with a large number of other statutory organisations.

However, as has been shown, the structures of the statutory organisations were very different. Though the operational structures of the DHA and FHSA were unified, the fact that the SSD was part of local government while the health services were part of a line that stretched directly to central government meant that they worked in different ways. The structural adjustments introduced by the NHS and Community Care Act, most noticeably the purchaser/provider split, only served to increase the differences.

The accountability framework was also different. The SSD was accountable to the Social Services Committee, a body of locally elected councillors. The health authorities were accountable to their members, who were severally appointed by the RHA and Secretary of State. Though the government described the post-1990 DHAs as "champions of the people"⁶⁸, there was some evidence (e.g. from comments made by members of the public during the public consultation over the strategy for health in Sunderland⁶⁹) that the health service was viewed in some quarters as a government bureaucracy which was not directly accountable to the people.

⁶⁸ Department of Health, *Developing Districts*, 1990.

⁶⁹ Sunderland Health Authority, *Strategy for Health*, 1994.

The differences in structure and lines of accountability do not necessarily mean that the organisations cannot work together, but they require greater understanding and insight to overcome the structural and ideological ignorance⁷⁰ that inhibit joint working. Collaboration, which is difficult anyway, becomes harder.

A number of devices were used in Sunderland to build joint working into the structures and systems, and transcend the difficulties that hampered collaboration, and these are described below. The other factors in this sector of the framework, namely domain, funding issues and culture, will be discussed in the next chapter.

The Primary Health Care Team

The Primary Health Care Team (PHCT), as we have seen, is a means of coordinating the efforts of people who work in or alongside general practice. Each PHCT was different in its membership and the way it operated, including whether or not meetings were held, the frequency and style of meetings. This makes it impossible to generalize about PHCTs. In some practices, the focus of the team was a regular meeting to discuss patients, which included those professionals with clinical interests, but excluded the administrative staff. In other practices, the team comprised the GPs and their employees, and in others, it included all those with an interest in the practice and its patients. This meant that when a new member was attached to a team, a great deal had to be negotiated, such as liaison and feedback, sharing of records and boundaries between responsibilities.

⁷⁰ Nocon, 1989.

Some practices were so large that they could no longer be thought of as "teams", but as Primary Care Organisations. This was less common in Sunderland, but a practice with five or six GPs could have a "team" of 40, which was too large a number to operate effectively as a team⁷¹. In these cases there could be many teams operating in the practice, working around a particular project, patient group or individual patient, or based on a particular professional or working group. These "teams" will form, disband and reform according to need.

Different relationships existed for different types of community nurses, depending on the nature of the work and the numbers of staff available. Community midwives were often attached to several practices. CPNs usually worked quite independently of the PHCT, liaising with the PHCT as necessary about individual patients. District Nurses and Health Visitors were attached to practices, though the degree of attachment varied. A project which aimed to strengthen links between district nurses and health visitors and PHCTs is discussed in Chapter Eight.

Where practices were fundholding, the relationship with the community nurses changed again. From 1993, fundholding practices were able to contract with Trusts for community nursing services, apart from community midwives⁷². This gave them more say in the type, quantity and quality of services they "bought". One practice bought a

⁷¹ N C H Stott, "Personal care and teamwork: implications for the general practice-based primary health care team", *Journal of Interprofessional Care*, 9:2, 1995, pp. 95-99 (pp. 97-98).

⁷² NHS Management Executive, *Guidance on the extension of the Hospital and Community Health Services elements of the GP fundholding scheme from 1 April 1993*, EL (92) 48, 1992.

CPN service in the surgery on a sessional rather than on an "as and when required" basis.

The problems of having too large a PHCT have already been mentioned. Despite this, there was a desire to bring a wider range of professional skills into the team. Dietitians and chiropodists were brought in to support diabetic clinics in surgeries, in order to give patients a more comprehensive service. Some practices employed counsellors, and some had voluntary counsellors from MIND. Under one fundholding contract, the Clinical Psychology service provided a weekly session in the Health Centre, with a monthly liaison session with the GPs. Another initiative sought to extend the role of the practice nurse to create practice nurse specialists, who would work more autonomously according to set protocols.

An important means of developing links between health and social services was the attachment of social workers to Primary Health Care Teams. This is discussed in detail in Chapter Seven.

A number of methods were available to promote teamwork, ranging from residential weekends⁷³ to training packages for use in the surgery⁷⁴. Members of sixteen PHCTs in Sunderland attended residential team building workshops during the research period.

⁷³ Jill Spratley, *Disease Prevention and Health Promotion in Primary Health Care: Team workshops organised by the Health Education Authority* (London: Health Education Authority, 1989).

⁷⁴ For instance, Peter Pritchard and James Pritchard, *Developing Teamwork in Primary Health Care: A Practical Workbook* (Oxford: Oxford Medical Publications, 1992).

Social Workers and Secondary Care

The means of providing social work support to hospitals also changed as part of the restructuring of the Social Services Department. The three hospital teams became an integral part of the mainstream social work service, with two teams drawn from the Older People's Division, and one from the Child Care Division. These hospital teams acted as a feeder into the area teams and as a bridge between hospital and community. The hospital social workers undertook work that could be completed on the day and referred more complex assessments to the area team. This reflected a change of emphasis, and was based on the supposition that workers in the community were best placed to assess clients' needs in the community.

Secondary Care Liaison with Primary, Community Health and Social Care

The relationship between GPs and hospitals was well-established. At a formal level it was conducted through a process of referral from GP to consultant and a flow of information from consultant to GP through clinic letters after out-patient appointments and discharge letters subsequent to hospital admission. However, GPs often complained about the length of time it took for information to reach them following a consultation or admission. Faxes were introduced to all practices with the aim of addressing this problem. It was thought that discharge letters could be faxed through to practices as the patient left the hospital door. There is no evidence, however, to show that the fax machines improved the speed of communication.

Poor communication could create a problem when discharged patients needed to be followed up or a patient required a prescription and the GP had no information about the drugs prescribed by the consultant. In addition, GPs noted that as hospital consultants were discharging patients from their clinics and from the wards sooner, the letters received from consultants contained much more detailed instructions requiring the GPs to carry out treatment on behalf of the consultants. GPs were concerned that this flow of delegated work would either need to be dammed or more resources put into primary care. The strategic shift of moving secondary care to primary care was about providing a better service to patients, not about giving hard-pressed GPs more work.

The key to the relationship between hospitals and the various community services was the hospital discharge policy. The foundation of the policy was the statement that "patients will not be discharged from hospital until a plan has been agreed which takes into consideration any continuing health, including rehabilitation, or social needs that they may have"⁷⁵. Hospital patients were put into four categories, each category requiring different levels of input and involvement. Patients with social care needs would not be discharged into the community until the systems were in place to provide their necessary support.

The chief concern of hospital consultants and managers was that the time taken to set up social support could mean that people stayed longer in hospitals beyond the point at which they were deemed medically fit. This could lead to "bed blocking", with

⁷⁵ City Hospitals Sunderland and Priority Health Care Wearside, *Hospital Discharge Policy* (1992).

relatively healthy people in hospital beds which were then not available for the ill. To prevent this required careful management of the critical points of contact: the ward's referral to social services, the social worker's first contact with the client, the time taken to make a full assessment, the time taken to put services in place or arrange an admission to residential or nursing home care. The timescales agreed between the health and social services in Sunderland were much longer than was common in other districts, which left the Sunderland hospitals with particular problems.

Relationships with the Independent Sector

There were four dimensions to relationships with the non-statutory sector: financial, registration and inspection, consultation, and the development of special initiatives.

Some voluntary organisations received grants from the Local Authority or Health Authority, where grants were given to organisations in order to carry out specified services. After the implementation of the Community Care reforms, the relationships based on grants from the Local Authority developed into more "business-like" contractual relationships based on costed programmes which were monitored. It was possible, though less usual, for contracts to work the other way. Thus, the Multiple Sclerosis (MS) Society paid for 18 hours a week of a community physiotherapist's time to work with a caseload of around 160 MS sufferers, though the Health Authority eventually took financial responsibility for this.

From April 1993, the Social Services Department became responsible for purchasing

residential and nursing home places for those assessed as needing them, who could not afford to pay for their own care. The mechanism for achieving this was through contracts with the residential care and nursing homes. The SSD maintained a register of homes which was made available to care managers and clients.

By law, residential care homes had to be registered with the Local Authority and nursing homes with the Secretary of State who delegated the responsibility to the Health Authority. The Authorities were also responsible for inspecting the Homes to ensure standards and quality⁷⁶.

The Joint Planning Forums organised by the Social Services Department and Health Commission every six months for several client groups gave an opportunity for voluntary organisations to inform the authorities of their opinions of the services provided and the needs of their client groups. This information was then supposed to be taken into account in development plans and purchasing strategies.

Consultative links were also in place for specific projects and initiatives. The SSD maintained close links with the organisations with which it held contracts or which were grant-aided. The Director of Social Services held a quarterly meeting for all residential and nursing home owners.

⁷⁶ There was no requirement to inspect small homes, with three places or less.

CHARGING POLICIES

One important difference between the provision of health and of social services relates to charging policies. This can be particularly important for clients and their families. Health care is, for the most part, free at the point of delivery, while charges may be made for some social care services. Parker identifies five purposes for charging for social services:

- i. to raise revenue and reduce public expense;
- ii. to reduce demand for services;
- iii. as a means of shifting priorities;
- iv. to check abuse of a free service; and
- v. as ideological symbols: as, for example, in the Conservative belief that "there should be charges" in the case of prescription charges, or the Labour Party desire to distinguish residential homes from the workhouses and make them more like private residential hotels.⁷⁷

Local authorities had to impose means-tested charges for some services, residential accommodation for example, but others were optional and variable (home help service, meals on wheels). During the research period, Sunderland SSD did not charge for domiciliary care. There were numerous anomalies and inconsistencies with charging mechanisms in different local authorities. Hudson refers to the "piecemeal drift towards

⁷⁷ R A Parker, "Charging for Social Services", *Journal of Social Policy*, 5:4, 1976, pp. 359-373.

more and higher charging for social care"⁷⁸ arising at least in part from the assumption that local authorities would recover 9% of home care and day services in charges when calculating the revenue support grant. On the other hand, means-tested charges for health care services were limited and marginal: charges for dental and optical services and prescriptions, with wide-ranging exemptions, especially for older people and children. Though the proportion of income from charges fell nationally between 1990 and 1994 for both services, the percentage received by social services was twice that received for health care (see Table 5.iv).

TABLE 5.v PROPORTION OF INCOME FROM CHARGES, 1990 AND 1994⁷⁹

	1990	1994
National Health Service	4.5%	3.1%
Personal Social Services	10.8%	8.0%

From the patients' and clients' point of view, all charges could be a burden. From 1993, Social Services Departments also took on the responsibility for funding placements in Nursing Homes and Residential Care Homes. These placements were means-tested and could cost a resident over £200 a week. The impact of charging policies on collaboration was subtle. From the client's point of view, which agency provided a service could make a great deal of difference financially, and this could affect the dynamic between service providers.

⁷⁸ Bob Hudson, "What price care?", *Health Service Journal*, 3 August 1995, pp. 24-25 (p. 24).

⁷⁹ Department of Health, *Health and Personal Social Services Statistics for England, 1995 edition* (London: HMSO, 1995) p. 113, table 7.2.

SUMMARY

This chapter has described Sunderland, its social and economic characteristics and its poor state of health. It showed that people in deprived areas with greater need for care than people in more affluent areas often get less of it. They are more likely to have multiple problems and have a higher need for coordinated care.

The chapter went on to describe the agencies which provide health and social care in Sunderland. It looked in detail at general medical services and used a number of indicators to show the poor level of these services.

The last section of the chapter used the framework for collaboration developed in Chapter Four to analyse the environment and the characteristics of the organisation in Sunderland to determine whether they are conducive to collaboration. It found that though the boundary shared by the health and social services was an advantage, the differences in the structures and accountability frameworks created barriers between the agencies. Though these were not insuperable, they required additional effort and willpower to overcome.

This chapter has set out the local context in which the agencies in Sunderland developed and implemented local policies for community care. That process is described in the next chapter.

CHAPTER SIX

COLLABORATION IN PLANNING

FOR COMMUNITY CARE

INTRODUCTION

This chapter examines collaboration at the strategic level of health and social services in Sunderland. It gives an account of the collaboration involved in planning in Sunderland for the implementation of the Community Care dimension of the 1990 Act and the organisational changes that took place in the health and social services.

Community Care Policy is very wide-ranging, requiring collaboration between the agencies on many different issues. This review of developments in Sunderland does not report on every aspect or every programme, but concentrates on collaboration between health and social services in three areas: the planning process and the publication of Community Care Plans, the development of strategies for collaboration between social workers and general medical practitioners, and the development of procedures for assessment and care management, a cornerstone of the policy. An account is given of the key themes: the process of Community Care Planning, policy

on the boundaries of care, assessment and care management, and collaboration between GPs and social workers. This account was drawn, initially, from departmental and personal files containing minutes of meetings and correspondence. The resulting report of events was then shown to key players, who confirmed and commented on it, and provided their own observations, some of which are included in the text. The researcher was also a minor player in planning for community care in Sunderland, and so there is an element of participant-observation.

JOINT PLANNING AND JOINT FINANCE: SUNDERLAND IN THE 1980S

In the late 1980s, the DHSS commissioned a study to look at the nature, extent and effectiveness of joint planning arrangements and the way in which joint finance was allocated. The study, carried out by the Centre for Research in Social Policy at Loughborough University and the Centre for Health Economics at York University, was published in 1989 as *Collaboration and Cost-Effectiveness*¹. Sunderland was one of the six sites studied. A preliminary unpublished report was produced², which looked at the formal and non-formal structures for joint planning between the Local Authority and District Health Authority and Family Practitioner Committee, as well as informal networks. It found that, of the six areas under consideration, Sunderland had the simplest and most stable structural relationships. However, despite the coterminosity

¹ B Hardy, A Turrell, A L Webb, G Wistow, *Collaboration and Cost-Effectiveness* (Loughborough: Centre for Research in Social Policy, 1989).

² B Hardy and A Turrell, *Joint Planning and Joint Finance in Sunderland* (Loughborough: Loughborough University of Technology, Centre for Research in Social Policy, 1987) used by kind permission of Brian Hardy.

of boundaries, the unitary Local Authority, and political, organisational and personnel stability, this did not lead to more advanced joint planning machinery. In fact, it was for these very reasons that complex machinery was felt to be unnecessary. There was little involvement of Local Authority departments other than the Social Services Department. Nor was there much formal involvement of the voluntary sector, which exerted little pressure to become involved. Joint planning was restricted to the formal structures, and was very much officer-led.

A distinction was made in the study between three types of planning: joint, parallel and separate³. Those interviewed in Sunderland reported that their planning was parallel. The Health Authority and Social Services Department planned separately, but came together to discuss the boundaries. The report remarks on the distinctive view held in Sunderland about these types, which involved "a respect for each other's specialism"⁴, and led to a view of planning as requiring collaboration in some areas but not others, and at some stages but not others. Even in relation to areas of common interest, such as mental handicap, not everything was shared, especially by the local authority. As Hardy and Turrell report, "the health authority would tend to bring issues to the joint planning team for that client group, whereas the local authority, if it was a development which they felt was a purely local authority issue, would go ahead ... to resolve it unilaterally,"⁵.

³ Hardy, Turrell, Webb, Wistow, 1989, pp.51-52.

⁴ Hardy and Turrell, 1987, p. 33-34.

⁵ *Ibid.*, p. 30.

The study found a lack of tangible positive outputs from joint strategies for client groups. However, there was a less tangible output in that informal collaboration was good.

This, then, was the picture of inter-agency coordination in Sunderland in 1987. It is probably a reasonably accurate reflection of the state of things in 1990. In the intervening period, there had been no significant change in personnel in either the Social Services Department or the Health Authority, though a planning officer had been appointed to the FPC.

ORGANISATIONAL DEVELOPMENTS IN THE HEALTH SERVICE AND SOCIAL SERVICES IN SUNDERLAND

Chapter Five established the organisational context for the development of community care. The period 1990 to 1994 was marked by unprecedented change in the organisations themselves and in the work they had to do. Though the health service had become accustomed to change by this time, there had been no change in the structure of the Social Services Department for nearly 20 years.

During the research period there were four different Directors or acting Directors, one of whom served twice. The Director of Social Services (A) retired at the end of October 1990. The Assistant Director (B) "acted up" until a successor (C) was appointed in February 1991. A year later this director left the department. The Assistant Director (B) took over until his retirement in September 1992. Director (D)

then took up his post.

This inevitably led to changes in style and direction. Under Director A, committee papers were written by Assistant Directors and their teams. Director C wrote committee papers himself, and did not keep his department informed about plans or developments. As one of his officers observed, "he wrote all committee papers, all the important ones he wrote himself, personally on his computer, typed them personally."

Another difficulty for the SSD was the gaps created by people acting up to other posts during the periods when Director B was in charge, when their usual duties were not necessarily taken from them. This meant that some staff working on developing Community Care also had substantial other work commitments. In contrast, the DHA seconded one officer to work full-time on Community Care issues for six months, and other officers had a clear remit, with time allowed, to work on Community Care.

It was Director (D) who established the new management structure described in Chapter Five. During the summer of 1993, several new staff joined the SSD as those posts in the new management structure which had been advertised externally were filled. The new blood brought in new ideas and fresh perspectives. However, the new officers had to establish themselves within the department before developing links with other organisations, and the end of the research period marked a period when officers had drawn back to a certain extent from close relationships with the health service in order to consolidate the department. The SSD had a much more complicated collaborative agenda than the health service, being required to work with other LA

departments (housing and education), the independent sector, voluntary organisations, and user and carer groups.

The frequent change of Directors of Social Services did inhibit progress and led to periods of "planning blight". As one observer put it, "there was an understandable reluctance to paint the incoming director into policies that he or she would not be attuned to. ... They had draft policies, but they were not adopted by anyone till the new director came..." One Director in particular provided little leadership; in a letter in 1991 to the Regional General Manager, he stated that "I also suggest we all take with a pinch of salt the commitment to introduce in April 1993 the residential contracting and funding arrangements"⁶. He gave his reasons for this view, but with hindsight it does appear extraordinarily naive and suggests a "head in the sand" approach to implementing the policy. He may well have been anticipating a change in government.

As shown in Chapter Five, all the statutory health and social service agencies were preoccupied with major organisational change, mainly in response to the requirements of the NHS and Community Care Act 1990. The Social Services Department had special problems with the frequent changes of Director, and additional pressures with the implementation of the Children Act. It also had to cope with the backwash of a child abuse scandal in a Local Authority Children's Home. At the same time, the Authorities had to implement the policies introduced by the NHS and Community Care

⁶ Letter from Director of Social Services, Sunderland Borough Council, to the Regional General Manager, Northern Regional Health Authority, "Meeting between Directors of Social Services (Northern Region) and Executive Directors and other Officers of the Regional Health Authority", 5 September 1991, p. 4.

Act, in addition to their existing functions of providing health and social care services. The level of turbulence created by reorganisation and by other problems did not promote collaboration, as the agencies had to turn away from their relationships with other organisations and concentrate on internal issues.

THE WIDER ORGANISATIONAL CONTEXT

It is also important to understand the wider organisational context and the changes taking place at the intermediate level of the bureaucratic machinery, between government department and local level, and the impact this had on relationships between the local level and the intermediate tier.

In 1990, at the start of the research period, the Northern Regional Health Authority was accountable to the NHSME and managerially responsible for the DHAs and FHSAs within its boundaries. In 1991, the Regional General Manager left for undisclosed reasons⁷ and was succeeded by the Regional Director of Public Health. In 1993, the government expressed an intention to reduce the number of managers in the health service at the regional level. The Northern Regional Health Authority responded with alacrity, reviewed its functions and significantly reduced the number of staff employed⁸. Later in the year, the government announced that the number of RHAs would be reduced from fourteen to eight from April 1994, and that the RHAs

⁷ *Health Service Journal*, 28 November 1991, p. 8.

⁸ *Ibid.*, p. 5.

would be abolished and replaced by outposts of the NHSE in April 1996⁹. The Northern Regional Health Authority was to be merged with a neighbouring RHA. Thus there was considerable upheaval within the RHA during the research period. These changes - in leadership, personnel, numbers of staff available to undertake work, and preparation for a new function - led to significant changes in how the RHA perceived its role and how it related to the local health authorities. Though the RHA was critical of the first Community Care Plan which Sunderland produced, it did not feel it appropriate to comment on subsequent plans, because, as a RHA observer put it, "they should be local ... we might have given some informal feedback, but very much on request. We haven't had a full process of checking plans." The reduction in staff meant that the RHA had to confine itself to the "non-negotiables", and was less able to be active in facilitating developments at local level. Though it did have a monitoring role, scrutiny was not as close as it had been.

The Social Services Inspectorate (SSI) is a professional division of the Department of Health and acts as the main link between the Department of Health and Local Authorities. It provides professional social work advice and knowledge and experience in the personal social services to Ministers and the Department of Health, supports and monitors the implementation of government policy, monitors the quality of social services provision, and carries out inspections of the personal social services. The SSI was reorganised in 1993, so that the policy wing was separated from the inspections division.

⁹ DoH, *Managing the New NHS*, 1993.

The relationships between the DHA and RHA and between the SSD and the SSI were very different. During this period, the DHA was accountable to the RHA. This meant that the DHA often had a clearer idea about what was expected, but it was at risk of censure if it did not perform. The SSI, however, had a purely advisory role in relation to the development of policy. It set boundaries and outcomes for work, but did not define the process. One officer described the relationship between the SSI and SSD as "less well-defined, more touchy-feely". Another commentator observed that there was also a difference in culture between the RHA and SSI, the RHA having an unequivocally bureaucratic stance, while many officers of the SSI had been drawn from fieldwork within the SSDs and had loyalties both to the field as well as to the DoH.

Both the RHA and the SSI had responsibilities for monitoring developments in policy and implementing community care within, respectively, the health service (DHA and FHSA) and the Local Authority. Some monitoring exercises were undertaken jointly across health and social care boundaries; others were carried out quite separately.

The Community Care Support Force has already been mentioned in Chapter Two. It was a body that enjoyed a temporary existence to assist health and social care authorities to prepare to implement the community care reforms. Though the junior minister for health, Brian Mawhinney, insisted that the Community Care Support Force was not a "hit squad"¹⁰, there was no doubt that its services were offered to authorities

¹⁰ Wendy Moore, "May the force be with you", *The Health Service Journal*, 24 September 1992, p. 12.

thought to be in difficulties. Sunderland came very close to receiving its attentions.

THE PLANNING SYSTEM

The structure of the planning system that existed before 1990 is shown in Figure 6.a. The formal mechanism for collaboration between Sunderland Health Authority and the Sunderland Borough (later, City) Council, and later, the Sunderland Family Health Services Authority was the Joint Consultative Committee (JCC), a quarterly meeting of Authority members. This was supported by a committee of officers, the Joint Officers' Group (JOG). The Joint Resources Working Party reported to JOG, and comprised senior officers, including finance officers, but not operational managers, from the Local Authority and Health Authorities. It considered the financial implications of plans, monitored joint finance arrangements and managed the financial and planning aspects of the discharge of long-stay patients into the community. A plethora of Joint Care Planning Teams (JCPTs) based on client groups also reported to JOG. The planning system tended to involve the coordination of activities between social services and the health service, though it was intended to incorporate a wider range of interests, including housing and education.

In the past, most of the work of the JCC was to do with joint planning and the approval of schemes requiring Joint Finance. It also steered the resettlement of patients from long-stay hospitals. With the advent of the NHS and Community Care Act 1990, its work increased dramatically. New responsibilities included the production of the Community Care Plan, the development of joint arrangements for

Joint Planning in Sunderland, 1986 - 1990

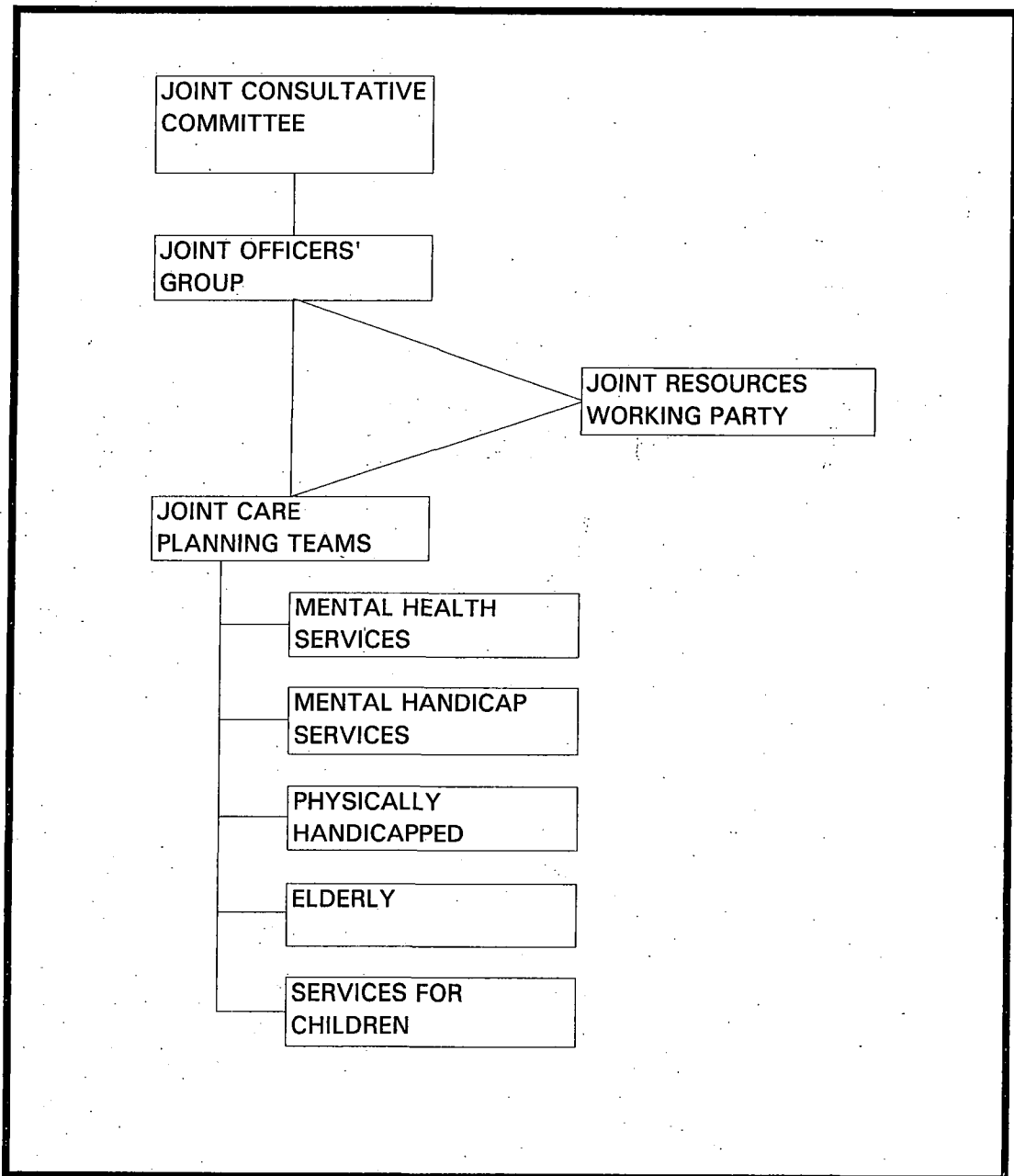


Figure 6.a

assessment and care management and the discharge of patients from acute hospitals, and approval of schemes for the Mental Illness Specific Grant (MISG).

There was also a good deal of contact between junior and middle-level officers of the Authorities, both at meetings and informally. With Community Care, this contact increased with all the new working groups and task teams that produced the reports which went to the JCC.

In September 1990, the JCC agreed to discontinue the Joint Care Planning Teams (JCPTs), at the behest of the DHA, on the grounds that they did not fit comfortably with the purchaser/provider split introduced by the 1990 legislation. Some observers also thought that their usefulness was limited. One interviewee described them as "stagnant". Another said, "They were ineffective; they didn't jointly plan, they joint talked, and joint talked about the same things, month after month. ... joint strategies were prepared. ... They were never implemented." Though they were quite large committees, they were still unrepresentative. Members did little work between meetings. The agendas were driven by planning staff from the statutory agencies. However, the JCPTs did provide an opportunity for officers of the statutory agencies to talk to one another, which was important for developing relationships. In the late 1980s the JCPTs had been producing or working towards joint strategies for the client care groups, though as one observer noted, the strategies were not then used to drive developments. The lack of joint strategies had been one of the criticisms of the Hardy and Turrell study¹¹.

¹¹ Hardy and Turrell, 1987, pp. 3, 84, 108.

The JCPTs were replaced by workshop-style events based on client groups (Older People, Physical Disabilities, Mental Illness, Learning Disabilities), comprised of officers of the agencies, representatives of the voluntary and commercial sectors, clients and carers, which met twice a year, in spring and autumn¹². This was seen as a way of increasing the involvement of carers and users. Despite the title of the programme, Joint Planning Forums, it was a consultative exercise which fed into the planning process, rather than a planning exercise in itself. Issues raised in the forums¹³ were passed into the planning process through Task Teams and the JOG and reported to JCC. Some of the early meetings were dominated by complaints of lack of consultation with the voluntary sector, clients and carers in the past. They became more productive as the Authorities' officers became more experienced in organising them, as those involved became more comfortable with the format, and as the range of groups and agencies invited grew.

The substitution of the forums for the JCPTs occurred in response to the NHS changes of the 1990 Act rather than the community care aspects, because they were seen by some to be inadequate. However, they did give the statutory agencies an opportunity to talk with voluntary organisations and users and carers.

The Task Teams were seen as a means of picking up issues raised by the forums and turning them into realistic plans. They were intended as time-limited groups that

¹² Joint Consultative Committee, Minutes of the Meeting of 25th September 1990, § 5.

¹³ [sic] The Latin may be incorrect, but this is what they were called in Sunderland.

would work on a specific issue and then wound up when the work was completed. Members were middle managers of the Social Services Department, District Health Authority and Family Health Services Authority. After the first round of forums, six Task Teams were commissioned on matters such as sensory disability, support for carers, clients' councils, and autism. Reports went to JOG and JCC. As a result, £13,000 funding was committed to two projects, though one project, involving £3,000, was later suspended when overtaken by other events. Another outcome of this work was the circulation by the Northern Regional Health Authority within the Region of the Sunderland report on support for carers as a model for good practice. Two more Task Teams came into being after the second round of forums, but by the end of the period in March 1994, there were no more. They were time consuming, and they caused very little change.

In January 1992, the Joint Resources Working Party was replaced by the Joint Planning Group (JPG), which had a wider remit, including community care planning, obtaining the input to planning of users, carers and voluntary agencies, and managing the resource implications of community care. The role of the JPG was to ensure that proposals to JOG and JCC were financially viable and consistent with plans. Figure 6.b shows the structure of the committees comprising the planning system in 1992, after the changes which had taken place over 18 months.

At the June 1993 meeting of the Joint Officers' Group (JOG), membership was extended to include the chief executives of the shadow Trusts. This meant that there was now health services provider as well as health-purchasing representation on JOG,

Joint Planning in Sunderland since 1992

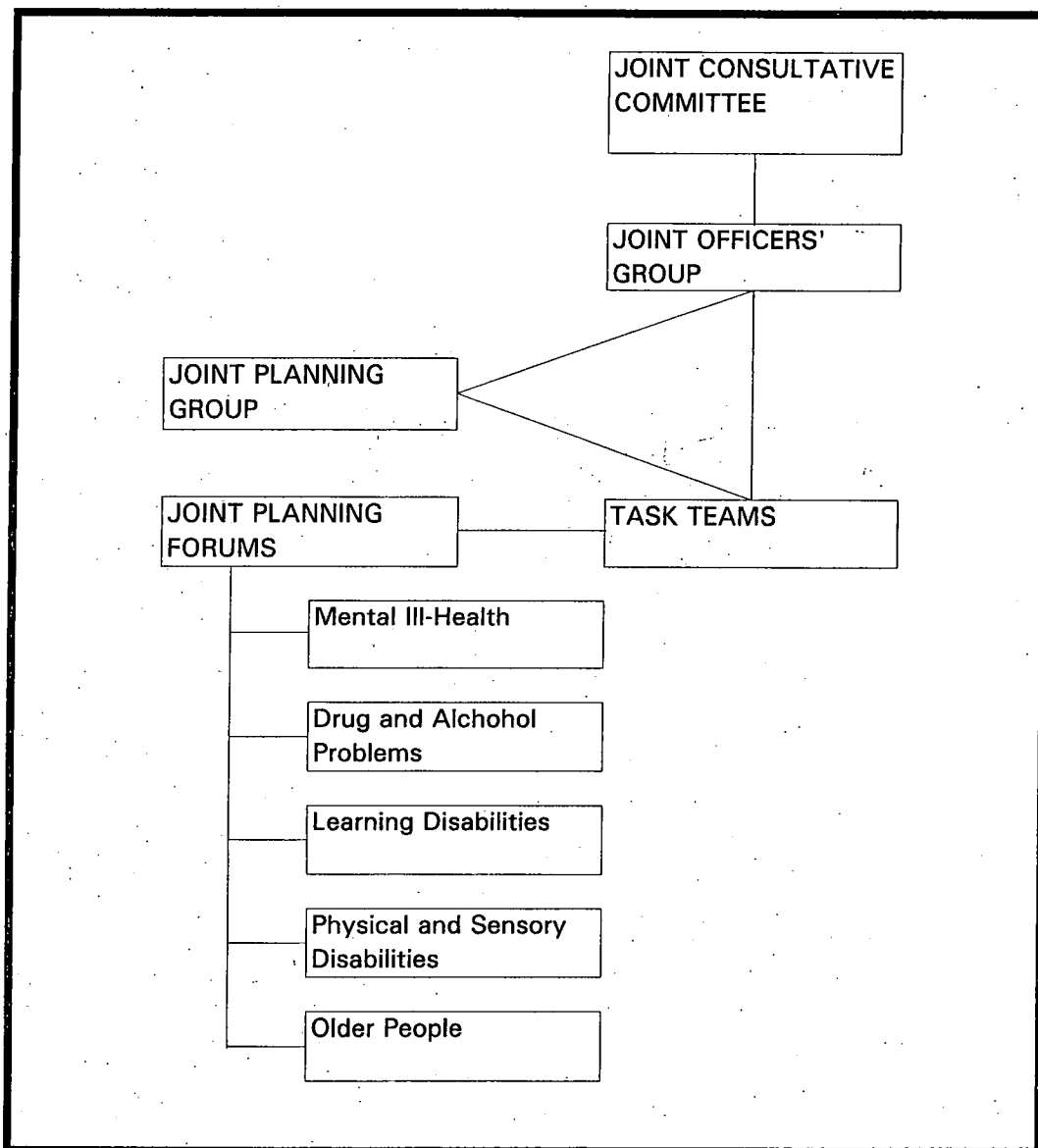


Figure 6.b

and was an acknowledgement that formal collaboration needed to take place between the health-providers and social services, and that there were issues which would be addressed by the JOG/JCC machinery that needed the agreement and the expertise of the providers. In 1994, the Trusts also achieved representation on the JCC.

Though the formal planning system described thus far was adjusted to take account of the new demands placed on it by Community Care policy, an additional system was also bolted on to provide a means for developing the detail of planning the implementation of community care. This bears out experience elsewhere¹⁴. Some groups ran in parallel, covering different aspects of work. Others ran concurrently, passing through a rapid series of incarnations. These changes occurred in response to different stages of the work to be accomplished, or when new staff were appointed or seconded, bringing new ideas about the way the work should be done. A chronology of these committees is given at Table 6.i, and an account of their development and the work they did is recounted below.

Funding for joint projects came from a number of sources. The main one was Joint Finance, which accounted for nearly £800,000 in 1993/94, and which was administered through the JCC. As a deliberate policy, the use of Joint Finance in the early 1990s had been protected and preserved to fund developments arising from the implementation of community care reforms. In addition, Sunderland was recognised as a deprived urban area, which meant that it attracted funding from the Urban

¹⁴ Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen, *Social Care in a Mixed Economy* (Buckingham: Open University Press, 1994) p. 65.

Programme. In 1992 the end of the Urban Programme was announced, and no new schemes were funded after 1993. In practice, Social Services attracted little in the way of Urban Programme funding. The priority was for capital spend and what revenue there was for community programmes went to the voluntary sector. The 1990 Act established special funding for projects for people with a severe mental illness (MISG), which brought in £208,000 in 1993/94. In 1992, Sunderland was one of the winners of the second and final round of City Challenge, which attracted £37.5 million funding over five years to the northern estates of the city. Of this, £1.8 million was dedicated to health and welfare projects. Occasionally, the RHA also made funding available for special initiatives, for which authorities were invited to submit bids, which sometimes brought extra funding to Sunderland for particular projects, such as the joint commissioning board for mental health.

TABLE 6.i: COMMUNITY CARE PLANNING COMMITTEES

DATE	COMMITTEE	REPORTING TO:	REMIT	MEMBERSHIP
March - May 1990 (A&CM group continued into 1991)	Five working groups: assessment & case management, finance, inspections, service procurement, information	Social Services Department	To consider responses to key development areas. A&CM group: To consider models of assessment and case management and areas of overlap between health and social services	Senior and middle managers of SSD. Health staff invited but little involvement in the production of the May 1990 reports. A&CM group: health staff joined the group later in the year.
October 1990	Boundaries of care task teams (6)	Assessment and case management group	Define which needs should be met by health or social services.	Junior and middle managers of SSD, DHA and FHSA
Sept 1991	Assessment and case management group	Joint Officer Group / CC	Develop a joint assessment procedure.	Senior officers of SSD, DHA and FHSA
March 1992	3 working groups	Joint Planning Group	Look at resource implications and the transfer of responsibilities of respite care units and learning disability units	
May - Oct 1992	Joint Issues Group	Joint Planning Group	To produce agreed joint policies and procedures on all outstanding areas of joint relevance to "Caring for People", particularly assessment and care management.	Middle-managers of SSD, DHA and FHSA, including some operational

DATE	COMMITTEE	REPORTING TO:	REMIT	MEMBERSHIP
Oct 1992 - March 1993	Joint Implementation Group	Joint Planning Group	To monitor implementation of joint policies and procedures.	Middle-managers of SSD, DHA and FHSA, including some operational. New chair.
March - Sept 1993	Joint Issues Group (Re- JIG)	Joint Planning Group	Strategic planning, monitor implementation, progress with the 8 key tasks identified by the DoH ¹⁵	Middle-managers of SSD, DHA and FHSA, including some operational. Senior managers of shadow Trusts. New chair.
April 1993	2 Joint Commissioning Boards	Joint Planning Group	Co-ordinate the commissioning of health and social care for two client groups, mental illness and learning disabilities.	Users, carers, GPs, CHC, middle- managers of SSD and Health Commission.
Sept 1993	Community Care Implementation Group	Joint Officers' Group	Review and manage the interface between health and social care in relation to Community Care Policy; to agree the appropriate response to new guidance.	Senior officers of SSD, Health Commission, and health service providers units

¹⁵ DoH, *Implementing Caring for People*, EL (92) 13 / CI (92) 10, 11 March 1992.

PLANNING FOR COMMUNITY CARE

There were three main phases in planning for the implementation of *Caring for People* in Sunderland in the period 1990-1994. In the first, Sunderland made an early start, the work being led very much by Social Services and minimal involvement from the health service. Inter-agency cooperation on developing community care policy was limited, but the plans produced at this stage, on assessment and case management, inspections, finance, service procurement and information, were ready to be implemented in 1991. They were based on the systems already in use in the SSD. When the date of implementation was postponed, there were no significant developments for the next year, though discussions about the boundaries of care continued. In the second phase, which began in 1992, the health service woke up to the need for progress, and drove the process for a time, even if from the back seat. Health service officers were given clear remits to work on community care. Many of the reports which formed the basis of Sunderland's approach originated from these people. Thirdly, when the new Director of Social Services (D) was appointed, the SSD took control of the process once again. By this time the balance of power had shifted. The SSD had clearly taken on the role of lead agency, it had control of the Special Transitional Grant, and it had a strong leader in charge. Thus the reason for the increased power was partly political, partly financial and partly personal.

Planning for community care in Sunderland began in the summer of 1989, when a one day seminar was held in Sunderland for departmental managers, the chairman and vice chairman of Social Services and some representatives invited from the Health Service.

The seminar was led by nationally recognised experts from the Personal Social Services Research Unit of the University of Kent. This event introduced the new community care policy. It had the effect of impressing on those present that community care was important, even if little content was absorbed. A second seminar was held six months later to introduce and discuss the implications of *Caring for People*, in which a local expert in community care issues took part. The programme includes a note from the Director which emphasises joint working: "In Sunderland we have, for some time, been working with other agencies to jointly plan and provide services for the people of the Borough and I welcome the opportunity to strengthen relationships which already exist".

At its January 1990 meeting, the Joint Consultative Committee (JCC) received and noted a Report of the Director of Social Services summarising the Department of Health (DoH) White Paper, *Caring for People*, and offering comments on it¹⁶. There are several comments on the need for collaboration. The difficulty in distinguishing between health care and social care needs "heightens the need for close working" and for "adequate boundary definitions at a local level"¹⁷. There is a reference to work already in hand: "We are already in discussions with health colleagues to establish how the roles of community nurses and our own Home Care service should be defined and

¹⁶ Joint Consultative Committee of Sunderland Borough Council and Sunderland Health Authority, Agenda for 16th January 1990, Paper 5.

¹⁷ *Ibid.*, § 5.1.

operate to get most effective use of the relevant skills."¹⁸ Another comment points out the difficulty of collaboration: "Probably the greatest bar to a constructive approach to professional and agency boundaries is that of resource - where that is lacking, each seeks to draw its boundaries back."¹⁹

However, when the Social Services Department started planning its response to *Caring for People*, there was very little involvement from other agencies. Five working groups were set up to discuss assessment and case management, inspections, finance, service procurement and information. The groups were given a short timescale of around two months to carry out their work, and reported in May 1990²⁰. The report on inspections recommended the setting up of an Inspections Unit which would be responsible in the first place for inspecting residential care homes and eventually extend its remit to all social care activities. It recognised the need for liaison with the health service. The Working Group on Finance looked at financial issues raised by *Caring for People*, particularly budget allocations for case management. It recommended that budgets be held at Area Controller level to begin with, which was a "no change" option though there was an intention to delegate budgets at a later stage, when appropriate staff training had taken place. The remit of the Working Group on

¹⁸ *Ibid.*, § 5.3. This work had been undertaken before the new community care legislation. Another piece of work reviewed the skills and deployment of Occupational Therapists across the agencies.

¹⁹ *Ibid.*, § 3.7.

²⁰ Working Group: Assessment/Case Management, Final Report, May 1990; Inspection: Report of the Working Group; Finance for Case Managers: Report of the Working Group on Finance; Contracts for Care: Interim Report of the Working Group on Service Procurement; The Information Working Party Report, May 1990.

Service Procurement was to consider options and priorities for promoting a mixed economy of care. It recommended a model of contract to be used with different private and voluntary providers. The purpose of the Information Working Party was to make recommendations about IT needs arising from *Caring for People* and *The Children Act* and the need to provide information to the public. There was no reference to the health service or other services.

Of these four groups, three name one person from the health service on the membership list, though these do not always appear to have been the most appropriate. The health service representatives were nominated by the health authorities, and the responsibility for the lack of collaboration in these groups must to some extent rest with them. Whether the failure to put forward appropriate nominations arose from a lack of understanding about the purpose and level of the groups, or a lack of wholehearted commitment to community care at that stage, is not clear. The FPC officer on the Service Procurement Working Group said that his role was to explain that residents of care homes had the right to be registered with any doctor of their choice, and after three meetings he did not really have a role! The Finance Working Group was comprised solely of officers of the SSD and Borough Treasurer's Department.

Membership of the Assessment and Case Management Group was drawn from operational staff and chaired by an Area Controller. Operational staff from the health service were invited, but, for the most part, did not attend. Again, there is an issue here about the appropriateness of membership from the health service, and their

commitment. The remit of the group was to look at models of assessment and of case management and the main areas of overlap between health and social care. The report recommended that the social profile used by the SSD should be the model of assessment for Care in the Community, and that other disciplines should be introduced to it. The Group also recommended that the role of Case Manager be vested with Senior Social Workers, though DHA staff could be Case Managers where SSD finance was not involved. There was recognition of the need for training, financial knowledge and information technology. In other words, the message of the group was that (i) systems already in use within Social Services were adequate; (ii) they did not need changing to meet new needs; and (iii) the health service and other care providers would have to adapt themselves to use SSD systems. It was an approach that left no room for mutual regard and negotiation towards a jointly owned system. The outcome may have been more "joint" had the quality of participation from the health service been better.

In addition, the Assessment and Case Management Group discussed involving GPs in case management, admissions to nursing homes and the need for all disciplines to contribute to multi-disciplinary assessment, though no firm models were proposed. Despite the name of the group, there was very little discussion of case management: "assessment and case management" were spoken of in the same breath as if they were one and the same.

There was a complete absence of collaboration in this exercise, in both the process and the outcomes. There was token involvement of officers from the health service, but the

reports give the impression of an underlying assumption that preparation for community care was essentially a social service task. The work was done in haste, anticipating April 1991 as the date for implementation, and this may have made collaboration more difficult. It also predated the practice guidance produced in 1991²¹, which emphasised the need for joint agreement of systems and procedures.

However, there were some important outcomes. Firstly, the Assessment and Case Management Group report had recognised that there was a problem of defining the boundaries between district nursing and domiciliary social care, and recommended further discussion with the District Health Authority. This led to the setting up of six Boundaries of Care Task Teams, one for each of the five client care groups (mental illness, mental handicap, the elderly, children and people with a physical disability) and one on district nursing and domiciliary care. They reported to the Assessment and Case Management Group, which continued meeting for another year. The discussions over the boundaries of care were an important part of planning for community care in Sunderland. An account of these deliberations is given below.

The other key outcome of the Assessment and Case Management Group was the social worker attachment to general practice (see Chapter Seven), which arose out of the recognition that social workers and GPs needed to work together in order to provide integrated care. However, this project and the work on boundaries of care represented all the progress made on community care issues in Sunderland for the next year.

²¹ Department of Health Social Services Inspectorate, Scottish Office Social Work Services Group (1991 a, b and c).

The internal planning mechanisms of the statutory agencies were very different. The DHA had a planning department. The Social Services Department, at the start of the period, had one person responsible for planning and information, though there was a planning department by the end of the period. In the FHSA, planning rested chiefly with one officer and also, to some extent, with the Independent Medical Adviser, who was very much involved in planning for community care, particularly for GPs. This meant that the agencies took different approaches to developing policy internally. The District Health Authority held a series of policy workshops about community care in 1991 and 1992 for senior officers and representatives of the planning department. In the SSD, planning for most of the period was vested in two officers, though other officers were brought in to contribute from their experience.

In the autumn of 1991, the Regional Health Authority (RHA) and Social Services Inspectorate (SSI) undertook the first round of monitoring progress towards the implementation of Community Care proposals. These then took place every six months²². This put extra pressure on health and local authorities to produce plans and conform to timescales.

By September 1991, there was little sign of further progress in developing policies and procedures for community care. The Health Authority convened a meeting of senior officers from the Health Authority (two UGMs, the Chief Nursing Officer, Director of Operations, two contracts and planning managers), FHSA (Independent Medical Advisor and planning manager) and SSD (two assistant directors and a principal

²² DoH, *Progress Review Issues for SSI/RHAs*, EL (91) 81, June 1991.

officer) to "facilitate the production of an assessment procedure which is "owned" by all concerned."²³ This group met on a number of occasions over the next few months and discussed developing a checklist to assist planning the discharge of patients from hospital, involving GPs in multi-disciplinary assessment, using the Primary Care Team with attached social workers as the focus for multi-disciplinary assessment. The group questioned the acceptability to other care professionals of using the Social Profile for assessment.

The hostile reception to the first Community Care Plan (see below) had three outcomes. A new working group, the Joint Issues Group (JIG), was created to drive the development of community care and develop robust processes and procedures. Sunderland was the subject of special attention by the Regional Health Authority, Social Services Inspectorate (SSI) and the Audit Commission, who considered sending a task-force in. Finally, the DHA seconded a senior officer to work full-time on some Community Care issues, mainly assessment and care management and the Care Programme Approach for mental health.

The HA senior officer brought together a small group of representatives from the three health provider units and from the central Health Authority planning department. They met for a short while as the Health Assessment Issues Group to agree a common procedure for the health sector for assessment and referral, and to discuss the levels of assessment in the Guidance and Care Management. After two months the group disbanded and some members became part of the Joint Issues Group. Even though this

²³ Letter from Contracts and Planning Manager, 17 September 1991.

was a purely health service group, minutes were sent to colleagues in the SSD. There are two observations to be made about this group: firstly, the low interest in Community Care issues from the acute unit is demonstrated in its nomination of a Nurse Manager, where the other two units were represented by more senior staff, and by the nurse manager's poor attendance record. Secondly, the minutes record some telling statements about the "them and us" attitude held by people in the health service:

Mr R pointed out that a referral to Social Services was for a definite need, whereas a referral to health resulted in a total assessment. (A "we do it properly" attitude.)

Dr C explained his concerns about Social Services as resource holders (demonstrating a lack of trust)

Mr B felt the aim of the process was to build up a relationship with Social Services and to break down some of their 'hurdles'. (A laudable aim, but there is no acknowledgement that there might also be health service hurdles.)²⁴

The Joint Issues Group was formed to produce joint policies and procedures for implementing community care in Sunderland on areas of common interest to health and social services. Its chief aim was to develop a jointly owned model of care management. Membership included Principal Officers from the SSD and planning officers from the DHA, operational managers from both services, and the FHSA Independent Medical Adviser. The researcher joined the group in July 1992 in order to "provide valuable strategic overview input and practical assistance with the pilot

²⁴ Sunderland Health Authority, Minutes of the Health Assessment Issues Group, April - June 1992.

project and the evaluation [i.e. of assessment and care management]²⁵. It was a period of intense activity. The Joint Issues Group met nearly every week, and its sub-committees met in the meantime. JIG coordinated the work of a number of sub-committees working on such issues as assessment and care management, liaison with GPs, joint training, information and publicity, management information systems and admission to residential care and nursing homes. This group proposed the use of a common referral and assessment procedure based on shared documentation, and identified levels of assessment and arrangements to facilitate communication between social services and GPs. In the meantime, the Chief Nursing Officer was responsible for producing the hospital discharge policy.

In June 1992, the JCC considered a number of collaborative initiatives. As well as three reports on the boundaries of care, it received a summary of a long report on assessment and care management, which stressed the need for "far more coordination" in assessing and delivering health and social care. It also approved in principle a proposal for a joint information resource centre to provide health and welfare information direct to the public. In the event, there were considerable difficulties in finding suitable premises and obtaining planning permission, but the resource centre was finally opened in the autumn of 1994.

A seminar was held in July 1992 for chairs and senior officers of the three agencies to bring all parties up-to-date with the planning for assessment and care management.

²⁵ Joint Issues Group, informal notes of the meeting held on 21st July 1992, § 2.6.

This resulted in a list of twelve recommendations about the future direction of the work, most of which were about the process of developing policy rather than decisions about policy. They included the development of a joint training strategy and the creation of a multi-agency group to work on publicity for Community Care. The meeting also recommended the adoption of a primary assessment document to be used by all agencies for referral and assessment, and to be tested in a pilot scheme and evaluated.²⁶

Sunderland was the subject of detailed monitoring from the SSI in September. Progress was now found to be satisfactory, and the progress monitor "Schedule of Milestones", reporting progress on the eight key tasks identified by the Department of Health²⁷, was considered an example of good practice to be shared with other authorities²⁸.

Meanwhile, the JIG was developing the shared documentation, the Primary Assessment Document (PAD), and a sub-group worked on a policy on confidentiality between GPs and social workers and on payments to GPs for additional assessments. Another group was producing a joint training package.

In October 1992, the Joint Issues Group became the Joint Implementation Group and

²⁶ Assessment/Care Management Seminar Notes, held on 16th July 1992.

²⁷ DoH, 1992, EL (92) 13.

²⁸ Joint Consultative Committee, Agenda for the meeting of 19 January 1993, Paper for Agenda Item 13.

concerned itself with implementing policy rather than developing it. Membership was more or less the same, though there was a new chair drawn from operational management, and the sub-groups continued with their work. The first issue of a local, jointly produced newsletter was published to inform staff of Sunderland's approach to community care and report on projects. The Hospital Discharge Policy went out to consultation. Progress, however, was slow.

Within a few months it was recognised that the task of developing policy as well as implementing it had not been completed after all, and the Joint Implementation Group was terminated and the Joint Issues Group reformed. There were some changes in membership and a review of the sub-groups.

Changes in the management structure and personnel in the SSD affected how the development and implementation of community care was managed. The Joint Issues Group was ended in September 1993. The efforts and energies of this series of groups had concentrated on processes rather than on policy making, for example, on producing a referral form rather than on developing a system of care management. This was probably because the work was placed at an inappropriate level, with officers insufficiently senior to make decisions on policy, or to take an overview of the whole process. The JIG was replaced by the Community Care Implementation Group. Its members were senior officers of the SSD, Health Commission and health service provider units. The number of sub-groups or associated groups was pared down to cover quality assurance and joint training only. The need to revisit the assessment procedure was recognised, including the question of whether the PAD should continue

to be regarded as the all-singing, all-dancing solution to managing assessments. Five months later, at the end of the research period, the group had met two or three times. The minutes show little evidence of joint policy making, though there was a good deal of sharing of information, and joint work where a joint agreement was required, as for the preconditions for the 1994/95 Special Transitional Grant.

In January 1993 the JCC approved a pilot scheme to establish two Joint Commissioning Boards (JCB) to plan and purchase services for People with Learning Disabilities and People with a Mental Illness. The latter was funded by a RHA initiative for special projects in Primary and Community Care Issues. Joint commissioning was regarded as a solution to the problem of joint working and as a means of developing care systems focused on the needs of clients rather than on the services themselves.²⁹

The two Joint Commissioning Officers would work across the agencies and involve voluntary and independent organisations, clients and carers. The remit of the two Boards was not absolutely clear; it was expected that their work would develop over time. They reported to JPG. Almost as soon as the two officers were in post, the need to comply with a RHA directive to formulate long-stay hospital retraction plans dominated the first phase of their work. This gave their work a more operational focus

²⁹ Bob Hudson and Julia Willis, *Analysis of Joint Commissioning Developments in the Northern Region* (Leeds: Nuffield Institute for Health, 1995) p. 2. Note that Bob Hudson saw an early draft of this chapter and interviewed me as part of his study of joint commissioning in Sunderland. I have indicated where I have used his work.

than the strategic role originally envisaged³⁰. Other issues addressed by the JCB for Learning Disabilities were challenging behaviours and the development of a special needs register. The officer for the Learning Disabilities Board was based in the Social Services Department, while the officer for the Mental Health Board was based in the Health Commission. Both were recruited from the Health Authority. Before a year was out, the Joint Commissioning Officer for Learning Disabilities had been absorbed into another post in the integrated management structure of Sunderland Health Commission, and his duties shared between other personnel in Social Services and the Joint Commissioning Officer Mental Health, who took on health service responsibilities for Learning Disabilities.

In many ways, the JCBs were very much like JCPTs with the inclusion of users and carers. Thus they were an attempt to expand collaboration to include users and carers. The interesting question about the Joint Commissioning Boards is how far they were "joint". A distinction has to be made between the two boards. The Social Services Department was the lead agency for planning and purchasing services for people with a Learning Disability³¹, whereas the Health Authority took the lead for mental health. The opportunity for "jointness" was greater for commissioning services for people with learning disabilities than it was for mental health. There was some evidence that the SSD saw the boards as working in the areas of common interest, with each agency working separately on aspects outwith this. This meant that collaboration was limited to a perception of what was properly "joint". Thus the Social Services Department

³⁰ *Ibid.*, p. 41.

³¹ DoH, 1989, § 2.16.

undertook a review of all its residential and respite services for each client group without any contact with either Board, though the reviews were brought to the JCC for information. A study of joint commissioning described the scheme in Sunderland as moving from "radical origins to a much more circumspect and incremental approach which [was] more consistent with the reality of local circumstances ... and joint commissioning now holds a much lower profile in the priorities of local commissioners".³²

Inter-agency coordination should have been easier in Sunderland than almost anywhere else, given the coterminosity of boundaries, a unitary Local Authority and a history (until 1990) of stability of structures and personnel. Officers of the Health Authority, Social Services Department and Family Health Services Authority had a good history of working together, at an informal level at least, and joint discussions about issues to do with care in the community started early. Despite the good will, however, progress was slow and outcomes limited. A number of blind alleys took a long time to explore. The groups exploring boundaries of care produced a lot of good work, but this was not then translated into policy.

The reasons for the lack of progress are clear. The lack of stability created by the frequent changes of Director of Social Services made it very difficult to plan, and meant that there was no vision about community care at the top of the lead agency to drive development. Though individual senior officers had windows open to aspects of the vision, none could see the whole landscape. When the current Director (D) arrived

³² Hudson and Willis, 1995, pp. 38-39.

he instituted substantial changes to the management structure, and this too for a time diverted attention from developing policy. At the same time, major structural changes were taking place in the health service, which sapped the managerial energies of senior officers. For at least part of the time, the work of developing policy rested at too low a level, with middle management, operating with little sense of direction. There was also a reluctance to address uncomfortable issues.

One officer pointed out that the Government's change of timing in the introduction of community care did not help the process either. "It undermined the credibility of the thing, and people who had begun to get up to speed with what was supposed to happen suddenly switched off. ... In terms of people's mental preparedness and willingness to solve problems and so on, had it gone forward from April '91, I think we would have made a better fist of it." Another officer recalled a Department of Health workshop which gave him the impression that policy developments were taking place "on the hoof" without thinking through the implications. Wistow *et al* make a similar observation, noting that community care policy is "a moving target, constantly being shaped and reshaped in the light of experience or fashion"³³.

The rest of this chapter examines key areas of work arising from collaborative planning on community care issues, namely, the boundaries of care between health and social services, the projects designed to improve collaboration at fieldworker level and to explore a model of care management, joint training, the development of a system of

³³ Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen, *Social Care in a Mixed Economy* (Buckingham: Open University Press, 1994), p. 23.

assessment and the production of the Community Care Plan. As important parts of the process of collaboration, the outcomes of these areas can help demonstrate the success or otherwise of collaboration.

THE COMMUNITY CARE PLAN

The first draft of the first Sunderland Community Care Plan (CCP) was produced in December 1991 and put out for consultation. Though it was published in the names of the two health authorities as well as the SSD, it concentrated on social services, like most of the first CCPs produced. At the March 1992 meeting of the JCC, comments were noted and the CCP was approved for publication. That day, an officer of the Regional Health Authority (RHA) wrote a letter with comments, complaining that the CCP did not meet DoH requirements and criticising the style and content of the CCP, the shortness of the consultation period, and the lack of clear commitments as to what would be delivered³⁴. The tone of the letter was patronising, and dismayed its recipients because an officer of the RHA had been at a meeting with the SSI a few weeks earlier, attended by officers of the Sunderland SSD, when the Plan had been discussed. There had been a discussion of the style of the document and the target audience, and the perception of the Sunderland participants was that the RHA had agreed with their approach. At this meeting, the RHA representative had indicated that comment might be forthcoming but gave no hint of its nature.

A few days later, at a heated meeting, a representative of the RHA criticised officers

³⁴ NRHA, Letter of 17 March 1992, "Community Care Plans 1992/93".

of Sunderland Health Authority for serious deficiencies in the CCP, which she described as "appalling". She was particularly concerned about lack of information on present service provision which prevented informed public debate of the CCP, the lack of specific health care proposals, the lack of strategic vision, the vague terminology, the lack of targets and timescales³⁵ and the lack of a clear training strategy. Subsequent correspondence indicates that a clash of personalities lay behind the fiery tone of the meeting³⁶.

Following this meeting, the Health Authority supplied further information to the RHA officer about work being done in Sunderland in relation to Community Care, which gave her a more positive view of progress. It seems that priority was given to developing systems for community care rather than producing plans about them. The requirement to produce a plan was to be fulfilled by building on the Social Services Department strategic plan. A letter from the Director to the Chief Executives several months earlier suggests that it was "more important to build up the machinery for change, for consultation and for working together as well as building up service developments than being over ambitious about the first plan. The danger was that the investment was put into the plan rather than services."³⁷

³⁵ File Note, "Meeting with [name] to discuss Community Care Plan and other CCP implementation issues - DHA/FHSA Questionnaire", 23 March 1992.

³⁶ Letter of 6 April 1992, "Assessing Progress in the Implementation of "Caring for People"".

³⁷ Letter from Director of Social Services to Chief Executives of DHA and FHSA, 27 August 1991.

However, some difficulty was also created by the inconsistent messages coming from above, from the Regional Health Authority and the Social Services Inspectorate. The SSI response to the Local Authority about the first Community Care Plan was much less critical than that of the RHA to the Health Authority. Officers of both the SSD and Sunderland Health Authority thought that "the RHA and SSI sing to a slightly different hymn sheet". One SSD officer gave an account of a meeting with the RHA, SSI, Audit Commission and officers of the three statutory agencies in Sunderland which took place during the consultation period for the first Community Care Plan and illustrates the confusion.

I said, 'Our approach is to keep it nice and simple', and I actually used the words, 'Janet and John language. Not full of statistics. Make it a small and easy to read document'. ... And I looked at the RHA at the time, so like tell me now if this isn't the approach that you want. Got any problems, because that's our approach. And they said, "No, no, that's fine. That's exactly what we want". I mean, bearing in mind they'd already criticised that approach. ... But I thought, you can't have it both ways, so we are asking you how you want it.

The first Community Care Plan was produced hurriedly and was scanty. The early plans were described as "position statements rather than strategic documents"³⁸. The second Sunderland plan was an enormous and unwieldy tome. It was intended to be both a planning tool and a document to explain plans to the public, two aims that were not compatible³⁹. A national analysis of the 1993/94 CCPs also found "no significantly

³⁸ Wistow, Leedham and Hardy, 1993, p. 32.

³⁹ *Ibid.*, p. 33 § 3.4, also identifies a third audience, the Department of Health itself.

greater clarity about purpose"⁴⁰ than the first round of plans. The structure of the document was firmly based on that used for SSD strategic planning documents in the past. It was a little more "joint" than the first CCP, with officers of the SSD and the two health authorities meeting to clarify responsibilities and timescales, and then writing their sections separately. In the event, this multi-authorship did not make for a smooth and consistent document. One officer observed that "it was two documents mashed into one, rather than a collaborative effort".

By the time the third CCP was produced, for 1994/95, a number of the process issues had been resolved and the production was much smoother. The SSD had carried out reviews of its services, and the resulting documents were used for internal planning, freeing the CCP to be a document for the public. The CCP was starting to develop a structure of its own. The "jointness" of production moved a stage further. One officer from the SSD was given the task of writing the plan, and the officers from the Health Commission passed on information on health service plans. This represented greater trust, in that the health service officers were prepared to relinquish control over their material. It also resulted in a better, more consistent document.

An analysis of the content of the three CCPs produced during the research period demonstrates how the plan developed over time and the changes in emphasis. The first CCP, covering 1992/93, was very short, equivalent to 19 pages of text. The content of the whole document was meagre. The main emphasis was on Community Care in

⁴⁰ DoH, *Community Care Monitoring and Development: Analysis of a Sample of English Community Care Plans 1993/94*, 1993, § 4.

general. This included a section on assessment and care management, setting out the principles rather than the process, which had not been completed. Though there was some awareness of areas that needed to be addressed, the plans for each client group were very thin. In a section about the implementation of the Children Act, under the heading of "medical surveillance" is not so much a plan as a question, "which Health professionals carry out surveillance duties for children accommodated in care?"

TABLE 6.ii: COMMUNITY CARE PLANS - ANALYSIS OF CONTENT

	1992/93		1993/94		1994/95	
	No. pages	%	No. pages	%	No. pages	%
Introduction	2.25	12%	26	15%	2.25	5%
Community Care	9.0	48%	49	28%	4.33	9.7%
Plans for Client Groups	7.5	40%	73	42%	35	78.5%
Other Issues	-		3	1.7%	3	6.7%
Appendix : SSD spending	-		22	12.7%	-	
TOTAL PAGES	18.75		173		44.58	

The second CCP, for 1993/94, was enormous by comparison, at 173 pages. It included a great deal of additional information. Thus the introduction contained a demographic overview, a financial overview, requirements for Community Care Plans, the policy framework. The section on Community Care printed details about assessment and care management, community care commissioning, carers, health promotion, the city challenge initiative, training, information, quality assurance, support and management. The section on plans for client care groups sets out Local Authority and health service (DHA and FHSA) plans separately. The failure to produce a fully integrated plan is recognised in the text:

Readers will note that the Local Authority and Health Authorities proposals for each client group are largely separate and follow different formats. This is because the Authorities have wider responsibilities calling for different methods of working.⁴¹

The plans indicate a lack of proper understanding of the needs of users and carers. So the section on the health aspects of visual disabilities concentrates on hospital ophthalmology services, with no mention of making other health services accessible to blind and partially sighted people. The document is difficult to read. It has a very bureaucratic style, with numbered paragraphs, and sections on policy framework, aims, objectives, present provision, plans and action points set out for every issue.

In the 1994/95 Community Care Plan, there is a clear change of emphasis in content, most of the document being devoted to plans for the client care groups. Progress on previous plans is set out, as well as plans for developments intended by the Authorities.

Thus the health and social services in Sunderland had taken three attempts to produce a CCP with which they were comfortable. Subsequent CCPs followed much the same pattern, though they continued to evolve. Two key issues had been resolved. The first was determining the principal audience of the plan. The SSD consistently saw it as a public document, though the guidance and the RHA also emphasised its role as a planning document. The second issue was the development of the process for producing the CCP, in terms of procedures, authorship, responsibilities and timescales,

⁴¹ City of Sunderland, Community Care Plan 1993/94, p. 9.

and of technical production.

Reports arising from the early rounds of RHA and SSI monitoring provide a snapshot of progress towards implementation and the degree of collaboration between Authorities in the Northern Region, though individual Authorities are not identified. The first found "clear evidence of effective joint working" in the Region, though progress in developing systems of assessment and care management was slow. The involvement of GPs and community nurses was particularly disappointing⁴². At the second round of monitoring, it was said that "the level of jointness between Authorities has been greater than might have been expected", with six of nine LAs producing joint CCPs⁴³.

Certainly in Sunderland, the officers were much more confident about what they were doing by the end of the research period. In terms of collaboration, greater trust had evolved among the players and officers worked together more effectively. Most of the officers involved already knew one another and had worked together on other projects. With a new venture, like the production of the CCP, they had to learn trust and cooperation in a new context. Collaboration developed in other settings was not necessarily transferred very easily. Relationships were uneasy at times during the production of the second CCP. It may have been that the collaboration that existed

⁴² NRHA and Social Services Inspectorate, "Caring for People" Implementation Monitoring Exercise: First Joint NRHA/SSI Northern Region Progress Review Report, September 1991.

⁴³ NRHA and Social Services Inspectorate, "Caring for People" Implementation Monitoring Exercise: Second Joint NRHA/SSI Northern Region Progress Review Report, April 1992.

before was superficial, and that this was challenged by the difficulties of producing the CCP. In any case, collaboration does not mean the absence of disagreement. It can only take place where differences are acknowledged⁴⁴. In Sunderland, there is evidence that trust began to develop, and that collaboration was improving, at least in relation to the Community Care Plan, even if it was hedged with caveats and caution.

BOUNDARIES OF CARE

The issue of the boundaries between social care and health care was already an area of concern, proved to be a key theme in discussions from 1990-1992 and was still a matter of discussion at the end of the research period. This issue was not unique to Sunderland. The problem was how to define where the responsibility of one finished and the responsibility of the other began. What is social care? What is health care? How are the overlaps and the gaps between them managed? There was a tendency for each agency, and the health service in particular, to draw in its boundary of provision. The health service was starting to say that high dependency care needs do not equate with health care needs, and were not necessarily the responsibility of the health service. The SSD found it difficult to recognise this concept, which could be regarded as of the health service drawing in its boundaries. The question of which needs should be met by the health service and which by the social services had not been resolved by the end of the research period, though there was greater clarity in certain areas, as in the there was a joint recognition that the responsibility for respite care rested with the SSD. The issue becomes more acute when considered in terms of finance. On the one

⁴⁴ Ovretveit, 1993, p. 144.

hand, there is the issue about which agency funds a service. On the other is the problem for clients when NHS services are free and some social care services are means-tested, which means the boundary between health and social care services can have a direct impact on a client's pocket. In relation to the boundary between district nursing and home care services, it raises the question of where personal care ends and nursing care begins⁴⁵

In October 1990, six task teams, reporting to the Assessment and Case Management Group, were set up to explore these boundaries of care. Membership was drawn mainly from junior and middle managers in Social Services, the DHA and FHSA. The six task teams would focus on the five main client groups (people with mental handicap, people with mental illness, people with physical disability, children, the elderly) and community health services (mainly community nursing). The expectation was that "from these reports it would be possible to determine firm policies as to whether a particular need should be met by the Health Authorities as a health care need or by Social Services as a matter for social care". Problems had already been recognised: "it is already possible to identify situations where current practice and resource allocation are different".

An interim report on the boundaries of care went to the JCC in June 1991. The JCC called for a further report to be presented to its meeting in January 1992, which would recommend (i) the boundaries between health and social care and the principles on

⁴⁵ Hilary Land, "The confused boundaries of community care" in Gabe, Calnan and Bury, eds., *The Sociology of the Health Service* (Routledge, 1991) pp. 203-221 (p. 216).

which they are based; (ii) the resource implications of change from current practice with indications of how these are to be met and in what time scale; (iii) how multi-disciplinary assessments would be arranged.

This report looked at bathing⁴⁶ and at the need to transfer elderly-care respite units from the Health Authority to the Local Authority, and identified other areas needing consideration, such as the feasibility of transferring resources, training implications for social services and alternative resourcing. The report was received, the work already done acknowledged, and a further report requested⁴⁷. Three working groups were then set up to look at resource implications and the transfer of responsibilities.

Reports from these groups were presented to the June 1992 meeting of the JCC. One recommended the transfer of funding for respite care units from the Health Authority to the Local Authority. This meant that what had been received as a free good when provided by the Health Authority became subject to means testing under the auspices of the Local Authority. At the end of the research period, in March 1994, this issue was still being discussed and a final decision delayed for a further six months to await the outcome of assessments. The second report recommended the transfer of responsibility for some residential care facilities for people with learning disabilities, though some services were to be retained by the Health Authority. The third put forward a proposal for a pilot project to test the feasibility of a Personal Care Service

⁴⁶ This largely duplicated the work and outcomes of the earlier JCPT for physical disabilities.

⁴⁷ Joint Consultative Committee, Minutes of the Meeting of January 1992, § 6.

by combining Domiciliary Care Assistants and District Nursing Auxiliaries. A further report was considered at the October meeting, when it was agreed that an application for a grant to support this pilot project should be submitted to the DoH; and in the event of an unsuccessful application, the pilot project should proceed funded from reallocations from the relevant authorities' main programmes. The grant application was unsuccessful, and the JCC Minutes record that "further consideration would be given to this matter in due course"⁴⁸. In effect, plans for the project were frozen.

Boundaries of care had been a major focus of discussion for over two years. The main outcome of all this effort was the intention to transfer two respite units from the Health Authority to the Local Authority, the transfer of residential homes for people with learning disabilities on a time limited basis to allow better analysis of the needs of residents, and a failed proposal for innovative joint working between domiciliary care staff and district nursing auxiliaries. The early phase of the work produced a report which outlined the areas of overlap. With hindsight, one participant felt that lack of progress was due to the group addressing the easy issues and avoiding the difficult ones.

THE ASSESSMENT PROCEDURE

In Sunderland, the process of devising a procedure for assessment focused on developing shared documentation rather than on a joint system of assessment. Even

⁴⁸ Joint Consultative Committee, Minutes of the Meeting of the 19th January 1993, § Matters Arising.

in the 1990 report on assessment and case management, the social profile used by the SSD was seen as the appropriate way of undertaking and recording assessments and the report recommended that "other agencies be introduced to it and trained in its use"⁴⁹. The July 1992 seminar had identified the need for common documentation to be used by health as well as social services. Under the auspices of the Joint Issues Group, a sub-group - with representatives of a range of health and social care agencies - developed the Primary Assessment Document (PAD), which was intended to be acceptable to and accepted by all the agencies and would be used within social services and between the health and social agencies to refer patients/clients and exchange initial information in order to signal the need for multi-disciplinary assessments. The PAD was a three-page document available in carbonated triplicate. It would act as a screening mechanism to identify needs and as an assessment tool for cases of simple needs. Full assessments would be made as necessary in whatever form the agency or department was accustomed to and would be referred to as the Supplementary (or Secondary) Assessment Document (SAD). For Social Services, the Supplementary Assessment Document was the Social Profile.

A long document setting out arrangements for assessment and care management went to the JCC meeting in October 1992. This described four levels of need for assessment, the process of assessment, the involvement of GPs in assessment and the Primary Assessment Document. A brief section on Care Management described the features of care management but did not set out a system. The implications for admissions to nursing and residential homes were given. There was an attempt to

⁴⁹ Working Group: Assessment/Case Management, Final Report, May 1990, p. 8.

include quality standards, but this was not fully developed. The document also identified staffing and training needs.

The JCC recommended the approval of the proposals to pilot the system of assessment, create a multi-agency group to monitor this, to identify resource implications, to review the process by September 1993, and to undertake joint training. By early 1993, there was a certain unease about the assessment system. Issues that needed to be resolved were not being addressed, including the role of the care manager, the role of health professionals in care management, criteria for admission to residential care or nursing homes, and the interface between the Care Programme Approach used for patients suffering from mental illness and care management. These concerns led at the end of March to the winding up of the Joint Implementation Group and the reconvening of the Joint Issues Group.

The PAD was tested using one Area Team, one general practice and one hospital ward. Adjustments were made to the form as a result of this, and the system was implemented throughout the district in February 1993 and evaluated by the researcher during March and April. The successful implementation of the PAD required the cooperation of senior management from the health service provider units. The mental health and rehabilitation unit and the community health services unit had been sending senior nurse managers to the operational sub-group, but the acute unit had not been represented, and had little understanding of the developments for implementing community care. It was January 1993 before the acute unit got on board and sent a representative to the Joint Implementation Group, despite repeated requests.

The evaluation of the PAD system for assessment was published in May, and found that the PAD was serving six separate functions: as a referral taking form, an assessment tool, to refer on to other disciplines, as a liaison form, to requisition equipment and to collect management information. Some practitioners were trying to use it as an assessment tool for all clients and finding it inadequate. The PAD was also being used more extensively than envisaged, with hospital wards and therapy departments using it as an internal referral document. The PAD was inadequate for this purpose, having been designed for use by social services and between them and the health services⁵⁰. Following the evaluation, guidance on using the PAD was clarified, so that the document was used as an initial referral taking document within social services and as a referral tool between health and social services. A separate form was developed for use by GPs, as it was felt that they would not use the standard form. In practice, they did not use the special form much either. The special studies noted the lack of involvement of GPs in assessment procedures generally⁵¹.

The fundamental problem with the assessment procedure was that it was concentrated on the use of one document rather than encompassing a cohesive system that brought together different styles of assessment by various practitioners. There was also a procedural inconsistency: the government required assessment systems to be in place by April 1993, but care management systems were not needed until a year later, though assessment is a function of care management and has to fit a model of care

⁵⁰ Meg Gilley, "Care in the Community in Sunderland: The Assessment Procedure: Evaluation Report", Sunderland Health Authority, 21 May 1993.

⁵¹ DoH, *Monitoring and Development: Assessment Special Study*, November 1993, p. 20-21, §§ 4.3-4.4

management, and not the other way round. Assessment was one area where collaboration was made sure that a client's needs were all taken into account, and a care package to meet those needs developed. It was important that collaboration be built into the system, so that a holistic assessment could be guaranteed, rather than be dependent on one practitioner remembering to refer to another. This was not the case in 1993, though the assessment and care management system was revised in 1995.

JOINT TRAINING

The need for joint training was a recurring theme in the early policy and guidance documents⁵². Joint training was seen as a way of developing greater understanding between practitioners, preventing duplication of effort, and was regarded as "a demonstration of a commitment to greater collaboration in the future"⁵³. By 1993, however, the tone had changed subtly, dropping references to jointness of training. A DoH circular reporting on progress with the eight key tasks, recorded the proportion of Authorities which had identified training needs and implemented training programmes, but not on the jointness of that training⁵⁴. It stated that further progress on training was a priority:

Authorities need to ensure that all relevant staff, in local authorities and health provider units, are fully informed of how the new arrangements

⁵² See: DoH (1992) EL (92) 13, reinforced by DoH (1992) EL (92) 65, in which joint training is one of the eight key tasks.

⁵³ DoH Social Services Inspectorate (1991c) § 5:29.

⁵⁴ DoH, *Implementing Caring for People*, EL (93) 18, 15 March 1993.

will work locally; where necessary staff should have received appropriate training.⁵⁵

Again, there was no reference to a joint or even coordinated training programme. Nor was it mentioned in the monitoring reports published in spring 1994. This raises two questions: how important was joint training for the implementation of community care, and was joint training an indicator of the success of collaboration?

If joint training was a measure of inter-agency collaboration, then Sunderland had some success in the field of mental health, though this was rather more limited in terms of general training. The JCC meeting of October 1992 agreed to establish a Staff Development and Training Board to assess joint training needs and plan ways of meeting them. The first joint training sessions on assessment and care management for fieldworker staff occurred in December 1992. Over 300 people attended, with good representation of social services staff and community health staff. General practices were not well represented, in common with experience elsewhere⁵⁶. Few hospital staff attended, particularly from the acute unit. It was difficult for wards to release staff for training, but the low level of involvement of the acute unit also reflected its then lack of interest and commitment to community care. The training did help to bring home the implications of community care to many staff in the field. Colleagues reported that people were talking about community care after the training.

⁵⁵ *Ibid.*

⁵⁶ DoH, *Implementing Caring for People: Training and Development*, July 1994, p. 19 § 4.

After a few sessions the Director of Social Services cancelled the more detailed training that had been planned, because he felt that each agency should train its staff in their own responsibilities before joint problem solving training could begin⁵⁷. Joint training was postponed again at a meeting in July 1993, because the two health service provider units wanted to complete in-house training before commencing joint training. By March 1994, the names of provider unit representatives on the Training Board had been proposed, but no further joint training had yet been arranged. It was still a recognised that the priority was "to get across the process of assessment and care management between all agencies including GPs"⁵⁸.

Though the extent of joint training on assessment and care management was limited, some training programmes relating to specific client groups were more successful. £15,000 of Mental Illness Specific Grant was used to fund joint training in mental health issues, involving staff from health and social services, voluntary organisations, users and carers. There was also one session for operational and non-operational staff in health and social services, users and carers, on matters to do with learning disabilities.

THE HOSPITAL DISCHARGE PROCEDURE

One of the two requirements of the "31 December 1992 agreements" was a hospital

⁵⁷ Joint Implementation Group, Minutes of 8th January 1993.

⁵⁸ Community Care Implementation Group, Minutes of Meeting held on 26 November 1993.

discharge policy agreed by the health service and SSD⁵⁹. The Sunderland policy was developed in 1992 by the Chief Nursing Officer of the DHA and incorporated the assessment procedure and the PAD document.

An early fear following the implementation of the policy was that it would lead to "bed blocking", and myths and rumours abounded. These anxieties were not confined to Sunderland. The concern was that the time required to carry out social care assessments would delay discharge and hospital consultants were accustomed to discharging patients from hospital when they were deemed medically fit, without regard to social circumstances. This was a particular worry to the shadow acute Trust, which intended to reduce the number of beds substantially, a move which would not tolerate bed blocking. The Trust and SSD each monitored the system, with the Trust finding examples of bed blocking and the SSD study finding little evidence that more than a few beds were occupied by people who should have been discharged. Some problems did emerge: delay in a patient or relative choosing a residential or nursing home could hold up discharge from hospital.

Of greater concern to the users, carers and voluntary organisations attending the Joint Planning Forums was whether the procedure was working, whether patients were being discharged appropriately into residential or nursing home care or to their own homes. There were few complaints and several letters of thanks, about the effectiveness of discharge into residential and nursing homes. However, people attending the Joint

⁵⁹ DoH, El (92) 67, 2 October 1992. The first requirement was about responsibilities for placing people in nursing homes and the numbers likely to be admitted to homes.

Planning Forums reported several stories of failure to have support systems in place in the community on discharge, which seemed to indicate that there were major problems. There were rumours that the procedure was being circumvented by ward staff. By 1994, an audit of the discharge procedure was planned by the acute provider unit.

In March 1994, the JCC received Sunderland's submission to the Department of Health on the second round of Health and Local Authority Agreements (LASSL (93) 16), which required an account of responsibilities for placing individuals in nursing home care and how hospital discharge arrangements would be integrated with assessment arrangements. This was signed by the Director of Social Services and the chief executives of the Health Commission and two provider Trusts.

On the face of it collaboration had been good. Sunderland had a new jointly agreed hospital discharge procedure in place, which took account of the assessment procedure. It did not appear to be resulting in significant problems of bed blocking. However, there was a great deal of anecdotal evidence of the failure of the procedure itself for patients returning to the community. This was due to be evaluated, but solely by the acute provider unit. Collaboration had been good in developing the process, but was not robust in the operation of the policy. This does appear to confirm the suggestion made in Chapter Four that there is something different about collaboration at different levels of organisations. However, that thesis assumed that collaboration would be better at the service level, where collaboration would be around clients, rather than at

the strategic level, where the focus of collaboration was policies and procedures⁶⁰.

COLLABORATION BETWEEN GENERAL PRACTITIONERS AND SOCIAL WORKERS

The first Assessment and Case Management Group was also responsible for planning a project to develop collaboration between social services and general practice through the attachment of a social worker to a practice. The pilot scheme to attach a social worker to a general practice began in March 1991. The project was evaluated by the researcher who came into post in April. A full report of the project and its aftermath is given in Chapter Seven.

Another issue was payment to GPs for their involvement in community care. This could be the result of additional demands on their time in writing reports they would not otherwise have produced, or the need for independent medical advice where there was a possibility that an existing doctor-patient relationship could be jeopardised by the assessment. On these occasions, a fee would be payable to GPs by the DHA for their collaboration in assessing patients and writing reports, and a schedule of fees was approved. The DHA had been concerned about the resource implications of this, as the SSD was effectively spending its money.

⁶⁰ Van de Ven and Walker, 1984, p. 617.

CARE MANAGEMENT FOR LONG-STAY PATIENTS WITH DISABILITIES

The DHA, SSD and FHSA together won a bid for funding from a RHA Initiative in Community Care for a project to examine the merit of a model of care management based in a long-stay ward for people with severe physical disabilities. The Care Manager came into post in April 1992 for twelve months, employed by the NHS unit and reporting to a multi-agency steering group. Her role was to develop a protocol for assessment for the client group involving clients and carers as much as possible, to explore the relationship between the health and social care needs of the patients, and to facilitate the discharge of as many patients as possible into the community. Before the project began, it was expected that two patients would be resettled. However, as a result of the project, six patients were discharged into the community, some of them with very complex needs. Others moved out after the end of the project. Funding was not made available for alternative packages of care, and the high cost of supporting these people in the community was absorbed into budgets for mainstream services that were not designed for this purpose.

The project evaluation demonstrated that the model of the dedicated care manager was very effective at addressing the needs of long-stay clients with complex needs. The Care Manager made good use of existing resources as well as developing innovative solutions⁶¹. In the longer term, this proved to be a somewhat naive conclusion, because fundamental issues about funding responsibilities to support these clients had

⁶¹ Sunderland Health Authority and Social Services Department, "Regional Initiatives on Community Care: Care Manager, Seaview Ward, Ryhope General Hospital: Project Evaluation", 8 August 1993.

not been addressed. The SSD took on responsibility for funding expensive care packages of clients with complex needs, and this was still an area of dispute three years later. The evaluation of the project also listed lessons to be learnt about running similar projects⁶², but there was little evidence of this information being used to inform developments. The Care Manager did provide a critique of the proposed assessment system in its early stages, though there was little further involvement in discussions about assessment and care management. The project may have been thought to be too specialised to have anything to say to a general system of care management.

The project illustrates the fragmented approach to developing community care policy. It was isolated from other, mainstream, developments. Its development had been dependent on the fortuitous availability of funding, rather than part of an integrated and planned programme. The project was time-limited and duly came to an end. The model was never repeated in Sunderland. As a collaborative project, it was very successful. It did lead to a better quality of life for the people who returned to the community after years in the Younger Disabled unit. But it also laid up problems for collaboration in the future. It was the first hint of a theme that would recur: of a successful collaborative project carried out in isolation from mainstream services that would later threaten the dynamic of collaboration in other areas.

CONCLUSIONS

This account of joint working between the health and social services in planning and

⁶² *Ibid.*

developing services permits an analysis of the elements of the strategic level of the framework that were not addressed in the previous chapter, namely collaborative mechanisms and collaborative attitudes.

Though the characteristics of the organisations themselves made collaboration difficult (see Chapter Five), the mechanisms for joint working appeared, at least on the surface, to function well. Formal processes for joint working were in place and had been strengthened. The replacement of the JCPTs by the Joint Planning Forums made collaboration with service users, carers and the voluntary sector more meaningful. Other groups had been added for the specific purpose of developing and implementing community care policy. There were a lot of meetings at which the health and social services worked together. Joint working at an informal level was also good. Most of the officers working on community care policy knew, or came to know, each other well, and met in order to produce work for meetings. It was clearly recognised that collaboration between officers and between the agencies would benefit clients, and perhaps less clearly, that the organisations would also benefit. Funding for projects arising out of collaborative activity was available through Joint Finance, and individual agencies committed additional funding. Thus the FHSA funded some aspects of the social worker attachments.

If collaboration means anything, it must have an outcome. Sunderland's success is mixed if measured by tangible outcomes of planning, such as meeting statutory obligations, shifting and targeting resources, and meeting the key objectives of community care. The Community Care Plan had been developed jointly, and though

this process had not been without problems, there was, at the end of the research period, a clear understanding of roles and responsibilities. The boundary between health and social care had been marked out in some areas, as in Learning Disabilities, but there were many uncertainties. Some joint training had taken place. A forum for planning joint training had sprung into being, been dissolved and then recreated. A system of assessment was in place, though there was a recognition that it needed adjustment. A policy for discharging patients from hospital had been agreed, though users reported that it was not working effectively in all cases. Models of joint working between GPs and social services were being tested. The Joint Planning Forums developed into a means of tapping the involvement of users and carers. Though there was a process for transforming the ideas and information generated in the Forums into real plans, these were more difficult to realise. The Care Manager project was a good example of what a dedicated Care Manager could achieve with clients with complex needs, though the project was isolated from other community care developments. The attachment of a social worker to a general practice demonstrated an effective way of collaboration with the PHCT.

In terms of intangible outcomes, relationships between officers of the health and social services were good on the whole. In the early years, there were signs of insularity and intransigence from both the SSD and the health services. This was demonstrated in the May 1990 report of the Working Group on Assessment and Case Management (see pages 239-240), and the notes of the Health Assessment Implementation Group (see page 242-243). Both of these were single agency groups, though the Assessment and Case Management Group had made some attempt to involve health service staff. Such

attitudes were less visible at joint meetings, which could mean that they were usually kept hidden or were under social control, or that where meetings were held jointly, members had a better chance to understand the dilemmas, difficulties and feelings of the other players. However, the agencies did work together during the period, and got to know each other better in terms of roles and responsibilities, strengths and weaknesses. There was considerable willingness to work jointly. The spirit of collaboration ebbed and flowed. There were tricky moments, but these probably helped collaboration in the long term, as officers marked their boundaries and showed that they were prepared to face differences between them. As the structures of the relevant organisations changed, there were times when the officers turned their attention to the internal dynamics of their agencies rather than on cooperation with officers of other agencies. This meant that relationships with other agencies became very secondary (see p. 222). However, by the end of the period, relationships appears to have been restored. It is now impossible to conceive of either health or social services developing community services for vulnerable client groups without referring to each other. However, each organisation still separately plans and purchases services that are not within the remit of joint working, even though these services may in the long run impinge on the business of the other agency. Acute secondary care in hospitals or social services day care services are examples.

As far as collaborative attitudes were concerned, the agencies were committed to the development of community care, to improving services for clients and to working with each other. Trust developed between those officers who worked together over time. However, the new officers appointed to the Social Services Department in 1993 had

to bond with their own department before they could develop ties with officers in the health service. Understanding grew about how each organisation worked, their culture and values, though they still had a long way to go, especially in adjusting to the implications of the 1990 legislation on how the other agency operated. Willingness to learn is difficult to measure. The experience of joint training showed the need for basic knowledge about community care and the role of individuals to promote it had to be addressed before staff could learn about the roles of others and how they intermeshed.

The whole arena of Community Care Policy was dynamic and developing all the time, at every level. Whatever the date of implementation, 1991, 1993 or some time still to come, the whole system, the whole process of change, was not going to be fully developed from day one. As the Department of Health stated, "these are early days in the implementation of a policy of long term change"⁶³. Community Care required workers from different agencies to think and act in new ways, and to cooperate much more closely. Development was necessarily incremental, changing a bit at a time, adjusting to new ideas, testing the implications before moving on. The problem in Sunderland was that because of other changes the thinking kept getting stuck. This was true of care management. Other problem areas were the hospital discharge policy and the involvement of GPs. One year after implementation, it was too early to talk of failures; rather that these were areas still in need of work. A report on the community care monitoring exercise in 1994 to the Social Services Committee of 13th June 1995 notes that the SSI found that "Foundations for effective collaboration were

⁶³ DoH, EL (93) 119, 23 December 1993, Annex.

seen as being in place with Health but it is acknowledged there are continuing areas for further development"⁶⁴.

⁶⁴ City of Sunderland, Social Services Committee, Agenda for Tuesday 13th June 1995, item no. 11.

CHAPTER SEVEN

SOCIAL WORKER ATTACHMENT **TO GENERAL PRACTICE**

INTRODUCTION

General medical practitioners, as providers of primary medical care in the community, have an important role to play in community care. However, as we have seen, engaging GPs in community care has been very difficult¹. This comes from the lack of clear strategy² and the fragmented nature of general practice arising from the independent contractor status of GPs³. The importance of building a system for assessment and managing care that included GPs was recognised at an early stage in planning for community care in Sunderland. The social worker attachment to general practice grew

¹ DoH, 1994a.

² Hudson, 1994, p. 24.

³ Leedham and Wistow, 1992, p. 16.

out of this⁴.

This chapter is the first of two exploring collaboration at the practitioner level. It is based on an evaluation of a project in which a social worker was attached to a general practice. This evaluation was used to determine and shape the future of social worker attachment in Sunderland. The chapter goes on to recount how these developments took place and the problems encountered. This affords an opportunity to look at collaboration at the operational management level. The evaluation was not designed so much as a way of measuring collaboration as a method of testing a model of providing a service, but is used in this chapter in a different way from the original intention, as a route to exploring relations between general practice and social work. The chapter examines the implications for collaboration of this model of working and of the difficulties that took place at the operational management level.

SOCIAL WORKER ATTACHMENT

There is a long history of social workers (formerly medical almoners) working alongside hospital doctors. However, the experience of social workers operating from a primary care setting is more patchy. The first attachment of an almoner to a general practice took place in the late 1940s⁵. Further attempts to bring general practitioners

⁴ Meg Gilley, "A Model for Assessment and Care Management - The Sunderland Project", in Multi-Agency Steering Group on Community Care, *Prize Winning Entries in A Regional Best Practice Competition* (Newcastle: Multi-Agency Steering Group on Community Care, Northern Regional Health Authority, 1993) p. 6.

⁵ See Goldberg and Neill, 1972, p. 19.

and social workers together took place over the next two decades, but developments were very much due to the enthusiasm of a few individuals. The majority of family doctors remained indifferent to the idea⁶. The Seebohm Report recognised the place of social worker attachment, and recommended that social service departments should collaborate with GPs and encourage experiments in joint working, including the facilitation of attachment schemes⁷. This was reiterated a few years later in a further report on social work support for the health services⁸, though it recognised that there was a shortage of trained social workers. The report called for accommodation for social workers to be included in the design of new health centres. By 1976 over half the social service departments in Great Britain had attachment or liaison schemes, many of which began in 1974 or afterwards. Over half the schemes were said to be permanent⁹. Within a few years, however, as the growth of Social Services Departments was checked by economic decline, the number of new attachment schemes declined and established ones were dismantled. Attachment and liaison schemes to general practice were seen as a luxury¹⁰. Rushton and Davies observe that where resources were scarce, Local Authority Social Service Departments were reluctant to fund schemes outwith their legal obligations¹¹.

⁶ Harwin, Cooper, Eastwood, and Goldberg, 1970, p. 560.

⁷ Committee on Local Authority and Allied Personal Social Services, 1968 (Seebohm Report), § 700.

⁸ DHSS, *Social Work Support for the Health Service* (HMSO, 1974) pp. 26-30.

⁹ Gilchrist, Gough, Horsfall-Turner, Ineson, Keele, Marks, and Scott, 1978, p. 684.

¹⁰ Corney, 1988, p. 29.

¹¹ Rushton and Davies, 1984, p. 77.

A good case can be made for collaboration between social workers and general medical practitioners on these grounds:

- Social service clients often suffer from ill-health or disability and are known to general practice.
- There is a need for health and social care services to be integrated: "it is important to try to provide a more integrated service catering for the social, emotional and health needs of patients and clients in a co-ordinated rather than a piecemeal fashion."¹²
- Social and psychological problems can result in illness, and illness itself can create social problems¹³.

However, even where a good case can be made for social work in general practice, there is a question of whether placing social workers in general practice takes them away from those who are badly disadvantaged socially and materially, because it makes them available to practice patients who have a good command of resources and better access to services. The classic reply to this has been that it enables the social worker to address problems before they become crises and so prevent much distress¹⁴.

However, there has so far been no research to substantiate this.

¹² Corney, 1988, p. 29.

¹³ Huntingdon, 1986, pp. 1152-1153.

¹⁴ Anthony W Clare and Roslyn H Corney, "Social Work and Primary Care Problems and Possibilities", in Anthony W Clare and Roslyn H Corney, eds., *Social Work and Primary Health Care* (London: Academic Press, 1982) pp. 337-344 (p. 340).

BACKGROUND TO THE SUNDERLAND PROJECT

The proposals for social worker attachment in Sunderland were developed following the outcome of a previous experiment carried out by the Family Practitioner Committee (now the FHSA) and Social Services Department. In September 1989, a pilot study began to look at better coordination between general practice and social services by holding regular weekly meetings between practice teams and social workers. Three practices at two health centres participated. The scheme at the site involving two practices collapsed after the third week, mainly because "the doctors themselves were sceptical about whether the scheme was a useful commitment of their time"¹⁵. At the other practice, the meetings continued for nearly a year. Those who participated in the project cited several benefits, but there were drawbacks because of the different ways in which the agencies worked, and the variable commitment of members of the primary health care team. Following this experiment, the FHSA undertook a survey of primary health care teams, asking about membership of primary health care teams, primary health care team meetings and methods of improving the effectiveness and efficacy of these teams. This showed that some practices were keen to develop stronger links in the form of social worker attachments to general practice.

Joint Funding was obtained for a pilot scheme for six months to provide a social worker and part-time clerical support attached to a general practice. A few months into the scheme, additional funding was found from slippage in the Joint Finance programme

¹⁵ Sunderland Family Practitioner Committee, "Primary Health Care Team Pilot Study", May 1990, p. 3.

to extend the project by a further six months. The social worker began her attachment at the medical centre on 11 March 1991. The practice was chosen because it had expressed an interest in social worker attachment in its reply to the FHSA survey. It was not one of the practices in the original pilot.

The practice was based in new purpose-built premises which had been open for about a year when the attachment commenced. Membership of the practice comprised four general practitioners employing a practice nurse, practice manager and a team of eight secretaries and receptionists. Two district nurses and 1.5 w.t.e. health visitors employed by the District Health Authority were attached to the practice. Two midwives held weekly clinics; a dietician attended diabetic clinics, and a chiropodist came once a month. The CPN came to the practice if there was a specific problem. Shortly after the project started, the practice gained training approval, with two of the general practitioners approved for training.

Like most practices in Sunderland, the practice did not serve a clearly defined area, and the patients came from all parts of the town. In October 1991, the practice had 7,338 patients, of whom about 150 were from a neighbouring district. The average of 1,835 patients per doctor was rather less than the average number of 2,096 patients per doctor in the borough, and closer to the list size of 1,700 recommended by the General Medical Services Committee. As the practice was near the better-off area of town, one might have expected the patients to be more middle class, but a significant proportion of patients attracted deprivation payments.

The social worker was provided with an office, part-time clerical support and a telephone. She agreed with the doctors that she would accept referrals from any member of the practice, and that referrals would be taken in any form, verbal or written. She retained the right to refuse referrals. She had full access to the medical notes held in the practice, and was bound by medical confidentiality.

The social worker remained accountable to the Social Services Department, receiving regular supervision/consultation from the Principal Officer (Health Services). She had access to social service information systems, equipment, and resources through the normal area team and hospital team network. She followed social services procedures for opening and allocating cases, assessment, reporting and closing cases, and completed the paperwork required.

The social worker was seconded to the attachment from her post as a senior social worker at the District General Hospital. She had many years experience of social work, both in hospitals and in area teams.

AIMS AND OBJECTIVES

The social worker attachment to a general practice was set up to explore the "boundaries of social and health care" and to "agree definitions and practice models of operating within and across those boundaries"¹⁶

¹⁶ Sunderland Health Authority, Memorandum of Agreement, Grants Under Care in the Community and Joint Finance Arrangements, scheme reference 90-1.

A paper prepared by the Family Health Services Authority (FHSA) in November 1990

said that the aims of the scheme were:

to assess the viability of providing a social work service to general practitioners in this way, to ascertain whether it is effective in providing the global approach to a particular client's needs as envisaged in *Caring for People* and to identify areas of conflict between each agency regarding the responsibility for particular categories of client problem.¹⁷

According to a number of internal and public documents, the purpose of evaluating the attachment of a social worker to a general practice was to test:

- the boundaries of social and health care and ways of working within and across those boundaries;
- the opportunities for providing an integrated or "seamless" service;
- whether it improves access to social services for people attending their GP;
- the value of earlier screening of potential social work referrals;
- the opportunity for improving collaboration between GPs and social services;
- whether it is effective in providing a comprehensive service; and
- to identify areas of conflict between the agencies¹⁸.

¹⁷ Sunderland FHSA, "Proposal for pilot study to evaluate a multi-disciplinary model of care based around general practice", November 1990.

¹⁸ Meg Gilley, *Social Worker Attachment to General Practice: the Sunderland Project* (Sunderland Health Authority, 1992) pp. 2-3, 5.

THE EVALUATION

The methods used for evaluating the project have already been described in Chapter Three. What follows is an account of the information yielded by each of the three principal research methods used in the evaluation: collection of data about the work undertaken by the social worker and the clients she saw; interviews with clients, members of the practice, the social worker and the Area Team; and the case comparison exercise.

Data about the work of the attached social worker and the clients she saw were collected for the period 11 March - 6 September 1991, the first six months of the project. The practice social worker dealt with 93 referrals involving 78 clients. Two-thirds of these were from the GPs. Almost one-third were from nurses, health visitors and the midwife. A small number of referrals were made by the receptionists. Sixty per cent of referrals for patients who had already seen the social worker came directly from the patients or relatives. The social worker felt that all the referrals she accepted were appropriate. Seven cases were turned down. Of these, three referrals were passed on to the Community Occupational Therapist; two were turned down because the social worker felt that they were not her job; one was for a client with multiple problems with various professionals already involved, where the social worker felt she had no role; the last concerned admission to private care, in which the social worker could not get involved because of the then policy of the Social Services Department.

The evaluator would have liked to compare the number of referrals made to the practice

social worker with the number of referrals made by the doctors to social services in the same six months of the previous year, but the SSD information system was not able to supply this information. It could give information on the aggregate number of referrals in that period of clients who had one of the doctors recorded as their GP, but this was unlikely to offer any insights.

Cooper identifies four elements of the role of the social worker in general practice: diagnosis and assessment, social case-work, links with statutory and voluntary services and securing cooperation in medical care¹⁹. Corney identifies five categories of work: (i) diagnosis and assessment, (ii) practical help, social brokerage and advocacy, (iii) counselling, (iv) supportive services, and (v) education²⁰. In Sunderland, the pattern of work was similar, though the social worker also had a limited role in securing compliance with treatment, and involvement in education was not recorded separately. Graham and Sher give a very different account of a social worker as a resource for dealing with people with psychological problems and for helping GPs to understand their negative feelings in dealing with difficult patients²¹. This is very much akin to recent accounts of the role of counselling in general practice²².

¹⁹ Cooper, 1971, pp. 541-542.

²⁰ Corney, 1983, pp. 109-110.

²¹ Hilary Graham and Mannie Sher, "Social Work and General Medical Practice: Personal Accounts of a Three-year Attachment", *British Journal of Social Work*, 1976, 6:2, pp. 233-249 (pp. 240-241).

²² Viv Ball, address to the "Counselling in General Practice" workshop of the Newcastle AGUDA conference, October 1992.

The social worker acted as a permanent duty officer as well as a social worker, and dealt with a large number of general queries and requests for advice in addition to her caseload. A wide range of interventions were called for (see Table 7.i), from liaising with other social workers and with other members of the practice, to assessment, treatment and mobilising resources. Where a client was already known to social services, the practice social worker liaised between the practice and the area team or hospital social worker. In most of these cases, the practice was unaware of social services involvement with a patient. 22% of the referrals accepted by the social worker were already known to social services.

TABLE 7.i: TYPE OF ACTION TAKEN

	FIRST EPISODE	SUBSEQUENT EPISODES
Liaison/Link - No client contact	14	6
Assessment and Treatment by practice social worker	32	9
Assessment and treatment and involvement of other services	25	
Assessment and referral to another service	2	
Allocated for assessment but client did not attend	1	
New case still to assess, assessment in progress	4	
TOTAL	78	15

If the social services department was not already actively involved with a client, the practice social worker undertook assessment. By the end of the evaluation, assessments

had been completed on 76% of accepted referrals. The social worker was then involved in providing care for most of these, though two cases were referred on to other services.

The type of work undertaken for the clients by the social worker was recorded (See Table 7.ii). Clients for whom the social worker undertook a liaison role were excluded, so that the table includes the action taken for the 64 other clients. For the four clients still being assessed, a forecast was made about the type of work the social worker expected to do. Types of work were classified according to whether the task was the main work carried out, or additional to it. The primary task was not necessarily the intervention expected by the referrer, but was the outcome of the social worker's assessment. Two clients had more than one "primary" task recorded, e.g support for carer and coordinating services. Clients could have more than one "secondary" intervention.

TABLE 7.ii: TYPE OF WORK UNDERTAKEN

	PRIMARY	SECONDARY
Counselling: Grief/Loss Marital/Interpersonal	16 8	4
Equipment, Adaptations, disabled car stickers, bus passes	4	6
Financial/material problems/advice	8	8
Coordinating services	20	11
Information about resources	3	14
Support for carer	3	8
Arranging residential/day care	4	2

The two major areas of work undertaken by the social worker were counselling (required for 44% of the 64 clients who received social work intervention) and coordinating services (required for 52% of clients). Thus counselling was seen as a much more important feature of social work in a general practice setting than it is elsewhere. This was later to prove a problem for social services managers who saw counselling as the icing on the cake when there was not enough cake to go round. Certainly, a review of the research into this area demonstrates the changes in attitudes to social worker attachment to general practice. One change evident in the literature is the perception of the proper work of a social worker in a health setting. In the early literature, emotional and psychological support was regarded as something a social worker could bring to a practice; more recent papers emphasise practical support. Preston-Shoot lists the following tasks:

co-ordinating statutory, voluntary and informal caring networks; preparing users and their carers for the tasks ahead. The provision of practical assistance, for example with benefits, or the promotion of liaison and communication between hospital and community services are also core functions.²³

Meanwhile, other occupational groups, such as counsellors, psychologists and Community Psychiatric Nurses, have stepped in and can now offer counselling to patients of general practice²⁴.

²³ Michael Preston-Shoot, "Social work in health care: necessity or luxury?", *Social Work Today*, 14 January 1988, p. 18.

²⁴ Michael Preston-Shoot, "Is social work ready for primary health care?", *Social Work Today*, 25 May 1987, p. 22.

The evaluator intended to make comparisons with the workload of the social services department as a whole, but this was not possible because the data received was flawed.

The practice social worker was able to mobilise a wide range of resources, 18% of which were health service resources. The ability of one person to put together packages of care with elements from different agencies was a major advantage of the attachment. The packages of care put together by the practice social worker called on a wide range of services: in all, 103 elements provided by social services, health services, voluntary organisations, local authority, utility companies, the church: a total of 35 departments or agencies. This was in addition to the resource of the social worker herself in providing counselling and support. In addition, the social worker passed on information about resources to clients.

The Clients

Two-thirds of the 76 clients referred were female. Very few cases involved children. This could have been due to the absence of the health visitors because of maternity and sick leave. Most (60%) of the clients were over 60, 42% were 75 or over. Just over one-third were adults aged under 60. Women aged 18-59 were a significant group, accounting for 26% of new referrals.

Half the clients lived in their own homes and half in rented accommodation. Thirty-two (42%) clients lived on their own; twenty-six (34%) lived with another person; eleven (14%) lived in three-person households; the rest (9 clients, 12%) lived in households

of between four and six persons.

Clients were classified as far as possible according to their levels of income, on information given by the clients to the social worker and the social worker's assessment of the household. A distinction was made between those clients on state benefits alone and those employed or receiving pensions above the basic state pension, or with additional sources of income. As might be expected, the majority, nearly two-thirds, were dependent on state benefits, including the state pension. However, over one-third had a level of income above the basic. The under-65s on state benefits tended to be clients too sick to work. (Table 7.iii).

Among the older clients, two-thirds of those on state pensions alone lived in rented accommodation, and two-thirds with additional income lived in their own homes. However, among the under 65s the numbers on state benefit and of earners were equally divided between rented and owner-occupied housing.

TABLE 7.iii: LEVELS OF INCOME

TENURE	CLIENTS AGED UNDER 65		CLIENTS AGED 65 AND OVER	
	State Benefit	Earning	State Benefit	State Benefit Plus
OWNER OCCUPIER	11	5	7	11
RENTED	11	4	14	5
NOT KNOWN	2		8	

The clients seen by the practice social worker were more middle class than the clients

seen by most other social workers (though medical social workers deal with clients from a wider social background). Much of the work of area team social work tends to be concentrated on clients from poorer economic and social backgrounds. Two conclusions are possible. On the one hand, it could be that social workers in general practice are more likely to be hijacked to provide services to the middle-class who generally have good access to services anyway. Alternatively, even those with financial resources may have difficulty resolving problems, but are unlikely to get help from area team-based social workers. This finding is supported by an earlier study which compared clients seen by mainstream social workers and those in general practice found that the latter came from a wider cross-section of the community. There was no evidence to show that the practice social worker clients had different or less severe problems²⁵

Clients were classified according to their primary medical condition (See Table 7.iv). The social service categories were adapted in an attempt to put the medical conditions into a context.

²⁵ Roslyn H Corney and Barbara A Bowen, "Referrals to Social Workers: A Comparative Study of a Local Authority Intake Team with a General Practice Attachment Scheme", in Anthony W Clare and Roslyn H Corney, eds., *Social Work and Primary Health Care* (London: Academic Press, 1982) pp. 31-43 (p. 42).

TABLE 7.iv: PRIMARY MEDICAL CONDITION

VERY SEVERELY SICK/HANDICAPPED	10
SEVERELY SICK/HANDICAPPED	19
MILDLY SICK/HANDICAPPED	17
MENTAL HEALTH: Anxiety, Depression, Neurosis, Addiction	16
ELDERLY MENTALLY ILL	9
LEARNING DIFFICULTIES	1
OTHER: Pregnancy, Child - behaviour, Temporary Ill-health	6
TOTAL	78

Of these clients, fifteen also had a degree of sensory handicap: twelve had visual problems, two had hearing problems and one had both visual and hearing handicaps. Three of the clients were terminally ill. Only two cases had been referred because of the sensory handicap. The practice social worker's access to medical records alerted her to address possible social difficulties arising from any medical condition the client might have incidental to the problem for which the patient was originally referred.

This pattern has similarities to that found among the clients of one of the earliest studies of social worker attachment²⁶. Of June Neill's clients, two-thirds were women, over one-third were elderly, and one-third live alone. Two-fifths had physical complaints and the rest psycho-social problems. Some clients would not have sought help from social services had there not been a practice social worker, but it was not possible to estimate the proportion of these.

²⁶ Goldberg and Neill, 1972, pp. 53-65.

Interviews: The Clients

Once cases were closed, interviews were held with as many clients and carers as possible. Cases were excluded if the social worker had not seen the client but had merely acted as a liaison, if contact had been minimal, if clients were confused, or if the doctor thought an interview would be detrimental to the patient's condition.

Twenty clients and two carers were interviewed (see Table 7.v). All but one of the cases had been closed. The client whose case was continuing was included because of the insights her case had to offer. Another carer had been approached for an interview, but had too many concerns of her own to wish to be involved. One other client was approached for an interview, but was then admitted to hospital and was not available.

TABLE 7.v: CLIENTS AND CARERS INTERVIEWED

		CLIENTS	CARERS
MALE	UNDER 65	3	
	65 AND OVER	3	
FEMALE	UNDER 65	8	1
	65 AND OVER	6	1
TOTAL		20	2

Of the interviews that took place, one client confused the social worker with the district nurses, and provided limited information. This had probably less to do with the impression given by the social worker than the client's own awareness of what was happening around her. Another interview was aborted because an elderly, confused

client could not remember the social worker.

Most people were surprised to be referred to a social worker in the practice, but almost all of them were happy to see her. One client, who knew of social workers through her job, reported, "I wasn't keen at first, but I agreed. I didn't think it would help". This reflects the advantage of discussing the referral with the patient before it is made, which does not often happen when practices refer to mainstream social services.

Most clients thought they had been helped by the social worker. One said she wasn't helped because there was nothing she wanted. (In fact, the social worker had arranged for the installation of a telephone and had alerted the GP that the client had stopped taking the tablets she had been given on her discharge). This client knew that the social worker had been to see her, but was unclear about her role.

Clients were asked about the sort of help that the social worker had given (Table III.iv). Some made a distinction between the main area of assistance and additional ones; for others, the various elements of help were equally important. The clients identified 50 elements of care. For many of them, the opportunity to talk about their worries was particularly important.

Clients were asked if there was any difference in seeing the social worker rather than the doctor or nurse. Two clients noted that doctors and nurses provide medical care while the social worker provides practical help and advice. Six felt that the social worker allowed them to talk; three others said she was more like a friend or a sister.

Four said that seeing the social worker was more informal and they felt more at ease. One client said that the social worker was more available. One man said, "I don't care who it is so long as they have a bit chat", but went on to say that the social worker had more knowledge of services available. Two other clients recognised her as a source of specialised knowledge and information.

If the practice social worker had not been available, twelve clients would not have known where to get help, or felt that their problems would not have been addressed. One felt that he "wouldn't know where to start". Six others thought that the area social worker, GP, solicitor, housing department, psychiatrist or psychologist would have been able to help. Two women, who had suffered miscarriage or a cot death, were particularly aware of the lack of services locally. One had made an effort to look for information and support groups and had found none; the other knew of someone in a similar position who had not had access to the kind of support she herself received from the practice social worker.

The eight clients who had previously seen a social worker were asked if there was any difference between seeing the practice social worker and the other social worker. Two said there was no difference. The others mentioned a range of advantages in seeing the practice social worker to seeing another social worker: it was quicker to get an appointment to see her; she was more accessible; she was able to provide what was required, and more quickly; she gave feedback on what was happening; she gave support to the carer; she provided a personal service or a "human face"; she was a member of a known team; she understood the medical problem.

Asked if there were any advantages or disadvantages to having a social worker in the practice, the only disadvantage mentioned was by a client who was in paid work and had difficulty making appointments to see the social worker. However, this related to the process rather than the principle of social worker attachment. Again, clients mentioned a range of advantages: ease of access; having someone to talk to when you need it; time to talk; liaison with other members of the practice; the social worker can take some of the burden off the doctors; the doctors can direct people to the social worker when appropriate; continuing care; source of information and advice; the social worker has an insight into the medical problems; the social worker can see you and get things done quickly. Nine clients and carers noted that the social worker kept them well informed about what was happening. No one said that they had insufficient information. Both carers questioned felt that their needs were taken into account. One remarked that this had not happened before, and the other said she felt she couldn't keep bothering the doctors about the practical aspects of her sister's care.

The respondents made a number of additional comments: several of those interviewed made positive comments about the personality of the practice social worker; several said that they didn't know what they would have done without her or that she took a lot of worry off them; two people remarked on how the social worker kept in touch with the family or took trouble to involve them. One client said that it was the quality of the service that was important, and said "it's not what they do that's important, it's how they treat you".

Interviews: Members of the Practice

Interviews were held with the GPs, practice manager and administrative staff, practice nurse and attached district nurses and health visitors.

The GPs each discussed five cases that they had referred to the social worker. In most of the cases, they felt that the patients had benefitted from the social worker's involvement. They received more comprehensive packages of care more quickly, and received support and counselling. The social worker was thought to be able to spend more time with the clients than they were, and this was a great benefit, both to the patients and to the GPs. The social worker was more informed of the medical side of the cases she dealt with than mainstream social workers. The social worker had also mobilised medical care appropriately when she thought it was necessary. The District Nurse also reported benefits for patients and noted that there was "more than one way of looking at a patient", and that by working together it was possible to get a fuller picture and to identify discrepancies in the story.

Two doctors remarked on cases where they and the social worker had worked together with the patient, and felt that the patient benefited from this complementary approach. Where team members felt there had been no or minimal benefit, this was because the client had failed to attend the appointment with the social worker, refused to continue seeing the social worker, or the case was seen as intractable. One doctor said that there had been situations when he had made a conscious decision not to refer to the social worker, either because the patient was likely to need a long-term follow up or because

several professionals were already involved.

The receptionists often found that patients would tell them about problems and ask if they should see the doctor. With the social worker in the practice, the receptionists were able to divert patients to the social worker, if that seemed most appropriate. They found this very helpful for those patients who did not want to "bother the doctor". If the social worker had not been there, the patient would have had to see the doctor, who would then direct them to social services.

There were also advantages for the practice. The prompt and regular feedback received from the social worker about the patients was particularly noted. Other advantages included the greater accessibility and availability of the social worker, and the skills and experience she brought to the practice. Practice members found it easier to deal with the social worker face to face. The social worker brought a wide knowledge of resources to the practice. She introduced an approach that would not have been considered before and was a worthwhile person to consult and from whom to get an opinion. The practice manager felt that the social worker had taught them a lot about using social service resources and tapping into the system. The Health Visitor had also received personal support from the social worker. Shortly before the health visitor went on maternity leave, one of her clients experienced a cot death, and the social worker supported the health visitor through her own distress at the situation.

The only negative features identified by members of the practice were to do with practical matters, such as getting hold of her when she was out, rather than with the

attachment itself.

The District Nurse and Health Visitor both thought that the social worker had saved them time. The District Nurse was able to make fewer visits to clients because, say, bathing aids had been obtained more quickly, and less time had been spent coordinating on the phone. The doctors felt that GP appointments were saved by the social worker attachment, but more time was spent talking with the social worker about cases, which meant that longer time was spent overall. One doctor considered that having the social worker in the practice had meant that he had done more visiting, because the social worker had alerted him to medical problems. He felt that he had therefore worked harder on individual cases, and that the cases were dealt with more satisfactorily.

Members of the practice had experienced considerable difficulties in dealing with social services before the attachment, and there were problems with availability and accessibility. There was little or no feedback; it was difficult to contact the social worker involved in a particular case because phones were engaged or because of the duty officer system; members of the team did not know whom they were dealing with. A doctor commented, "I couldn't put a name to a team social worker". The Health Visitor remarked, "they treat you as an idiot. They don't treat you as a fellow professional". Another doctor felt that social workers try to look for a medical reason for passing the buck to the practice. One doctor observed that team social workers intervened in a crisis, but the practice social worker could take a preventative role.

Members of the practice were asked what advice they would offer to anyone wishing

to set up a similar scheme. They said that it was important that an attachment should only be made to a team which already worked well, and that the parties should discuss working together before the social worker joined the practice. The social worker should explain to the practice what she can do and should be free to turn down referrals. There should be regular meetings for feedback. In addition, practical matters like clerical support and access to notes ought to be planned. The social worker needs her own office and a separate telephone line. One doctor said that practices should have open minds about social worker attachment, and should recognise that the social worker is not a subordinate member of the team, but an equal.

One doctor concluded, "I can't imagine what it would be like not to have a social worker attached now. The work is there, and the quality is improved by accessibility". The District Nurse felt more positive about social workers as a result of the project. She said, "I used to be very negative". The practice manager had a stereotyped view of social workers ("hippie types"), and felt that the practice social worker was "about the only sensible one I've met". Her view of social workers had not changed, but she saw the practice social worker as an exception.

Interviews: The Social Worker

The social worker found working in the practice very worthwhile; it was satisfying to work in a multi-disciplinary team, and she appreciated the variety of work. She enjoyed the autonomy and the degree of control over her workload and was conscious that this setting offers greater freedom of approach than is possible, in her experience, in other

fieldwork settings. Generally the work was challenging but satisfying. She said, "it feels what I think social work is about, and I had forgotten how nice it can be". She felt nearer to the clients, and more relevant, "as if I had a place in the scheme of things". However, there was a price to pay; the worker had to accept much greater personal responsibility for the service offered, was more exposed and does not have the protection of a large department to fall back on. "You stand or fall by your own efforts".

The social worker carried an average case load of around 25 clients, though the range was between 20 and over 30 cases. On coming into the practice, she had made a point of taking on all cases referred to her, unless they were obviously inappropriate, so that she could assess what practice referrals meant and what they might hide. Certainly there were several cases where the social worker had been asked to provide a simple item, such as Vitalcall Alarms or benefit advice, but assessment had highlighted other needs which resulted in recommendations of a fuller package of care. A number of tasks undertaken by the social worker could equally well have been done by someone unqualified, e.g. assessing for straightforward equipment, delivering and fitting equipment, transporting clients and checking that plans have been completed. In the longer term, she felt that she might redirect some referrals so that they could be dealt with at the most appropriate level, and to save herself time. As for her workload, she said, "I just know that I'm busy, and the longer I'm here, the busier it is".

The common theme running through all referrals or queries was that the patient was suffering from some form of illness and was known to the practice because of this. The

problems could be directly related to the illness and the impact of this on the patient's functioning or on their family, or the anxieties themselves were generating or contributing to some form of illness or ill-health.

A noticeable feature of the work was the high number of referrals received where the task was primarily a counselling one - counselling for loss or bereavement of some kind or for an interpersonal problem, and such cases were often presented to the referrer with symptoms of anxiety or depression. This had major implications for the social worker's time as such cases invariably necessitated long term and regular contact.

The practice members were generally well acquainted with their patients, their families and their social circumstances and so were well placed to be initial recipients of a patient's concerns or to recognise the possible links between presenting ill health and social or emotional factors at home. The social worker was recognised as one member of a multi-disciplinary team, seeking to respond to the medical, nursing, emotional and social needs of patients and accepting the interplay between all those factors when offering a support network to those experiencing ill health.

Patients and families also gave feedback to practice members. The social worker's performance was thus under more constant and direct scrutiny, from both the consumer and the referrer, than is the case in many other settings.

As the project was initially for only six months, during which time the worker took 20 days leave and six bank holidays, there was always considerable pressure to undertake

and complete as much work as possible. For this reason a fast pace of work was maintained. No overtime was claimed and much written work was done at home. Within a normal social work setting, it would not, in the social worker's opinion, always be possible to sustain that level of input.

The major advantage for the social worker in the practice was the way she could work with other members of the practice. It was easier to confer with the referrer and with other members of the practice involved in a case. Liaison took place face to face without the need for written communication or formal meetings or even telephone calls. It was easier to invoke the skills of the other members of the practice in order to complete assessments and to obtain the appropriate resources. A GP would undertake a visit to clarify or simplify a medication regime where the giving of medicine needed to be organised and was a problem, and district nurses would order equipment quickly where a need was identified by the worker. It was easier to link in to health resources, such as CPNs and registration for the visually handicapped, as GPs could initiate such referrals very quickly after discussion. The social worker found the atmosphere of trust in the practice a great advantage: everyone in the practice had his/her own role and skills; they were expected to get on with it, and they were each accepted and recognised for what they brought to the team. This certainly enhanced job satisfaction for the worker.

The social worker felt that she was recognised as part of an identified, named team, and that this was particularly important for some patients - "one feels more accepted, patients already have the name of the worker and have received some impression of

them from the referrer". All members of the practice discussed referral to the social worker with the patient before referring the patient. This meant that not only did the patients know about the referral, but they also participated in the decision. This was often not the case in other settings.

In the practice, problems were usually identified at an earlier stage, when people were showing symptoms of anxiety or strain. It was then possible to respond to clients more quickly than in hospital or team settings where the allocation system could lead to delays.

When medical students or trainees were based in the practice, the social worker had the opportunity to influence their approach to total patient care and to highlight the social and emotional aspects of illness as well as enhance the student's perception of the social work role. Two students had the opportunity to undertake visits with the social worker.

The social worker could see no obvious disadvantages, though some of the problems mentioned below could be disadvantages in certain circumstances.

The social worker identified the factors which would facilitate attachment. These included the right sort of accommodation, with access to a room where clients could be interviewed comfortably. Access to basic and specialised reference books and general information was required. Strong links with other sections of the Social Services Department were essential, which could be difficult for someone taking up an attachment from outside the area. A social worker in general practice needs to be

experienced because of the greater autonomy of the work. Some tasks required the presence of more than one worker, such as the protection of property, where a worker could not go to an unoccupied house alone, or transport for someone who was severely disabled. When these arose, the social worker was able to enlist the help of a member of the social work team, but this depended on their goodwill.

The difficulties that the social worker experienced with the attachment were generally related to systems and practices in the Social Services Department. She found the system of record keeping a burden in the practice. Information held on computer was often incomplete or inaccurate, which meant time spent tracking down who was involved. This occasionally led to duplication.

It should not be assumed, however, that relationships with the Social Services Department were difficult. The practice social worker was able to link without difficulty into the computer systems in both the District General Hospital and a local Area Team, for the purpose of checking Social Services involvement with cases. Similarly, requests for resources were usually dealt with easily and speedily and joint working and liaison appeared to take place smoothly. However, one local team did not accept the assessments she had made and insisted on sending another social worker out to assess the client, which resulted in duplication and delays.

The social worker identified a number of areas of work which she felt might be developed should attachments be made permanent, such as planning for hospital discharges, support for carers, counselling people with a newly diagnosed condition,

building up a local volunteer group and group work.

Interviews: The Area Team

The Area Team felt that the practice social worker was working at the boundaries of care, with cases where it was not always clear which agency should be providing help. Her position meant that the practice social worker was able to resolve some of these issues. The team was confident that her requests for aids and equipment were appropriate. The Community Occupational Therapists (COTs) occasionally conducted joint assessments with the practice social worker. They found that her knowledge of the client's medical circumstances gave another valuable perspective to the work. The Domiciliary Care Organiser appreciated the improved quality of information coming from the practice because of the attachment, which afforded a full account of the client and his/her problems, and helped her to prioritise the demand more effectively.

The Domiciliary Care Organiser was concerned about the number of elderly people who were admitted to private residential homes when they could be supported at home, given an appropriate package of care. She said that in two cases, the practice social worker had been able to get everyone together to compile a package of care to support the elderly people in their own homes. In other words, the social worker was taking on a care manager-type role, though care management had not then been introduced in Sunderland.

On occasion, the area team had used the social worker as an arbitrator and negotiator

in relations with the practice, when the team wanted to persuade the doctors to access a particular resource. They felt that this was not a very effective use of her role. On the one hand, it had not been successful, and on the other, there was a feeling that the GPs should be able to respect the professional judgement of the area social workers as much as the practice social worker.

Thus, the practice attachment had improved the quality of information received by the area team, though it had not been completely successful in breaking down the barriers between the practice and the team.

Case Comparisons

As part of the evaluation of the attachment of a social worker to general practice, case comparisons were undertaken in order to identify similarities and differences in the way cases are handled in different settings: in the practice, in hospital, and in an area team. The exercise was operationally useful and personally satisfying to those who took part. However, its value as a research tool was more limited. The exercise was useful in demonstrating similarities and differences in social work done in different settings. However, it did not offer any particular insights into the wider research on collaboration. This was hardly surprising because it was not part of the intention of the exercise. This shows the difficulties of using studies designed for one purpose in a different way, of applying *post hoc* meanings to *ad hoc* research.

RESULTS OF THE EVALUATION

The evaluation was overwhelmingly favourable about the benefits of social worker attachment to general practice. In terms of the aims of the evaluation, the project had demonstrated that attaching a social worker to a general practice did create a means of working across the boundaries between health and social care. Collaboration between the practice and social services improved only to the extent that the social worker acted as an intermediary between the two. The Area Team still experienced problems relating to the GPs and the practice retained stereotypical and negative views about Social Services as a whole. The practice social worker undoubtedly improved access to social services for many of the practice patients, who received a comprehensive and integrated service. They found it an acceptable way of receiving a service²⁷. Some of these patients would not have received a service from the Area Team or hospital social work service. The practice social worker did intervene at a much earlier stage²⁸, but it was not possible within the scope of the evaluation to explore the long-term effects of this, or compare these cases with similar clients who had not had the support of the practice social worker.

A cost-benefit analysis ought to be part of any evaluation of this type in order to identify whether the benefits of the project justified the costs. However, this was not within the remit of this evaluation. While the project was funded from Joint Finance,

²⁷ Ratoff, 1970, p. 477.

²⁸ This was the experience of earlier studies, for example Ratoff, 1970. This approach is commended by the DoH, 1994a, p. 8.

it was additional to the "normal" provision of social services. Indeed, social worker attachment to general practice would always be a more expensive way of delivering a social care service, because other forms of delivery would still be required, and because it makes the service available to people who would not otherwise seek social care²⁹.

SOCIAL WORKER ATTACHMENT AFTER THE EVALUATION

The evaluation marked not so much the end of the story as the beginning, and the development of social worker attachment after the evaluation was probably more interesting than the evaluation itself. As a result of the evaluation, the social worker attachment was made permanent, though the grade of the post was reassessed as basic grade. The social worker, who was on the senior grade, chose to take a grade and salary cut in order to remain with the practice.

The JCC received the report of the success of the social worker attachment in January 1992, and the project was extended for a further period of six months, funded from Joint Finance. At the next meeting of the JCC, there was discussion of a paper proposing the Primary Care Team as the vehicle for multi-disciplinary assessments. It was resolved to recommend to the constituent authorities that (a) approval be given to the development of the concept of Primary Care Teamwork; (b) there be agreement that the FHSA should fund the present pilot for the rest of the financial year and fund the initial costs of setting up three new schemes; (c) the Social Services Department would take up the funding thereafter; and (d) the programme would be reviewed in January

²⁹ Gilley, 1993, p. 6.

1993³⁰. The evaluator (i.e. the researcher) was expected to monitor developments and provide advice in setting up the new projects.

In the early attachments, one social worker worked with one practice, though the practices were of different sizes, in different areas of Sunderland. An early failure showed how necessary it was to prepare the ground thoroughly, when one attachment collapsed after the social worker had been appointed, but before she had taken up her post, because the practice could not offer suitable accommodation. Towards the end of 1993, there was a change in the pattern of attachments, one social worker being attached to two practices, either in one health centre, or in separate premises.

In the meantime, the new Director of Social Services (D) came into post and reorganised the Social Services Department. The role of the generic practice social worker fitted less comfortably into the new structure, which divided the fieldworkers into three sections, working with children, older people and adults with disabilities. The practice social workers were placed in the division for older people, and were not expected to undertake extensive work with other types of client. Younger clients (i.e. under 65) were still referred to the practice social workers, who would carry out the initial assessment. If the work needed by the client was quick and easy or if the nature of the case meant that it was best done by the practice social worker, the practice social worker would carry it out. However, if the client was likely to require a greater level of input, the case would be referred to the appropriate Division. This put the practices in direct touch with a wider range of specialist resources and could promote

³⁰ Joint Consultative Committee, Minutes of the Meeting, 17 March 1992, § 5.

collaboration with other parts of the SSD. but it detracted from the sense of the practice social worker working with the practice patients (which could, in any case, become an isolationist rather than a collaborative approach). It also put restrictions on the type of work the practice social worker could undertake. Early attachments were certainly based on generic social workers. Cooper argued that "the social worker in general practice should be as much a generalist as the doctor, the former having the right of access to specialist colleagues (in child care, mental health, etc.), just as the latter has to hospital specialists."³¹ A choice has to be made between a generalist service and administrative convenience.

The evaluation itself also came to be interpreted in a new way. Originally, it had been seen as endorsing attachment because it made access to social care easier. It was now perceived as a problem because it provided a social care service to people who would not otherwise have received one. A report by the Director of Social Services to the Social Services (Health Care and General) Sub-Committee in October 1993 notes:

While the original attachment was seen as offering an improved social/health care service, the evaluation report by Meg Gilley, the Primary Health Care Project Worker in November 1991 did identify certain limitations: the Social Worker was undertaking work that although beneficial, would not have commanded the same priority for scarce social work time in any other of the Department's Assessment settings ...

The report recognised that there would never be sufficient resources to allow every general practice its own social work attachment, and proposed an additional model of

³¹ Cooper, 1971, p. 542.

joint working between social workers and general practices. The proposal was that Team Managers from the Older Person's Division would work with each Sunderland practice, in order to create links and assess the demand on social services made by the Primary Health Care Team, so as to establish the most appropriate type and level of attachment. It was envisaged that the Team Manager links would work in different ways:

For some the linkage might mean attendance at Primary Care Team meetings, for others a regular visit to exchange referrals and assessments through the Practice Manager, and for some a routine of face to face meetings with the General Practitioners themselves.

It was recognised that different PHCTs would require different links with social services, which might be a social worker from either the Children's or Older People's Division, a welfare assistant or a home care assessor. Variations on this model have been successful elsewhere. A project in Salford developed links between practices and social workers leading to an agreement between them about means of referral and contact, times of availability and definition of roles³². One important difference was that this scheme was driven forward by a project manager.

Though the JCC report was more realistic than the papers proposing the original attachment about the limitations of developing attachments, nevertheless it moved the goal posts. Previously, collaboration between GPs and social workers had been envisaged in terms of social worker attachments to general practice, though it was

³² Andrea Elkind Janet Chapman, Jeff Girling, Lyndon Jones, "PASS Notes", *Health Service Journal*, 4 May 1995, pp. 30-31.

recognised that it would take time (and resources) to establish a network of social workers to cover all practices. In reality, it would have taken many years for Sunderland to get to a stage where every practice had its own attached social worker, if this was ever possible at all. Now, the chief vehicle for developing collaboration was through Team Manager liaison, at least in the first instance. This was not popular with the GPs, who saw it as a poor substitute for attachment. They also feared that linkage would be a substitute for attachment rather than a parallel means of contact.

The Team Manager Link Scheme linked team managers with practices in order to establish a relationship between the practice and social services and ascertain what sort of relationship was required in the longer term. The Link Scheme had little success. By February 1995, fifteen months after the proposal had been agreed, fewer than half the practices in Sunderland had met with a Team Manager. Team Managers had made contact with the practices by letter or telephone on 69 occasions, resulting in 25 meetings, half of them with practices that already had a more formal link with Social Services through attachment or liaison arrangements. There are a number of reasons for this failure. The LMC resistance to the project was important, as this seemed to foster passive resistance, so that approaches from the Team Managers were not responded to. On the other hand, Team Managers were busy people with a wide range of responsibilities, and it was not necessarily easy to pursue a relationship with a reluctant partner. There did seem to be the attitude among some GPs that "if you won't let us have an attached social worker we won't cooperate with you." It was almost as if the success of the original attachment project meant that GPs were not prepared to consider anything less than full attachment, even on an interim basis. In other words,

viewed from a longer perspective, the evaluation was possibly counter-productive to fostering alternative forms of collaboration between general practice and social services. Once you have driven a Rolls-Royce, a Ford Escort won't do!

By mid-1994 there were six social workers attached to nine practices. Each attachment was slightly different (see Table 7.vi). This was inevitable, given the different circumstances and needs of each practice, and in any case, the original evaluation had recommended that a variety of models of attachment could be tested.

TABLE 7.vi: SOCIAL WORKER ATTACHMENTS IN SUNDERLAND, AS AT MID-1994

DATE OF INCEPTION	DESCRIPTION
March 1991	Full-time social worker attached to one medium-sized practice.
Summer 1992	Full-time social worker attached to one (smallish) practice. Since this attachment was established, this worker's responsibilities were extended, and she also liaised with one other (small) practice.
April 1993	Full-time social worker attached to one (large) practice.
1993	Full-time social worker attached to two (one small, one medium sized) practices in a health centre.
January 1994	Full-time social worker attached to two (one small, one medium sized) practices in separate premises.
Summer 1994	Part-time social worker liaising with two practices (medium - large) in one health centre, taking referrals, discussing cases and feeding back on what has been done. She would undertake some of the work herself, but the rest was funnelled towards other workers in the area team. Thus, though the patients may not actually see the practice social worker, the link for the practices was with that worker.

A further area of controversy was the proposal by the Social Services to make alterations to attachments already established. In one case, a social worker was asked

to develop a liaison with another practice, whereby the social worker spent half a day a week with the second practice. Another proposal of the evaluation report, which was not implemented, was to give a social worker support from a welfare assistant, who could undertake some of the less demanding tasks, thus releasing the social worker to work with a second practice. For the LMC, there was an issue about whether established attachments should be subject to alteration, and how any changes should be carried out.

There was also a concern within the Social Services Department that practice social workers might become isolated from the rest of the department³³. This was identified as a potential danger in the evaluation report. For this reason, practice social workers were required to spend 10% of their time (half a day a week) working from the Area Team. The practices saw this as an erosion of social services commitment.

Thus, the LMC had several concerns about the development of social worker attachments: the adoption of the Linkage Scheme, changes in the model of attachment, the restriction on the generic role, and the restriction on time spent with the practice. There was very much a sense that "this trend should not be allowed to continue"³⁴. The LMC was also concerned that the changes had not been discussed with the Committee.

Other development work did take place. The evaluator met regularly with the Team

³³ Mailik and Ashley, 1981, p. 133.

³⁴ Letter from the Chairman of the LMC to Sunderland Health Commission, 30 September 1994.

Manager for PHCT Liaison, the practice social workers and their team managers during 1994. This group produced operational guidance on social worker attachment, a guide to financial responsibilities resolving issues not previously addressed, and a report on a survey of practice social worker workload.

Though funding was identified by the SSD for two more attachments, development did not take place. The reasons for this were accommodation problems in the practice, pressures on the area teams, and a general lack of enthusiasm among all concerned.

COLLABORATION BETWEEN HEALTH AND SOCIAL SERVICES

The evaluation of the initial attachment project in Sunderland confirmed earlier research that social worker attachment to general practice was a good way of encouraging collaboration between health and social services³⁵. Initially, there was considerable commitment to developing attachments from all concerned. Four years after the first project began, the scheme was very much less healthy. The temperature had risen on several occasions, with somewhat fevered debate. In the end, the patient was declared to be chronically ailing and left to manage on his own. Where attachments were in place, they worked well, and these practices were privileged to have a good relationship - if not with Social Services as a whole - at least with the practice social worker. For the other 80% of practices, contact with Social Services was as limited as ever.

One problem was the different perceptions about the nature of social work and its clientele. Within the practice, there was a view that part of the social worker's role was

³⁵ Goldberg and Neill, 1972, p. 173ff.

somehow therapeutic. This understanding of social work was common in the literature, especially in articles written wholly or partly by doctors³⁶. Yet for managers within social services in the 1990s, "therapy", epitomised by counselling, was an expensive luxury. In any case, as a result of the NHS and Community Care Act, the role of social workers moved towards the assessment of need and planning and managing care packages for individuals. Though this may necessitate the use of counselling skills in assessment, counselling was very much a subordinate role. Counselling as a therapy was now seen as a separate role and not part of social work. Indeed, some practices did employ a counsellor. One practice in Sunderland had both a social worker and a counsellor.

At an organisational level, relationships had probably deteriorated. The LMC was disgruntled and cynical about relations with Social Services, and Social Services despairing about relations with GPs. The question is whether this was due to some failure in the process or the individuals concerned, or whether there is a fundamental and insoluble problem about collaboration between GPs and social services.

A number of factors contributed to the breakdown. Firstly, in the honeymoon period, the agencies and the evaluator were reluctant to face the reality that there would never be sufficient funding to give every practice access to a practice social worker. The pilot project was very successful and raised expectations among GPs which could never be fulfilled. When the Social Services Department tried to spread the practice social

³⁶ Graham and Sher, 1976; Allan I F Scott, Christopher Freeman, "Edinburgh primary care depression study: treatment outcome, patient satisfaction, and cost after 16 weeks", *British Medical Journal*, 1992, 304, pp. 883-887.

worker resource more evenly (and more thinly), it met considerable resistance from the GPs. An attempt to introduce an additional means of joint working failed, because it was not what the GPs wanted. Secondly, organisational change in the Social Services Department created an environment less conducive to generic social work in a practice setting. It also brought in new managers. Though the Social Services Department expressed its continued commitment to social worker attachment, the commitment of the new regime to the existing project was not the same as if it had conceived and promoted the project itself.

Collaboration appeared much better within the project, between individual social workers and GPs in individual practices. The characteristics of the team and the attachment facilitated collaboration. The nature of membership of the team was one factor, with the attached social worker as a full member of the team. Before the pilot attachment began, the social worker and the practice formed a clear agreement on how the project would work, and a clear understanding was established of roles and responsibilities, both within the team and beyond it³⁷. There was an implied understanding that the practice and the social worker were both working for the good of patients, but this shared goal was not agreed explicitly. Leadership was not discussed explicitly though leadership can be the most important determinant of the shape and direction of the team³⁸. The social worker accepted the role of the senior partner as leader of the team, just as her role as a co-equal professional was accepted within the team.

³⁷ Corney, 1988, p. 30.

³⁸ Ovretveit, 1993, pp. 121-138.

Collaborative mechanisms within the team were also good. The social worker was based on the practice premises, which meant that she was seen as part of the team, and was readily available when another member wished to refer or discuss a patient. The team met formally once a week, with agenda items added by any member of the team. The staff common room facilitated frequent informal meetings during the working day. These factors all contributed to good communication within the team. On the other hand, there was little joint training within the team, except when someone came to talk to the team as a whole, usually within the context of the weekly meeting. Time was not set aside specifically for team building and bonding. Indeed, this would probably have appeared laughable to most PHCTs where time is under considerable pressure.

Within the team, there was strong evidence of positive collaborative attitudes. All members were committed to the attachment. Trust was built up between them relatively quickly. Having worked in hospitals for some time, the social worker had a good understanding of health care systems and of the culture of medicine and nursing, and the potential for tensions between that and her own professional background. The team had less insight into the world of social work, certainly at the beginning of the attachment. Indeed, most members showed some prejudice against social services as a whole. However, the onus was on the social worker to share her knowledge and insights and educate the other members of the team. Equality, which was discussed in Chapter Four, never arose as an issue. There was, therefore, at least on the surface, a positive dynamic for collaboration within the team, and the circumstances of the team within which the attachment operated were generally favourable. However, though the team worked well together, there was no attempt to address the fundamental differences

between the world of medicine and the world of social care³⁹. Furthermore, the attachment did almost nothing to improve the relationship of the practice with other parts of the Social Services Department. Collaboration was limited to the team, confined to practice territory. Goldberg and Neill had proposed as one possible model of attachment a temporary relationship in which a social worker was attached for a limited time in order to build lines of communication and habits of joint working⁴⁰. This was endorsed by a DHSS report⁴¹. Our evidence is that this would not work.

The problems for social worker attachment arose not from within the team but from beyond it, from the agencies which had fostered it in the first place. The agencies were part of the environment in which the attachment operated, and the environment changed over the course of the research period. However, the fact that the GPs as a body were unable to acknowledge and adapt to the changing environment points to a deeper problem in the relationship. They wanted collaboration with social workers, but on their terms, and were not prepared to compromise. It is social work's willingness to go along with this sort of attitude that Bywaters condemns when he speaks of social work's attempts to "seek accommodation, compromise or influence within the individualistic medical paradigm", rather than "asserting independent principles for social work practice in relation to health"⁴². It was collaboration built on a shaky foundation, on the belief

³⁹ Huntingdon, 1981a; June Huntingdon, "Time Orientations in the Collaboration of Social Workers and General Practitioners", *Social Science and Medicine*, 1981, 15A, pp. 203-210.

⁴⁰ Goldberg and Neill, 1972, p. 174.

⁴¹ DHSS, 1974, p. 26 § 45.

⁴² Bywaters, 1986, p. 665.

that social workers could, like doctors, offer a kind of healing. Real collaboration will only come about when the players are willing to acknowledge that they are different and can learn to transcend and celebrate and use those differences and are willing to acknowledge the practical and resource issues which may mean they have to work with a "Ford Escort" service.

By March 1994, there was still a long way to go to develop effective working relationships between GPs and social services and, indeed, with other parts of the health service. This was not peculiar to Sunderland, as the DoH monitoring and development exercise showed⁴³. If anything, Sunderland appeared to be making better progress in this than other areas of the country. These gaps were seen clearly by users, carers and voluntary organisations who complained at the Joint Planning Forums that the GPs did not seem to know or understand what was happening with community care. However, the rift was very deep, and though it was possible to build bridges across it, they were temporary and tenuous structures, which did not abolish the fundamental divisions.

⁴³ DoH (1993f) EL (93) 119, Annex.

CHAPTER EIGHT

THE MANAGEMENT OF DISTRICT NURSES AND HEALTH VISITORS BY GENERAL PRACTITIONERS

INTRODUCTION

This chapter is not about collaboration between health and social services, but about better collaboration between two different parts of the health service. Primary Health Care Teams have a key role in the delivery of community care¹, but calling them "teams" hides the disparate character of their members. There are nearly as many difficulties in developing collaboration between community nurses and GPs as there are between GPs and social workers.

Community nurses² (in this case, health visitors and district nurses) were employed

¹ DoH (1990a) p. 10, § 2.6.

² "Community nurses" is a generic term for all nurses who work in the community, used in the Cumberledge Report (DHSS, 1986a). However, the use of a single term hides many differences. District Nurses provide nursing care to ill people usually in their own homes, including the assessment and delivery of

by Hospital and Community Health Service (HCHS) provider units, later to become NHS Trusts. They were, however, expected to work beside general medical practitioners (GPs), who are independent contractors, and their employees. The relationship between the community nursing staff and the GPs and their staff was usually described as "teamwork", a term which conjures up images of "pulling together" and "collaboration". In practice, the term glosses over the difficulties of working together, especially when the structure of the relationship was flawed³. The community nurses reported to their nurse managers within a bureaucratic hierarchy, and often had priorities set by their employers which were not compatible with the priorities of the practice. This could be a major barrier to teamwork. This problem has been recognised in a number of reports and by several commentators during the last fifteen years⁴; thus Beales speaks of "the uneasy alliance of people ultimately devoted to different, and frequently opposing, sides"⁵. This is reflected in comments made by GPs in Sunderland in a survey carried out by the FHSA which indicated the resentment of nurse management felt in some practices:⁶

treatment programmes. Health Visitors work for the most part with well people to prevent illness and injury, including child protection. Health Visitors have all trained as nurses, but have received further training, and regard themselves as an independent profession. Most District Nurses also have a specialist post-basic qualification, but are still firmly nurses.

³ Ovretveit, 1993, p. 3.

⁴ For example, Beales, 1978, p. 67; Report of the Royal Commission on the National Health Service, 1979, HMSO, section 7.25; Greig, 1988, p. 76; Chris Salisbury, "Working in partnership with nurses", *British Journal of General Practice*, October 1991, pp. 398-399.

⁵ Beales, 1978, p. 67.

⁶ Sunderland FHSA, "Checklists for GP Practices", June 1991.

Community Nurses are given protocols behind our backs which we are never consulted or informed about.

All a senior nurse will tell us when consulted is that there is "no money for anything we want".

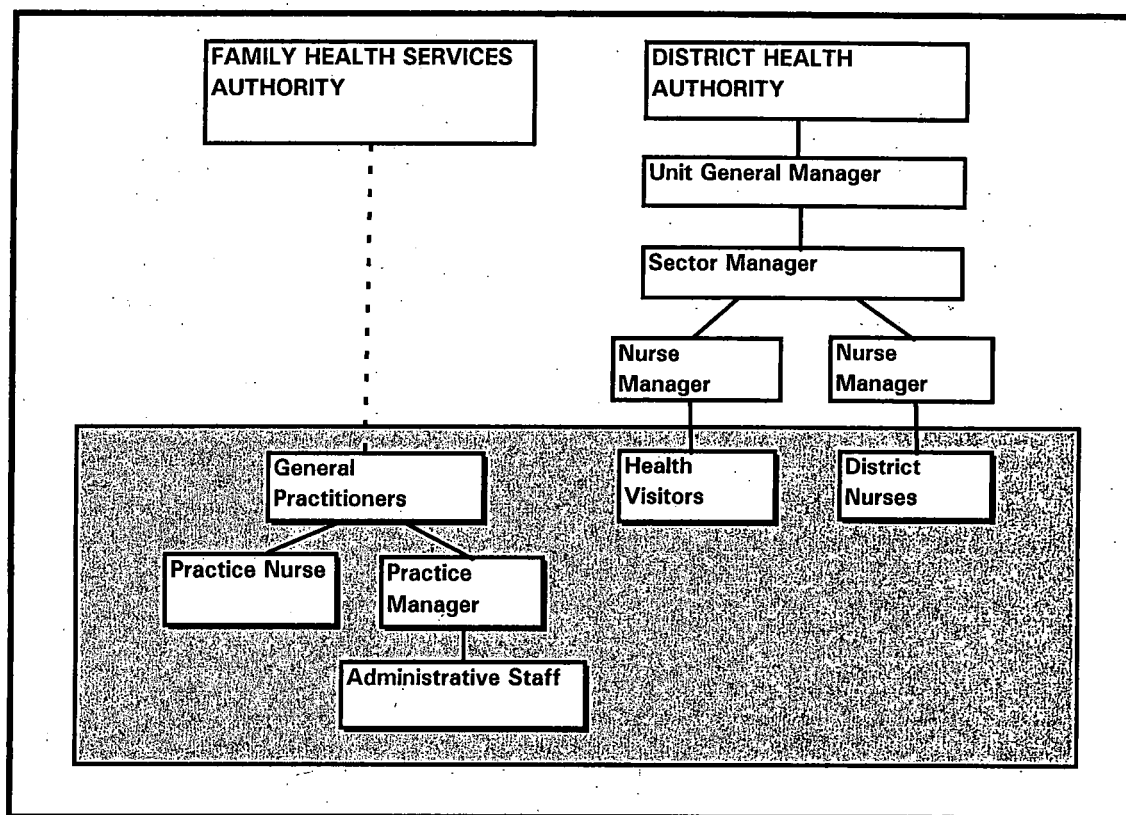
I would not seek help from senior nurse managers. Previous attempts at involving nurse managers have only proved a hindrance to the development of services to our patients.

There is great scope for the expansion of the role of our community nursing sisters. They have great skills in nursing and communicating with patients and their families. Unfortunately any invitation to expand their role is usually prevented by the dead hand of unimaginative nurse managers.

The Directly Managed Staff Project in Sunderland was set up to seek to attempt to overcome this difficulty, by transferring to general practitioners the management of district nurses and health visitors in three pilot practices in Sunderland and Seaham. One aim of the project was to remove the organizational barrier to teamworking, so that practices, district nurses and health visitors could share common goals. It was also expected that accommodating staff in surgeries would improve communication. Figure 8.a shows the management structure at the start of the project. District nurses and health visitors reported to nurse managers, but were expected to work in the PHCT with GPs, who were in contractual relationship to the FHSA, and who employed practice nurses, practice managers and administrative staff.

We are not aware of any written reports of similar experiments, as the Sunderland project was one of the first in the country. The model was rejected by the

**SUNDERLAND PRIMARY HEALTH CARE TEAMS
MANAGEMENT STRUCTURE, 1992**



KEY

- Primary Health Care Team
- Line Relationship
- Contractual Relationship

Figure 8.a

Cumberledge Report⁷, but was proposed in the Roy Report on nursing in the community. This suggested a number of models for organising and managing community nursing services. One of these was that "community services would be brought under the control and management of general practice"⁸. This was supported by an editorial in the *British Journal of General Practice*⁹, though the responses from the community nurses themselves and their professional associations were negative¹⁰.

PRIMARY HEALTH CARE TEAMS

A discussion of the nature of PHCTs is provided in Chapter Four (pages 148-1516) and an overview of PHCTs in Sunderland is offered in Chapter Five. This section will describe the development of PHCTs in Britain.

The concept of health professionals working together in a health centre was first mooted in the Dawson Report of 1920, and the promotion of this model has been confirmed, developed and strengthened in reports on primary health care published since then. During the first two decades of the NHS, two initiatives opened the way for primary health care teams: the establishment of health centres and the attachment of district nurses and health visitors to general practice.

⁷ DHSS, 1986a, p. 48.

⁸ NHS Management Executive, *Nursing in the Community*, October 1990, p. 14.

⁹ Salisbury, 1991.

¹⁰ Christina Potrykus, "Secrecy and confusion over GP managed units", *Health Visitor*, 65:7, 1992, p. 216; Catherine Jackson, "New world, new dilemmas", *Health Visitor*, 67:1, January 1994, pp. 8-9.

The National Health Service Act 1946 required every Local Authority to set up health centres, premises which could accommodate the community health services and general practices. In the early years of the NHS, the development of the health centre programme was slow, though it picked up in the 1970s. Springwell Health Centre in Sunderland, opened by Aneurin Bevan in 1956, was the eighth purpose-built health centre to be established after the Act. By 1977, there were 731 health centres, housing 3,800 (17%)¹¹ general practitioners. For many years there was an assumption among policy makers that accommodating community health staff and GPs together would result in cooperation.

Early experiments with attachment schemes started in the mid-1950s. Attachment of community nursing staff to general practice was recommended by the Gillie Report in 1963¹², and by 1975 almost 80% of home nurses and health visitors were attached to general practice. The number of attachments then started to go down as some authorities, particularly in the inner cities, began to abandon attachment schemes.

Both schemes, the development of health centres and the attachment of district nurses and health visitors, were designed to facilitate contact between health professionals. As the Chief Medical Officer reported in 1967, "the answer to many of our present-day problems of medical care and health promotion in the community appears to lie with doctors working together from modern, well-designed premises and having not

¹¹ DHSS, *Annual Report 1977* (London: HMSO) p. 21.

¹² Central Health Services Council, *The Field of Work of the Family Doctor* (London: HMSO, 1963) (Gillie Report), chapter X, pp. 32-33.

only the assistance of a trained secretary and receptionist, but also the willing co-operation of members of the local authorities' nursing team"¹³.

Policy to develop inter-disciplinary primary health care teams was made explicit in the DHSS Annual Report of 1974¹⁴. This represented a shift from the perception of services centred on doctors with support from others to the idea of professionals working together and providing mutual support. The Royal Commission on the National Health Service endorsed the development of primary health care teams, but recognised that teamwork was at an early stage¹⁵. Underlying this was an understanding that teamwork in itself requires energy, commitment and input, beyond the provision of adequate premises and the attachment of staff, though quite what this extra input should be was not made explicit.

By the late 70s, there was concern that commitment to the idea of the primary health care team was waning because some attachment schemes were being dismantled, particularly in urban areas, and a working party led by Dr Wilfrid Harding was set up "to examine problems associated with the establishment and operation of primary health care teams and to recommend solutions"¹⁶. The Harding Report identified a range of problems with primary health care teams and made 50 recommendations

¹³ Ministry of Health, *On the State of the Public Health 1967* (London: HMSO, 1968) p. 225.

¹⁴ DHSS, *Annual Report 1974*, HMSO, Chapter 4, p. 36.

¹⁵ Royal Commission on the National Health Service, 1979, § 7.4.

¹⁶ Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee, 1981, p. 1.

regarding premises, staff groups, record keeping, training, organisational factors, communications and special arrangements for rural and urban areas. These solutions were still very much in terms of practical organisation.

In the meantime, the World Health Organisation, in its Declaration of Alma-Ata of 1978¹⁷, recognised the key role of primary health care in achieving an acceptable level of health, and endorsed the place of the primary health care team in delivering first level health care. This offered a much more radical perception of primary health care in making it the focus of a country's health system, and with its emphasis on the rights of people to participate in planning and implementing health care.

Primary health care achieved political prominence again in Britain with the publication of the 1986 Green Paper on primary health care. This said that "primary health care is best provided when family doctors, community nurses and practices nurses work together as members of a primary health care team."¹⁸ The Report of the Community Nursing Review (Cumberledge), published at the same time as the Green Paper, concurred, stating that

nurses are at their most effective when they and general practitioners work together in an active primary health care team. This is the best means of delivering comprehensive care to the consumer ...¹⁹

¹⁷ World Health Organisation, *Primary Health Care* (Report of the International Conference on Primary Health Care, Alma-Ata 1978) (Geneva: WHO, 1978).

¹⁸ DHSS, 1986c, p. 46.

¹⁹ DHSS, 1986a, Foreword.

However, the Cumberledge Report concluded that, "in many places the primary health care team is more a concept than a reality".²⁰ Its recommendation that community nurses be organised by neighbourhoods was not received well and was not adopted as policy. Instead, with the 1990 GP Contract, government policy focused primary health care very firmly with the general practitioners.

Proposals made by the White Paper, *Promoting Better Health*²¹, that followed the Green Paper, *Primary Health Care: An Agenda for Discussion*, were incorporated into the 1990 General Medical Contract and the NHS and Community Care Act 1990. The 1990 Contract made some payments to GPs dependent on their achieving targets for certain screening and preventative work, and on the provision of health promotion clinics. In practice, this meant that GPs had greater need of an effective primary health care team: achieving vaccination and immunisation targets, for instance, required the co-operation of the health visitor, practice nurse and GP. Simultaneously, the NHS and Community Care Act 1990 introduced General Practice Fundholding, which gave larger practices the opportunity to purchase secondary health care for their patients. This had the effect of emphasising the business aspect of general practice, and also altered the dynamics of the primary health care team. From April 1993, fundholding practices held the budgets for community nursing services.

²⁰ DHSS, 1986a, Foreword.

²¹ *Promoting Better Health: the Government's Programme for Improving Primary Health Care*, CM 249 (London: HMSO, 1987).

THE DIRECT MANAGEMENT PROJECT

In the summer of 1991, Sunderland Health Authority (HA) and Sunderland Family Health Services Authority (FHSA) submitted proposals to the Regional Health Authority (RHA) for a project to test the management of district nursing and health visiting staff by GPs. Though the proposals did not win funding from the RHA, the HA, the Community Health Services Unit and the FHSA decided to set up a pilot project in one practice in Sunderland for one year. Subsequently, interest in the project developed in Seaham and the Community Health Services Unit agreed with Durham FHSA, which was responsible for the general medical services in that area, that two Seaham practices be included in the project. In two practices, the management of District Nurses and Health Visitors was passed to the GPs, and in one other practice, the GPs took over the management of the District Nurses alone.

During the pilot, the health visitors and district nurses became accountable to the general practitioners of the practices in which they worked, rather than to their nurse managers. The Health Authority continued to pay salaries and mileage expenses, and the nurses retained their terms and conditions of employment. The nurses still had access to Health Authority resources, including home loans, Macmillan nurses, twilight nurses, Marie Curie nurses, and the Communicom system, as well as specialist services provided by the Continence Adviser and the Specialist Nurse in Child Protection. They were not obliged to complete Health Authority paperwork apart from Korner returns, but had to negotiate the information to be collected for the good of the patients. Staff remained professionally accountable for their work.

The GPs took on the responsibility for providing the services, managing the staff, providing accommodation and signing claim forms for enhanced hours and mileage.

The main differences between the former working arrangements and the pilot were that the HA staff were based at the practice premises rather than on HA premises and they reported to the GPs rather than to a Nurse Manager. The GPs were responsible for providing district nursing and health visiting services as well as managing the staff themselves.

In summer 1992, a few months after the Sunderland project had started, the NHS Management Executive published its guidance on extending the GP fundholding scheme to include community health services²². Although there were differences between the Sunderland project and the way that GP fundholders would purchase community services, it was hoped that experience of the Sunderland project would be useful in developing this purchasing role. Indeed, the two fundholding practices in the project found that the project helped them prepare for their new responsibilities, and one practice said the experience gave them insight into some of the factors that they then built into their contracts for community nursing and for paramedical staff. One practice used part of its fund to buy equipment for the district nurses, and was negotiating for additional auxiliary nursing hours. However, there was no attempt to consider the implications of fundholder purchasing of community services in relation

²² NHS Management Executive, 1992b, EL (92) 48.

to community care²³.

AIMS AND OBJECTIVES

The project was evaluated to measure the impact on the primary health care team (PHCT) of removing the perceived structural barrier to teamworking, and to examine the proposition that teams will work more effectively when district nurses and health visitors are managed from within the team by general practitioners.

The questions the study needed to address related to:

- Whether those involved liked working in this way. Was there more or less job satisfaction, autonomy, ability to respond to perceived needs, freedom to do a good job, freedom to use and develop skills?
- Whether this model improved team working/collaboration. Were professionals more willing to share common approaches, common goals, common objectives? Was communication better?
- Whether there was greater understanding of and development of roles. Did teams take the opportunity to explore what health professionals could do and reach a better understanding of roles? Could roles be changed and developed to meet the needs of patients and of the practice? Could protocols be developed so that nurses can, for example, assess ears for syringing without

²³ DoH 1993h, p. 21, § 4.5; DoH, *Implementing Caring for People: Care Management*, July 1994, p. 44, § 8.7-8.9.

patients having to see the GP first?

- Whether it improved the quality or quantity of service for the patient. Was the service to patients more coordinated or more comprehensive as a result of the project? Could the practice respond to local needs more effectively? Is there greater continuity?
- Was this model more efficient/cost-effective? Were the skills of nurses and health visitors used more effectively? Could work be shared among the team so that members are doing jobs appropriate to their skills?
- Professional accountability for district nurses and health visitors. Did nurses miss the support of their managers, or the wider nursing team? What was the best source of professional support for nurses and health visitors who are managed by GPs? How important to the community nurses was a professional structure to which they were accountable but which protects them?
- Whether there were any difficulties in working this way.
- What it meant for general practitioners to manage district nurses and health visitors.

FINDINGS

As with the evaluation of social worker attachment, a number of methods were used in this study: interviews were held with members of the primary Health Care Teams, discussions took place with other groups with an interest in the project, questionnaires measured the way the teams functioned over time, and my own observations were an important part of the study. To preserve anonymity, the three practices have been

called A, B and C.

Interviews

Participants were asked about the benefits they had received from the project. These can be grouped into six areas: better working together; better communication, liaison and reporting; new, improved or extended services; better quality of working, greater flexibility, and the empowerment of the community nursing staff.

General comments were made about better teamwork, and the value of knowing people personally. Many respondents referred to closer links between specific groups and individuals, between, for example, practice nurses and district nurses, or administrative staff and community nurses.

Reports of improved communication included easier and quicker means of contact which meant a speedier response to patients' needs. Liaison was also much easier: a practice nurse reported greater liaison with the Health Visitor over smears and family planning. One doctor cited the example of a patient with a herpes rash whom he had visited one morning. The district nurses were able to visit that afternoon to give the treatment and report back to the doctor next morning. Previously, this straightforward series of transactions would have taken several days to achieve. Another doctor said that it was now possible to tell a patient that the district nurse would come to carry out a particular task. Previously, it had not been possible to guarantee the service.

New services had been provided as a result of the project, including the development of surveillance schemes for the over-75s, and the participation of the district nurses in one practice in a diabetic programme. Some services were extended: in one practice which had a busy treatment room, the district nurses extended the hours of the treatment room service by 25% by spending more time there rather than on community visits, which meant a better service for patients. Other services were given in a new way. In both practices with participating health visitors, the HVs had taken on responsibility for childhood vaccinations and immunisations, freeing the GP and the practice nurse who had been doing them before to do other things, and giving the HVs greater opportunity to build up relationships with their clients.

Several people reported examples of the better quality of working that was possible when health practitioners worked more closely together. In one practice the pilot staff attended PHCT meetings more regularly and had more input into them. There was evidence in one practice that boundaries between practice nurses and district nurses were becoming fuzzier, that staff were becoming more integrated, and there was less demarcation of roles.

The greater flexibility afforded by the project was also a major benefit. Nurse managers did not prevent community nursing staff from involvement in new services, which made it easier for developments to occur. In one practice, the district nurses reported that it was now possible to provide a service that was more sensitive to patient needs by using their weekend duty more flexibly, both in the type of work undertaken and in the organisation of their hours.

There was some evidence that some staff were empowered by the project to take more control over their work. One district nurse said she felt more responsible, made better decisions and was fulfilling her role better. Another respondent said there was "more scope to work on your initiative once the protocol is set" and direct energies more effectively towards patient needs. Another nurse said her work was more varied, and another appreciated being "allowed to do commonsense things and not just policy".

As for drawbacks and problems, the key issues mentioned at the second interview were accommodation, cover arrangements, professional isolation, staff issues and administrative issues. There was a change in emphasis in the issues raised by the respondents in the final round of interviews. Peer and professional isolation was much less of a problem, except among staff who felt vulnerable in other ways and for other reasons. This may be a particular problem in smaller practices. Administrative problems, particularly those for which the Health Authority was responsible, became a much greater concern. There were also issues to do with team dynamics and staffing levels.

The nursing team was a major strength of the previous working arrangements. The district nurses and health visitors worked in teams based on Health Authority premises which came together on a daily basis when staff returned to base to carry out routine administrative tasks and use each other as sounding boards. Staff covered for each other's patients during absences. The nursing and health visitor teams were a source of mutual support, both personally and professionally. This is what the pilot staff missed when they spoke of peer or professional isolation. The issue was discussed

at a Pilot Staff Meeting in November. Several of the pilot staff said that they now had become used to the separation from the nursing team. A health visitor said that she now discussed things with the district nurse; the shared knowledge of the patient made up for the different professional perspectives. One said she still felt strongly about being isolated from her peers. Previously, if a district nurse found a patient very difficult, it had been possible to arrange for another nurse to visit occasionally, to take the pressure off. This was not possible within the new arrangements.

A number of problems of working in teams were reported. One respondent said that she had hoped for joint working between the practice nurse and district nurse, but that expectation had not been fulfilled. This is interesting, as the opposite was reported in another practice. Attached staff found that they were more aware of the internal politics of the practice once they were based there. There was also evidence that some members of the practice were not included in discussions about the project, though they would have liked to have been more involved.

Practical problems were an issue at each stage of the evaluation. In the early part of the project, these were identified as accommodation, arrangements for covering staff during absences and administrative difficulties in relation to receiving supplies and information. By the end of the project, some of these had been wholly or partially resolved. Others, however, had become worse, particularly those which depended on the Health Authority provider unit. In the last few months of the project, the arrangements for cover during absence proved less effective. There was a seasonal problem in trying to find people to cover absence at a time when staff were using up

their leave entitlements. There were also problems in receiving supplies of goods ordered, and in getting Health Authority information. Two examples of the latter were significant: (1) a second-level nurse interested in the conversion course to first-level registered nurse only heard about a meeting to discuss this on the grapevine; (2) because the district nursing sister in Practice A was acting up to the role, the post had to be advertised to be filled officially. She only saw the advertisement for the job on the closing day, and only then because another nurse brought it to her attention.

There is an issue about the capacity to develop new services when resources (staff and accommodation) are limited. Thus few new services were developed in Practice A, where the number of patients per district nurse was higher than in the other practices. In Practice B, the over-75 surveillance has been achieved at the expense of the high under-5 caseload carried by the Health Visitor. At the same time, initiatives such as Care in the Community, earlier discharge from hospital and more day case surgery put greater pressure on primary care services. There is a need to develop a methodology for determining appropriate staffing levels which is sensitive to local differences and which would obtain the commitment of purchasers and providers of primary care services. This would need to take into account the natural inclination of many nurses to do as much for the patient as humanly possible, which may mean that the care they offer goes beyond nursing care, and is given for a longer period than is required for clinical reasons.

As for management by GPs, the pilot staff felt that the doctors were not managing them. Insofar as they were being managed, they were managing themselves. One

doctor was aware of the extra responsibility that the project gave him, but others felt that either they were not managing the staff or were not themselves involved. One practice explicitly took the stance of being professionals working alongside each other. There was some evidence of practices trying to plan for services in order to meet patient needs, but it was limited.

Certainly the pilot staff did not want to be *employed* by GPs. This conclusion emerged in the interviews, and was confirmed in discussion at the Pilot Staff Meeting in November. The prospect of employment by GPs laid open fears about terms and conditions of employment, becoming handmaidens directed by GPs, and being required to become more problem-oriented rather than dealing with people who have problems. Set against this is the perception of one of the practice nurses who found working for GPs very liberating.

Pilot staff were also worried about skill mix, particularly in relation to the possible future of the pilot. They were concerned that GPs would want to employ or contract for staff at the lowest possible grade, and might require nurses to undertake duties beyond the grade on which they were employed.

Most people spoke favourably of the project and wanted it to continue. All the GPs thought that the project was a success and said that they would recommend this model to another practice. Seven pilot staff were happy to continue with the arrangements;

two members of staff were critical of the project²⁴. Respondents also offered useful advice about setting up similar projects, which were taken into account in developing protocols and checklists.

Focus Groups

District nurses and health visitors who were not included in the pilots expressed concerns about the project in the focus group discussion. They were worried about grading, as GPs might want staff at a lower grade than the community staff felt appropriate. The group was also anxious about what would happen if DNs and HVs did not get on with the GPs in a practice, and felt that there were some GPs with whom few community nurses would choose to work permanently. They felt that GPs did not always value their role, and nor did some practice managers. They were concerned that GPs took a task-centred approach and did not consider the needs of the whole person, and that if they were managing community health staff they might require them to take the same approach. The group was reluctant to give up the nursing team. A health visitor said that one benefit of the nursing team was that new staff joined the team with new ideas, knowledge and enthusiasm, which helped the whole team.

Practice nurses with whom the project was discussed felt that they were responsible

²⁴ Both respondents came from the same practice, which was going through other changes at the same time as the project. Both felt isolated from the professional group. One felt the scheme was too expensive and the other that GPs were not capable of managing nurses and health visitors.

for keeping themselves up to date with clinical developments. This raises interesting questions about autonomy and the tension between personal autonomy and professional autonomy. GPs enjoy a high degree of personal autonomy. District nurses prefer to promote a sense of professional autonomy, with clinical support systems contained within the profession. The practice nurses who contributed to the study appeared to be moving away from the sense of a profession which embodied a distinctive approach to health care towards a concept of the individual nurse making her particular contribution to primary health care. This is an area worth further study, given concerns that changes in the GP contract and purchasing community nursing through fundholding may increase GP control over nursing²⁵.

The Sector Manager, who had been responsible for implementing the project from the provider side, was most enthusiastic about the project and could see all sorts of possibilities. The Nurse Managers were more cautious, acknowledging the possibilities of the project, but also expressing worries. Of particular concern was the issue of professional support. The Nurse Managers made a distinction between their line management functions and the provision of professional advice and support, including the monitoring of quality. The former role could be undertaken by someone who was not a nurse, but the latter was specialised and needed a nurse. Child Protection was cited as a specific example where specialist supervision was required by the Department of Health.

²⁵ Anne Witz, "The challenge of nursing" in Jonathan Gabe, David Kelleher and Gareth Williams, *Challenging Medicine* (London: Routledge, 1994) pp. 23-45 (p. 42).

Questionnaires

Researchers have for a long time been looking for ways to measure team working. The study attempted to do this. As part of the interview process, respondents were asked about their perceptions how their team functioned. The questions on team functioning in this study were developed by a fellow researcher in a neighbouring city. At the time, the methodology was still under development, though the work has since been written up²⁶.

The questions and the scoring methodology appear in Appendices A and D. When the responses are analyzed by practice, Practice B emerged with the least developed sense of teamwork: team members felt less involved in decision making, were less clear about the goals of the team, were less convinced about its progress, and were less likely to work through conflicts and differences. When the responses are analyzed by job, it is clear that GPs have a more positive perception of the way the team functions than other members, and employed staff (practice managers, practice nurses and administrative staff) had a more positive view than the pilot staff (District Nurses and Health Visitors). Analysis of the responses by sex was not undertaken: only a small number, five, of the interviewees were men, and they were all GPs. It was, therefore, impossible to determine whether responses were influenced by sex or profession.

Scores were assigned to the questionnaires completed by the PHCT members at each stage of the evaluation (Tables 8.i and 8.ii), and compared over time. There were

²⁶ Pearson, forthcoming.

marginal changes in the scores of Practice A and Practice B, depending on whether the figures were analyzed to include or exclude the results of the administrative staff. However, the score for Practice C fell significantly by 20% or 24%, depending on the inclusion or exclusion of the administrative staff. Practice C started the project with the highest scores, and ended it with the lowest scores.

TABLE 8.i: COMPARISON OF PRACTICE TEAM SCORES (EXCLUDING ADMINISTRATIVE STAFF) OVER THE STUDY PERIOD

	A	B	C
FIRST INTERVIEW	39.1	30.7	39.3
SECOND INTERVIEW	33.6	33.8	35.8
FINAL INTERVIEW	37.6	32.1	30.5

TABLE 8.ii: COMPARISON OF PRACTICE TEAM SCORES (INCLUDING ADMINISTRATIVE STAFF) OVER THE STUDY PERIOD

	A	B	C
FIRST INTERVIEW	36.4	32.5	40.1
FINAL INTERVIEW	35.6	32.2	32.2

When the scores were analyzed by employment group (Table 8.iii), there were small changes in the scores of the doctors and those of the pilot staff. The biggest change was in the score of the staff employed by the practices, when the views of the administrative staff were not included, which ended 16.5% down on the original score. When the administrative staff were included, the decrease was 8%.

CHANGES IN INDIVIDUAL SCORES BY PRACTICE

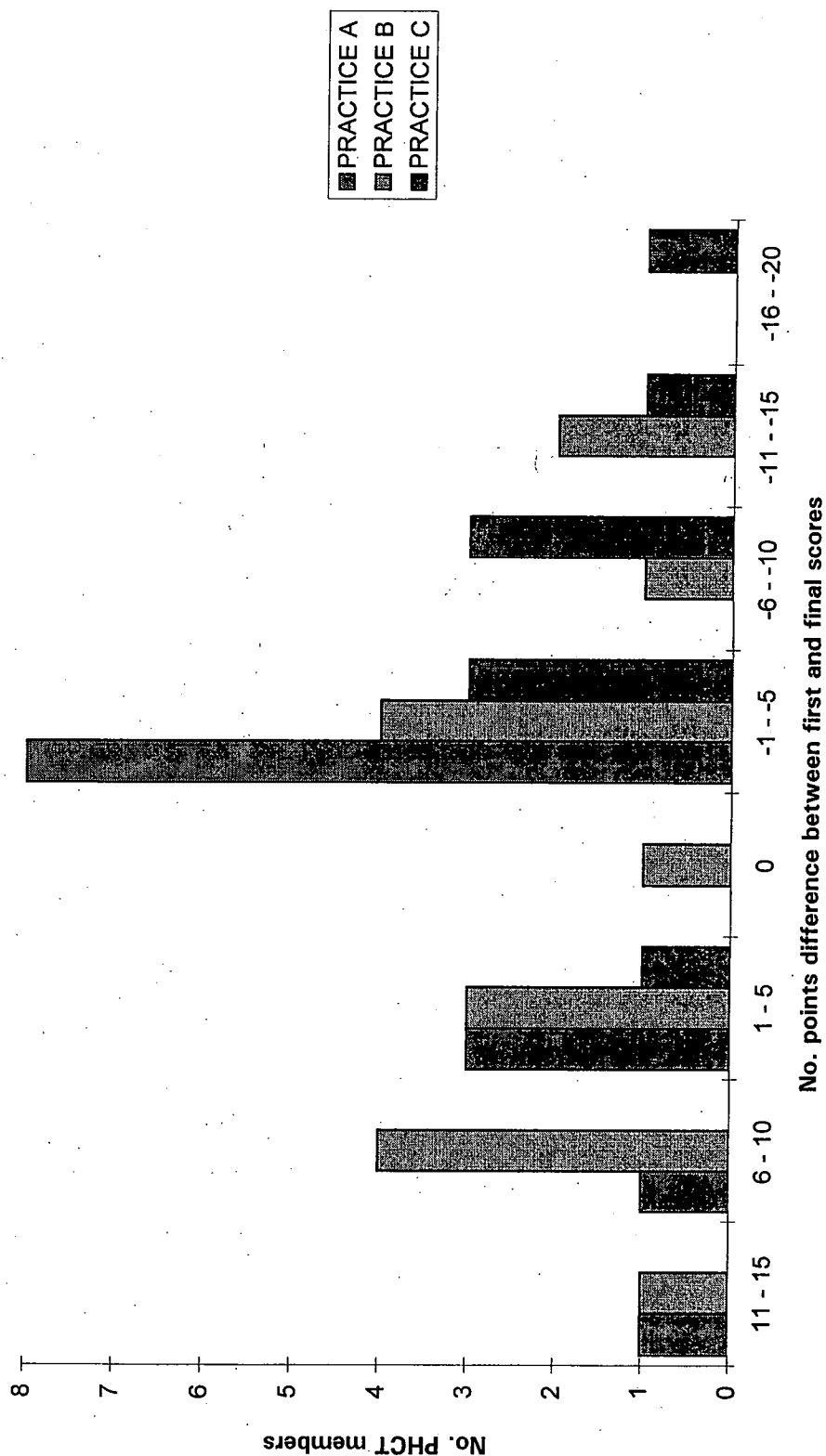


Figure 8.b

TABLE 8.iii: COMPARISON OF EMPLOYMENT GROUP SCORES OVER THE STUDY PERIOD

	GPs	GP EMPLOYED (INCL. ADMIN)	GP EMPLOYED (EXCL. ADMIN)	PILOT STAFF
FIRST	39.1	35.8	37.5	32.4
SECOND	38.9		32.1	31.8
FINAL	40.7	32.6	31.3	30.7

Figure 8.b shows the changes in individual scores in each practice. The changes in scores were produced when each team member's score at the first interview was subtracted from his or her score at the final interview. In Practice A, five team members had final scores higher than their original results, and eight had lower final scores. In Practice B, eight people had higher scores, seven had lower scores and one had the same result. In Practice C, only one person finished the project with a higher score, and every other person interviewed had a lower score; one team member lost 20 points between interviews.

The key question is what caused the changes to the scores. What happened in Practice C to bring down the score so dramatically? Why are the scores of the practice managers and practice nurses particularly affected? What effect did the project have on the results?

During the year that the pilot took place, Practice C was preparing for fundholding, which meant that many changes were taking place in the collection of data and the management of the practice. Practice A had been a fundholding practice since the

first wave, and had settled down to the business of managing the fund and adapting to change as it came along. Practice B was not involved in fundholding, and did not have the associated administrative and management burden. Practice C was also the smallest practice, and perhaps the changes were felt more strongly by more members of the team.

One possible reason for the reduction in the scores of the practice managers and practice nurses is that the project threatened the practice-employed staff. However, the responses to the interviews make this unlikely. Two of the practice nurses spoke positively about the project, but one felt that it had not fulfilled her expectations. She had hoped to be able to work closely with the pilot staff, but felt that the organisation of the practice inhibited the degree of integration she wanted. The practice managers were also supportive of the project, and one was certainly more positive about it at the end of the project than at the beginning. The evidence is, therefore, that the reduction in the score is not associated with the project but was due to other factors.

It is difficult to assess the impact of the project on the scores. In Practice A, the fall in the score half-way through the project reflects the difficulties experienced in the early stages of the scheme, with the final figures reflecting the resolution of the problems. In Practice B, the slight improvement in the figures reflects a situation in which relationships had improved a little, but where there were no changes in the organization of the team. The downturn in Practice C is almost certainly due to factors unconnected with the project.

In the second round of interviews, two additional questions were put. Respondents were asked which of five statements best described their team. These statements were developed from Armitage's taxonomy of collaboration²⁷. Three-quarters of the respondents reported good levels of collaboration, with Practice B attracting three scores in the lower levels, while the other two practices each had only one lower score. Asked about their satisfaction with the team, half those interviewed were satisfied with their teamwork. Only one person was very satisfied. Nearly half were neither satisfied nor unsatisfied, and two people were unsatisfied. There was a higher level of satisfaction in Practices A and C.

Ethnographic Account

The impact of the project can also be demonstrated from an ethnographic account of what happened in one practice.

The medical centre, opened in 1987, was purpose-built and owned by the partners. There were three doctors with eight thousand patients, which meant that the average list size was very high. The practice attracted numerous students as patients, as it was close to university residences. The practice-employed staff at the premises included the practice manager, a practice nurse and nine administrative staff.

No formal primary health care team meetings were held. The coffee break every morning, between the morning surgery and the doctors going out on calls, was a time

²⁷ Armitage, 1983, p. 76.

when the doctors and nurses could discuss patients.

Four district nurses (two district nursing sisters, one staff nurse, and one part-time auxiliary) were assigned to the practice, together with a health visitor. The health visitor had a large caseload (480) and needed more support. The practice and the health visitor decided that they would prefer this support to be in the form of a part-time (28 hours) "D" grade staff nurse rather than from a part-time (18 1/2 hours) "G" grade Health Visitor. There was a delay in making the appointment, and the health visitor worked on her own until September.

The two District Nursing Sisters and the Health Visitor had worked with the practice before the project began. The staff nurse was new to the practice, and had just completed the conversion course to first level nurse. The auxiliary nurse was new to the practice and had not worked as a nurse before. She therefore needed more training and supervision than might otherwise have been the case, and could take on a narrower range of activities. It was necessary to spend time inducting and training these new members of staff before new areas of work could be developed.

The early part of the project was spent discussing job descriptions, making a service agreement and working on protocols. This practice was the only one of the three practices in the project to produce a service agreement for the project, or statement of intent. This said that "the doctors do not see themselves as employers, but rather as members of the Practice Team, working in association with the nurses and health visitors; each member having their own field of expertise." The aims for the project

were:

- To make services more relevant to patients' needs as perceived by the Practice Team, rather than outside agencies.
- To improve communications by working from a common base, using the same secretarial services and sharing the same amenities, e.g. Common Room.
- To explore how the roles of the CNs and HVs can be extended and current skills more appropriately deployed.
- To promote team spirit and loyalty in the interests of good working relationships.

The district nurses increased the time spent in the treatment room by 25%²⁸. When the university term began, the practice nurse was overwhelmed by students registering with the practice, and the district nurses carried out some of the new patient checks. The district nurses had envisaged starting clinics within the practice, but found that their fluctuating workload in the community made it difficult to give a firm commitment to regular clinics. They undertook some over-75 checks on the patients they were already visiting.

The practice particularly wanted to develop an effective system for screening the over-75s, using questionnaires in the first instance, and devoted some time to this project.

The plan was that the health visitor should manage the system for the over-75 checks,

²⁸ In Sunderland, district nurses have, by tradition, provided treatment room cover in health centres and in GP surgeries. The amount of support varies throughout the district.

though the checks would be carried out by all the clinical members of the team. The delay in appointing a staff nurse to support the health visitor meant, however, that the health visitor was not able to take on extra work. Shortly after the health visitor assistant started work, the Hib (*Haemophilus influenzae* type b) vaccination programme was imposed, which put more pressure on the health visiting service.

In the meantime, the health visitor took on the immunisations of children, which had previously been done by the practice nurse. The practice was already meeting the upper target for immunisations, but the proportion of children immunised rose from 90% to almost 99%. The practice nurse continued to do the immunisations in the absence of the health visitor, but she also able developed new skills and services.

Accommodation was a major problem as there was not enough room in the practice for all the activity. This was a particular problem for the health visitor. The severest difficulties occurred on Wednesday afternoons when the two midwives held their antenatal clinic. The practice was considering appointing another partner, but was concerned that there was now no room to accommodate him/her.

The district nurses regretted the lack of a PHCT meeting, and started one, which met weekly. One doctor came once, but otherwise the GPs did not take part. After a few meetings, it became "a grumble session", and fizzled out. The doctors and district nurses met informally every morning in the common room while the doctors sorted out their home visits. They assumed that the health visitor would join them, though it was never discussed, but it was not a convenient time of day for her because she

was out of the surgery, visiting clients.

The Health Visiting Assistant took up her post in September 1992. She assisted at baby clinics, and carried out most of the over-75 assessments. The Health Visitor was, however, still carrying a large caseload of under-5s, which meant that her service to families was more superficial than she would have liked. She was not able to be proactive, but relied on families approaching her when there were difficulties.

At the end of the project, the Health Visitor went on maternity leave. There was uncertainty about how her absence would be covered, but the provider unit did supply a health visitor to cover the practice. The usual means of covering absence had been for the health visitors working in the sector to share the workload among them.

Financial Information

Sunderland FHSA and Durham FHSA each funded 0.5 WTE district nurse or health visitor. The cost of using bank nurses for cover also had to be borne. The extra staffing costs attributable to the project are £19,400 for extra staff and £2,064 for bank nurses. Non-staff costs came to £14,226. Travel expenses accounted for £10,301 of this, and the rest included the purchase of communication devices and charges, the installation of telephones and other items. The time taken in setting up the project, the Sector Manager's time to attend meetings, clerical input, the time of the Senior Nurse Child Protection in supervision and the evaluation were not costed. The cost of providing a community nursing service in this way, with community

nursing staff dedicated to a practice, will be more expensive than the traditional model, as the Provider Unit has less flexibility to deploy staff.

DISCUSSION

From the evidence generated by the research, it is now possible to address some of the questions posed at the beginning of the study.

There was a good deal of satisfaction with the model from members of all professions. The staff in one practice were much less happy, though this was due to factors not related to the project. Some community nursing staff felt more empowered.

Different levels of teamwork operated at the three practices before the pilot which meant that it was possible to assess the impact of the project in different settings. As a result of the project, there was some degree of improvement in informal communication and collaboration at all three practices. This was probably mainly due to pilot staff being based in the surgeries. There was no change in the way any of the practices held meetings, apart from the failed attempt by the pilot staff in Practice B to start a PHCT meeting. Only in Practice A was there any change in the remit of the meetings held. There was some evidence of better collaboration in patient care, but no indication of joint working on practice policies or protocols, though there were discussions about service developments within the practices.

It was hoped that the project would enable practices and community staff to identify the needs of patients and to develop services and determine priorities to meet them. This occurred to some extent, though not in the thoroughgoing way envisaged. The *New World, New Opportunities* report also recognises the need for strategic planning and sees all members of the PHCT as contributing to it. The report states:

Within the practice, **GPs, their professional colleagues and other staff** should contribute to mission statements and business plans. It is important that all members of the staff feel they are contributing to the practice and its development, are clear about their role and their lines of accountability, are confident in their skills and training, and are responsible for their clinical practice²⁹.

One practice tried to reach a better understanding of the role of the district nurses by undertaking a survey of tasks, but otherwise there was little evidence of greater understanding of roles. In one practice, the community staff felt that the doctors still did not understand them.

The roles of the community staff were developed to some extent, the health visitors undertaking vaccinations and immunisations, and some of the district nurses providing venepuncture and male catheterisation. This was hampered by the provider unit's failure to arrange adequate training.

The model meant that it was possible to provide services sensitive to local needs, though new services could take time to evolve. In some practices, however, the

²⁹ NHS Management Executive, 1993, p. 29 para 5.5; emphasis as in the report.

development of new services may require additional staffing resources, though in others, there is room for adjustments by reassessing priorities. There was better continuity for patients, who saw the same community nursing staff, and better co-ordination between professionals.

It is more expensive to offer a service in which staff are dedicated to working with a particular practice and do not cover staff shortages in other practices arising from annual, maternity or sick leave. There are start-up costs, but the biggest costs relate to staff. One reason for the extra cost is that it is not possible to divide staff if, say, a practice is due 1.25 WTE district nurses. The problem of dividing staff becomes more acute when skill mix is taken into account. Within the pilot scheme, some of the extra costs arose from the policy of keeping the pilot practices completely separate from the others, which made it necessary to use bank nurses on some occasions.

Travel costs could be greater where community nurses are serving a practice population more widely spread than the geographical area served by a nursing team.

District nurses and health visitors need professional advice and support³⁰. During the pilot, the Director of Nursing in the Community Health Services Unit was committed to provide support to the staff if disputes arose between them and the GPs. The Sector Manager kept staff informed of developments in the Unit, changes in policy and in clinical practice, such as the Hib immunisation programme. However, the staff

³⁰ Andrew Rix and Glyn Jones Elwyn, "Managing health visitors in general practice", *Health Visitor*, 1996, 69:1, pp. 15-16.

missed their nurse managers. They missed having someone to discuss problems relating to patients and the practice. They missed having someone to help them in their professional development.

Standards of quality must also be maintained. This means that staff need to learn new skills as clinical practice changes and update familiar skills; they need protocols and standards for their work; and they need systems by which the quality of their work is tested and guaranteed.

Set against this is the position of the practice nurse who does not have access to this kind of support, generally speaking does not want it, and feels that she is responsible and able to keep herself up to date, and responsible for the quality of her nursing.

Towards the end of the project, a new report from the NHS Management Executive, *New World, New Opportunities*, confirmed the need for clinical supervision for primary health care nurses. One Key to Progress is:

Purchasers should ensure that professional advice is available to all primary health care professionals. This will involve, for example, professional nursing advice to nurses and guidance on employment and health and safety issues to GPs.³¹

The importance of this professional advice and support cannot be stressed enough to help nurses develop their role, identify education and training needs and make

³¹ NHS Management Executive, 1993, p. 30, para 6.5.

opportunities for training available, act as a sounding board for problems and help define nursing practice protocols. This could be provided either by a line manager or by a clinical nurse specialist who would act as an advisor or mentor. It is interesting that GPs do not feel the same need. Within the project, staff did meet with the nurse manager more formally once a month to receive information and discuss matters of professional interest.

One issue that did not arise within the project - probably because it was regarded as a pilot - was the implication of this model of working for promotion prospects. If District Nurses and Health Visitors do not report to managers, there would be fewer posts available for those who want to move on. In fact, the number of nurse managers was cut back severely during the reorganisation of the community health services into the new NHS Trust.

A number of other difficulties were identified with this model of working, namely accommodation, peer isolation and fragmentation of the service. These will be discussed in turn.

Accommodation turned out to be a bigger problem than anyone had anticipated. Though all of the practices had a good standard of accommodation, none of them were built to house community health staff. Health visitors need an office of their own where they can keep their desk and filing cabinets and see clients. District nurses require space for desks and files, but can work more flexibly. Practices may also be developing in other ways which demand room: considering another partner,

consultant clinics, developing health promotion clinics or other new services. These developments will also put pressure on the space available. Even the most modern practice premises are not planned to provide adequate room for the whole primary health care team. In the longer term, when new practice premises are built account should be taken of the additional staff and activities modern practices now have to house. The Department of Health may need to consider relaxing the strictures of the Cost Rent Scheme to enable GPs to build bigger premises, particularly in inner urban areas where practice income could be limited by the type of population served, as people living in deprived areas were less likely to take up preventative measures such as immunisation and screening. Alternatively, RHAs and DHAs together with FHSAs may need to restart building or adapting health centres.

Peer isolation was often cited as one of the problems of the district nurses and health visitors. They missed the informal chat, encouragement and support provided daily by the nursing team. Instead of the nursing team, the pilot staff were expected to relate to the primary health care team, and relationships with members of the team certainly improved, though they do not yet appear to have supplanted the felt need for the nursing team. The problem is more acute for health visitors, as there are fewer health visitors in a practice than district nurses. It would be very difficult, if not impossible, to organise things so that the nurses were members of a nursing team (beyond the handful of nurses working with a practice) and of the primary health care team and related well to both; the effect would be to dilute relationships with both groups. In the end, a choice has to be made: either the district nurses and health visitors are based in nursing teams, with good peer support and a weaker relationship

with the primary health care team, or they are based in practices and build up relationships with their multidisciplinary colleagues and lose the camaraderie of the nursing team. The switch from the former to the latter takes time to develop, and may, as in this project, leave the staff bereft of support for a while, particularly in small practices where there are few peers to provide nursing team support.

There is a difference in focus between primary medical services and community health services. The former address the needs of patients registered with the practice (or even just with those individuals with whom the practice comes into contact), and the latter serve the needs of the wider community. Government policy is clearly to focus primary care services on general practice. This could result in the fragmentation of the service. The view of the HVA was that services "will be delivered in a piecemeal way if left to a number of different GPs"³². This, however, could be avoided if some body, presumably the FHSA or a joint primary and secondary care purchasing authority, could take a wider view of primary health services and develop contracts locally with GPs and/or PHCTs to ensure consistency and quality.

During the project there was confusion about what management meant, and in particular, what it meant to manage district nurses and health visitors. One practice used the model of professionals working alongside one another, managing themselves. In another practice, the GPs wanted a degree of control over the work of the pilot staff, and in the third, there was an awareness that more information was needed to

³² Health Visitors Association, letter to the Unit General Manager, Sunderland Community Health Services Unit, 4 August 1992.

manage effectively. The pilot staff perceived management in terms of what they were used to from their nurse managers. They felt that, apart from signing mileage forms, none of the GPs really took on board the issues of daily management: the nurses contacted the nurse manager themselves when they needed to arrange cover. They also felt that the doctors would not be interested in the issues they might previously have discussed with the nurse manager. Some staff did feel that the freedom from their nurse management structures meant that they were able to work more effectively.

The distinction by the nurse managers between their line management functions and their professional advice role was very helpful. Anyone undertaking the line management of district nurses and health visitors would, if they were not already trained nurses, need some training in nursing issues, such as grading and tasks appropriate to each grade. However, as mentioned above, provision is required for professional advice and support, including the monitoring of quality, and this can only come from nurses. Another dimension of management which, in the provider unit, would fall into the role of the sector manager, is business planning. For practices, this would involve identifying the needs of patients and of the practice and planning services and determining priorities to meet those needs.

If this is what managing community nurses means, should GPs do it? The research showed that GPs do not have the time, inclination or skills to 'manage' community nurses and the services they provide in any of the dimensions identified above. This model does, therefore, raise questions about professional dominance.

The doctors had heavy clinical commitments, given the numbers of patients and the nature of the areas served by the three practices. Any reluctance to take on non-clinical tasks is understandable: GPs do not themselves want to be spending time on daily administrative tasks like arranging cover for nurses' absence. Neither doctors nor nurses wish to spend time on administration that could be spent on patients. These tasks could be allocated to the practice manager or his/her representative, though practice managers are also stretched. The task of managing the direction and the work of the practice is the responsibility of the GPs, but it is one to which district nurses and health visitors could make a valuable contribution, because of awareness of patients' needs and their knowledge of what can be offered to them.

Most practices lack effective management structures, systems and skills, or, indeed, any inclination to implement them. Business planning is undertaken in few general practices. In this respect, general practice lags behind other sectors of the health service. Though doctors may regret the need to become more businesslike, there is value in taking a step back to plan how the practice is to develop to meet the needs of the practice population. In effect, this process is similar to audit, except that it examines the overall work and direction of the practice in order to offer the right services to the right patients, at the right time, by the right members of the PHCT.

There is also an issue about whether any profession should manage another. No one would expect doctors to manage, say, social workers. The health service has become accustomed to general management in recent years, though the question of whether it is appropriate for one professional to manage another professional with whom

he/she has to work, is a different matter. Though the professions are interdependent (and hierarchical), they are different, and membership of one does not by itself qualify someone to control a member of the other. Indeed, because of different professional perspectives and training, it may be very difficult for a member of one to manage a member of the other.

For many decades district nurses and health visitors have been struggling for professional recognition. By accepting management by general practitioners they may risk relinquishing the struggle for equal professional status. Though nursing has traditionally been the subordinate occupation, for reasons of earnings, entry requirements, length and difficulty of training and sex, it is open to question whether structures should be created which perpetuate the inequality between the professions, in which nurses are "handmaidens" to doctors³³.

On the other hand, there is a need for all professionals in primary care to work together to provide an effective, co-ordinated service to patients. The process of doing that needs to be controlled, as it will not occur automatically simply by putting people together. Working together and providing a service needs to be managed and these are appropriate areas of control for GPs, though it would not be fitting for doctors to control what nurses should do and how they should do it. As one of the practice nurses put it, "They [the GPs] set the boundaries and I manage my own nursing." The evaluation report concluded that tasks that would be suitable as part of this control would include:

³³ DHSS, 1986a, p. 48.

- co-ordinating the work of all members of the PHCT;
- agreeing with community nurses the priorities for nursing services within the practice;
- developing practice protocols and procedures with the community nurses;
- developing systems for and undertaking clinical audit;
- ensuring community nurses are registered with the UKCC.

Inappropriate tasks were telling community nurses what to do and telling them how to do it.

The leadership role of managing the process need not be undertaken by a doctor. Yet the doctor is legally responsible for the patients registered with him/her, has financial and (possibly) estate interests and responsibilities in the practice, and the financial success of the practice determines her/his income. There is also a related political dimension in that current health policy emphasises the central role of GPs.

CONCLUSIONS OF THE EVALUATION

It is important to make a number of distinctions in evaluating the project. The outcome of handing over the management of district nurses and health visitors to general practitioners needs to be distinguished from outcomes arising from accommodating the pilot staff in the surgeries and dedicating them solely to their practices. Problems occurring because of the impact of change or for reasons outside the project need to be separated from those arising from the management of

district nurses and health visitors by GPs.

The aspects of the project which worked particularly well arose from basing the district nurses and health visitors in the general practice surgeries where their time was devoted to the needs of the patients registered with the practice. The benefits were better communication, better working relationships within the PHCT, better liaison and reporting and improved collaboration in patient care. Clearly this is not a new observation, as it has been advocated as part of the policy of attaching district nurses and health visitors to general practices for many years. However in Sunderland, as in many other places, the attachment scheme implemented was a watered down version, in which the staff were based in nursing teams in the health centres and aligned to practices. This project has shown that a more thoroughgoing attachment could benefit the delivery of primary care.

The more controversial dimension of the project was the management of the community nursing staff by the general practitioners. This had partial success in that it made it easier for community nurses to work with practices to develop services on the one hand, and created stronger team links on the other. Some community nurses were empowered to fulfil their roles better and make better decisions. On the whole, however, the GPs did not 'manage' the community nurses, who tended to manage their own day to day work, and only to a limited extent did the GPs manage the process of collaboration and planning.

The inference is that closer attachment, with district nurses and health visitors

accommodated in GP surgeries, would be sufficient to achieve the benefits seen in the project. However, that would not address the problem of the management structure of the PHCT. It would also result in the loss of control and flexibility to deploy staff and resources by the provider unit. If that control is to be relinquished, the benefits must outweigh the costs. For this project to have the full impact, GPs need to manage, and to manage effectively.

The project addressed the issue of what it means for GPs to manage district nurses and health visitors. It identified the areas in which GPs (or their Practice Managers) might manage community nursing staff; namely, day to day management and strategic business planning. It identified the need for clinical supervision for community nurses, which need not necessarily be provided by line managers. It showed that though it is appropriate for GPs (or their deputies) to control the process of working together and providing a service, it is not appropriate for doctors to control what nurses should do and how they should do it.

The evaluation proposed two management structures based on this experience. The first was similar to the model operating in the pilot, but the management functions are made explicit. The second took a step back, keeping the district nurses and health visitors within the management structure of the provider unit, but releasing them to work more closely with the practice.

1. The GPs take on the responsibility for the district nursing and health visiting services for their patients; they manage the staff, in the sense that they have

overall responsibility for their work, some aspects of which they delegate; daily administration is managed by the practice manager or her representative; professional advice and support and quality monitoring are provided by a clinical nurse specialist employed by the provider unit or FHSA; the PHCT is responsible for planning services and setting priorities.

2. The district nurses and health visitors remain within the management structure of the provider unit, but are based in practice premises. They work with the practice to establish the needs of the practice and the patients and set priorities accordingly. Their workload is determined by the practice, and any community commitments additional to their work in the practice are explicit and agreed with the practice. The nurse managers help the staff develop their skills to meet the needs of practices, and provide professional support, monitor quality and arrange cover. Practices have named staff, who will not be moved without consultation with all parties.

Whichever of these models is implemented, the cost of providing the district nursing and health visiting services would in most circumstances be greater, for three reasons: the flexibility to move staff around to cover absences or other duties would be lost, whole staff would be attached and not whole-time equivalents, and practice-dedicated staff would cover more widely dispersed patients. Whether these costs are outweighed by the benefits is something which still needs to be explored.

DIRECT MANAGEMENT AFTER THE EVALUATION

Following the evaluation of the project, Sunderland Health Authority, Family Health Services Authority and the provider unit agreed to follow the second and weaker option, to ensure that the community nursing staff got the professional support they needed. It was, however, understood that nurse managers would undertake a "hands off" role, enabling staff to work effectively with the practices. Practices were expected to think strategically about their services.

Thus the expansion of the project was no longer about the management of community nursing staff by general practitioners, but about bringing professionals together in a way in which they could work more effectively. It may be that management by general practitioners will be considered again in the future, but for the time being GPs were not interested and lacked the necessary skills. The second option was an opportunity for GPs to develop these skills while the community nurses still worked under the umbrella of the provider unit. The original problem, that the structure of the PHCT inhibited teamworking, remained, and the second option was just another attempt to work around it. Perhaps it was not that the concept of direct management had failed, but rather that general practice, certainly in Sunderland, was not ready for it. On the other hand, the future might open up other possibilities not available at the time of the evaluation, such as salaried GPs working alongside other health professionals, community nurses working as independent practitioners with shares in the practice, or contracts which are placed with PHCTs as a whole, rather than with individual GPs.

There was considerable interest in the scheme from other practices. To guide the implementation of the scheme, a steering group was set up, and a set of guidelines and a checklist of issues to be addressed was produced. A draft Service Agreement was drawn up, which made roles and expectations explicit. At the end of March 1994, there were plans to extend the project to fifteen other practices in Sunderland.

From that point, implementation of the project sailed into turbulent waters. The Local Medical Committee expressed considerable concern about the level of staffing in district nursing and health visiting and instructed the practices not to cooperate with the scheme until additional resources had been invested in community nursing. A review of community nursing was undertaken, which confirmed the need for additional staff. The Health Commission invested an additional £150,000 to fund five district nursing posts and some clerical staff to support health visitors in order to release them for more face-to-face work with clients. By this time, another year had passed and enthusiasm for the scheme had diminished. Implementation plans were revived, but progress was slow. In any case, the government had announced proposals for community fundholding³⁴ and some of the practices which had been intending to take part in the project now expressed an interest in community fundholding. The world had moved on, and the Direct Management Project had been overtaken by events.

³⁴ NHS Executive, *Developing NHS purchasing and GP fundholding*, HSG (95) 4, 25 January 1995.

IMPLICATIONS FOR COLLABORATION

This pilot project attracted a great deal of interest nationally. It was not altogether successful in the form in which it was originally conceived, in that the management of district nurses and health visitors was not transferred to GPs. However, the project had moderate success in showing a possible way forward for improving collaboration between general practice and community nurses. From other points of view, this might be regarded as a more satisfactory outcome of the evaluation, in that it kept the predominantly female callings of district nursing and health visiting independent of substantially male medical control.

The project brought out a number of implications for collaboration: firstly, that collaboration between health professionals cannot be assumed. Indeed, as West and Field show, "primary health care teams have less clear objectives, lower levels of participation, lower levels of interaction frequency and poorer task orientation than the other groups of teams with which they were compared."³⁵ Collaboration within the health service is not automatic, and divisions between different parts of the health service can be nearly as great as between the health service and social services. Second, collaboration needs to be worked at and can be improved with effort.

Thirdly, this project shows a tension between collaboration at different levels: though collaboration may be achieved to some degree at one level (in this case, at the level of individual fieldworkers), there may be blocks to collaboration at other levels (at the

³⁵ Michael and Field, 1995, p. 120.

group, or organisational, level). Though the LMC supported the idea of the scheme in principle, it halted further development until other associated needs (for additional resources) were met. The further development of both this project and the social worker attachment, therefore, was held back by the LMC which wanted to ensure that the schemes would benefit the practices and services for their patients, and would not put any burden on the resources of the practices. Certainly, Sunderland GPs did feel under pressure as a result of the 1990 Contract with all its additional demands and what they saw as rising expectations among their patients. They felt obliged to protect their corner. Though they saw that there were benefits to both projects, the costs of collaboration were perceived as too high. Brown, Flynn and Wistow have shown that joint projects are successful where there is system-wide support for joint working³⁶. In Sunderland, though there was a good history of collaboration between the health authorities and the local authority, this did not extend to the LMC.

Collaborative mechanisms were employed in different ways between the Direct Management Project and the social worker attachment. One marked difference was that in this project more assumptions were made about the dynamic of the team. In the social worker attachment, time and effort were devoted to agreeing roles and responsibilities³⁷, methods of referral and access to case notes. In the direct management project, it was assumed that one of the doctors would lead the team and that all those involved aimed to supply co-ordinated health care to the patients.

³⁶ Stephen Brown, Margaret Flynn and Gerald Wistow, *Back to the Future: Joint Work for People with Learning Disabilities* (Leeds: The National Development Team and The Nuffield Institute for Health Services Studies, 1992) p. 19.

³⁷ Ovretveit, 1990, § 4; DHSS, 1987, para 9.5.

Though there was some discussion about new roles for the district nurses and health visitors, assumptions were made about the core of their activities. However, whereas the social worker attachment meant a new relationship between the PHCT and a new member of the team, the direct management project was about strengthening an existing relationship. One of the PHCTs in the scheme did put together an agreed statement about the project and how it would work, but on the whole, there was little effort to create a new dynamic. This left room for possible misunderstanding and frustration. This occurred in Practice C, where dissatisfaction developed among members of the team because of the impact of changes in the practice which were introduced without any consideration of the effect on individuals. This does imply that it is easier to establish a good relationship from the start than to overcome inertia and improve an existing state of affairs.

Bringing all members of the team into the practice accommodation did have benefits, including better communication³⁸. Formal meetings took place in two practices, and were very much missed by some members of the team in the practice that did not have them³⁹. In one of the practices that held meetings, separate meetings were held between the doctors and the attached staff and between the doctors and the employed staff. This did not help to integrate the team as a whole. One practice had an understanding about when the doctors were available for informal consultation, though this did not necessarily fit in with the working of other members of the team.

³⁸ Gregson, Cartlidge, Bond, 1992, p. 28.

³⁹ Gaynor Bennett-Emslie and James McIntosh, "Promoting collaboration in the primary care team - the role of the practice meeting", *Journal of Interprofessional Care*, 1995, 9:3, pp. 251-256.

Generally speaking, however, being based on the same premises did make informal encounters easier. None of the teams had a formal system for learning or training together, though special events might be arranged if a drug company representative was making a presentation. None of the practices spent any time in "team building". Thus some mechanisms to facilitate collaboration were present in some of the practices, but the number of these factors and the degree to which they were employed varied in each practice.

Collaborative attitudes also varied in degree in each practice. As to commitment, there was general commitment to the patient and to teamwork, and a rather more mixed commitment to the project itself. Trust in other members of the team could not be assumed. The participants showed limited insights into their own or their colleagues occupational systems. There was certainly little discussion of the implications of different professional perspectives for joint working. The project did pose a challenge for the idea of equality, in that the management of one profession was vested in another. Though the issue of equality as such was not raised in the interviews, the nurses and health visitors seemed aware that they needed to assert equality with the doctors, whereas the social worker just assumed it.

Collaboration did not operate in the same way in all the teams. Each PHCT was different, and it is difficult to generalise about how teams work as a whole. However, the PHCTs in the study tended to be task-oriented and spent little time on developing the internal dynamic of the team. Joint working happened because it was necessary to deliver an integrated service to the patient, and it happened with an economy of

effort and resources. But below the surface of collaboration, there were, in some teams, rumblings of discontent, with little opportunity to address the causes.

Thus, collaboration within identifiable and long-standing teams within the health service was as fragile as collaboration between health and social care workers. Nevertheless, there was an assumption that PHCTs were here to stay, however shaky their foundations. The continued existence of social worker attachments, on the other hand, was not guaranteed.

CHAPTER NINE

CONCLUSION

INTRODUCTION

One problem in social research is the sense of shooting at a moving target, and this has been very much the experience with this study. Not only was there the turmoil of introducing community care policy at a time of considerable organisational change, but the policy itself has been bedding down and maturing, so that what seemed to be crucial in 1991 may be *passé* in 1995. Collaborative projects that seemed just right in 1992 were quickly overtaken by events. Nevertheless, this experience itself has something to say about collaboration, as do the individual projects. This chapter will summarise the main themes of each of the preceding chapters, examine the material in the context of the literature and will then discuss some of the key issues arising from the thesis. It will go on to propose areas of further research. Finally, it will draw out the lessons to be learnt from doing the research.

SUMMARY OF PREVIOUS CHAPTERS

What has this study told us about collaboration and its place in the relationship between health and social services in Sunderland in 1990-1994? The study itself arose from a collaborative initiative, on which the researcher was employed to evaluate projects. This is described in the first chapter, which also introduces the themes and background of the study. The second chapter shows how the evaluations, which were undertaken as part of my employment, formed part of the case study on which the research is based. The research went further than the original remit of the evaluations, by analysing them in the wider setting of the developments in community care policy and exploring the implications for the nature of collaboration between health and social services and within the health service.

Chapter Three sets out the political and ideological background to the 1990 NHS and Community Care Act and explained the reforms and content of the new policies on community care. It shows the fundamental tensions between the philosophies which underpinned community care, namely between resource efficiency, a belief in the power of markets and consumer choice and involvement. In addition, the structures created by government and the dynamic of relationships between the government and local authorities, between government departments and between different organisations in the restructured health and social services, proved to be impediments to collaboration between health and social services at the local level. Collaboration, paradoxically, was expected to be the means by which these difficulties would be overcome. There was much talk about collaboration in the guidance documents, and

some attempt to build collaboration into the process, but this showed little understanding of the fundamental problems of collaboration and there was little investment in helping it happen.

The Act itself created new boundaries between purchasers and providers. In social services this division was maintained under a common head. In the health service, the division was much more radical, and the functions were split into separate organisations. From the point of view of the SSDs, this division in the health service meant that there were more people with whom they had to work, more organisations to take account of. Anticipating subsequent changes to legislation, the executives of the district health authority and family health services authority were merged. Nevertheless, on balance, more divisions were created in the health services in Sunderland than were dissolved. In 1989, there were the DHA and the FHSA; in 1994, there were the Health Commission, serving the DHA and FHSA and two separate NHS Trusts. GP Fundholders were also beginning to become important players. If the new shape of the statutory agencies was not conducive to collaboration, the process of reorganisation was a considerable hindrance, diverting the resources and energies of officers and authorities away from joint working¹.

The concept of collaboration is examined in Chapter Four, which demonstrates a gap between the aspiration towards and the practice of collaboration. The gap occurs because collaboration is not easy. It is not a free good. Nor are the benefits self-evident. Even if they were, collaboration has costs, and the costs may outweigh the

¹ DoH, 1994b, p. 4.

benefits. What is required is an environment which promotes and values collaboration - if collaboration is what is wanted!

The chapter also considers studies of collaborative planning between health and social services and studies of collaboration between social workers and general practitioners and within primary health care teams. Studies of joint planning in the late 1970s and early 1980s demonstrated that collaborative working between agencies failed to meet expectations, but that expectations had been unreasonably high. Studies of social worker attachments to general practice were generally, though not universally, positive about this model of collaborative endeavour, but such attachments tended to get lost on the wayside of economic retrenchment. Primary health care teams are a long-established method of bringing together workers from different health care organisations, but are acknowledged to be "more a concept than a reality"². Collaboration among different health service workers can be at least as difficult as among workers from separate health and social service agencies. The chapter concludes by drawing out of the literature a framework of the factors that influence collaboration in four categories: the environment, characteristics of the organisation, collaborative mechanisms and collaborative attitudes. These factors are set against the three levels of collaboration: strategic, operational and practitioner. This framework is used in the case study to measure collaboration in Sunderland.

Chapter Five describes the high level of social and economic deprivation in Sunderland, indicators of poor health experience, and also the primary care,

² DHSS, 1986a, Foreword.

community health and social care services available to meet the needs arising from these circumstances. It describes some of the ways in which the services attempted to work together to provide a coordinated response. The chapter then goes on to analyse the environmental factors that helped or hindered collaboration in Sunderland in 1990-1994. It finds a high level of turbulence caused by the introduction of new legislation, economic uncertainty at a time when demand on services was growing, and a lack of policy coordination at departmental level and between central and local government. The only environmental factor which fostered collaboration was the pressure to collaborate. The characteristics of the organisations also created problems for collaboration. The structure and funding, culture and lines of accountability were very different in the health service and in the SSD. Both services were pre-occupied with re-organisation. The one organisational factor which favoured collaboration was the coterminous geographical boundaries.

Chapter Six examines collaboration at the strategic level in Sunderland, and gives an account of planning between the health service and the SSD for the implementation of community care policies. A number of issues are explored in the chapter, namely the Community Care Plan, boundaries of care issues between health and social services, the assessment procedure, joint training, the hospital discharge procedure, and care management for long-stay patients with disabilities. In the early stage of preparation for community care, collaboration was nominal, but it became a stronger feature of the process of developing policies as time went on. The joint planning system was strengthened, and widened to include service users, carers and voluntary organisations. Informal collaboration was also good. However, though officers of

the various agencies were talking together and producing policies, collaboration was taking place at the wrong level, between junior and middle managers, rather than senior managers. There was a lack of direction from senior management, and different aspects of community care were developed piecemeal, rather than as parts of a coherent whole. This was mainly because of the frequent change of Directors in the SSD, which resulted in planning blight, changes of direction and a lack of vision for community care for much of the research period. With considerable difficulty, the health and social services in Sunderland succeeded in putting into place the main cornerstones of community care policy, even though some of those processes were not entirely robust, such as the assessment procedure and the operation of the hospital discharge procedure. Relationships between individual officers improved, as did more formal relationships between the agencies. However, the need for the SSD to work jointly with a much wider range of organisations diluted its commitment to collaboration with the health service.

The next two chapters look at two projects at the practitioner level. The first was designed to improve collaboration between primary health care and social services, by attaching a social worker to a PHCT. The second was an attempt to strengthen collaboration between workers in two different arms of the health service, GPs and district nurses and health visitors. Both projects demonstrated the fragility and vulnerability of special projects, confirming the findings of Hardy and colleagues³. Though they were still operating at the end of the research period, there were problems in rolling out both projects. Within the projects, collaboration between

³ Hardy, Wistow, and Turrell, 1992, p. 212.

participants appeared to be very good in the social worker attachment and improving in the direct management project. However, collaboration among the various stakeholding bodies was not sufficient to overcome the difficulties that arose in implementing the schemes further. There seems to be a difference between setting up a collaborative project and establishing a system for collaboration.

The evaluation of the social worker attachment confirmed other studies which found that this model was a successful way of fostering collaboration between social workers and general practice⁴. This method of providing a social work service gained approval from the social worker, the members of the practice and the patients. The attachment led to good collaborative working between the practice and the social worker, but did nothing to improve relationships between the practice and social services in general. It was a good way of ensuring multi-disciplinary assessments for community care, and meant that clients received a coordinated package of care. The service from the social worker was more accessible and more acceptable to the patients, and was used by a wider range of clients than were found in mainstream social work. However, this success created a problem. The attachment extended a social work service beyond the very poor and needy to include the middle-class who had problems arising from poor health. There were insufficient resources to support this level of service across the city. It was also a more expensive way of giving a service because separate facilities and administrative support were required.

⁴ Goldberg and Neill, 1972; Brian Ruddy, "Brief Encounters", *Health Service Journal*, 17 September 1992, pp. 22-24.

The researcher was in a unique position to monitor the development of social worker attachment in Sunderland after the evaluation. This chapter therefore includes an account of what happened after the formal study was over, and offers insights into the difficulties of collaboration at the operational management level. Social worker attachment was rolled out to include five more social workers and nine practices. However, following the arrival of the new Director in 1992, the implications of extending the service to a wider clientele were no longer acceptable. Furthermore, with the reorganisation of the SSD, attachment did not fit well with mainstream services. The Department recognised the impossibility of providing the same level of social work support to every practice, which would have required twice as many social workers as were available in the Older Person's Division. Another method of developing links between Team Managers and practices was promoted, but was rejected by general practice in Sunderland.

This account demonstrates the tensions in collaboration at different levels of the participating organisations. The project was conceived and promoted at the strategic level as part of the planning for community care. Collaboration at the practitioner level was very successful. Planners from the different organisations worked together to extend the project. Then the project encountered philosophical problems about the nature of social work and funding difficulties. Another method of developing collaborative links was proposed, but was tacitly rejected by the GPs, who saw it as a poor substitute for the model that they had come to expect. Good collaboration at one level does not guarantee that collaboration will also succeed at another. Operational managers in the SSD did not appear to be as committed to collaboration

as their strategic-level managers or as their fieldworkers. The "wildcard" element of general practitioners was also a problem. Though the Health Commission was working with the SSD to promote collaboration, it had no control over GPs, who would not cooperate unless they could get what they wanted. This finding was also true of the Direct Management Project, where there was some improvement of collaboration at the practitioner level, but barriers that could not be overcome at the operational management level.

It appears, therefore, that though individual projects may have some success where collaboration occurs at one or two levels of the organisations involved, if success is to be sustainable and generalisable, collaboration is needed at all levels of the organisation. Future studies of collaborative projects will need to bear this in mind and take account of the place of the project in the wider organisational context.

The second project at the fieldworker level, the Direct Management Project, was a scheme to improve collaboration between workers from two different parts of the health service, rather than between health and social services. Health visitors and district nurses were employed within one part of the health service, while GPs were independent practitioners within the family health services. Though there was a long tradition of health visitors and district nurses working with GPs and attached to practices, the relationship was not always straightforward, and there were tensions because the district nurses and health visitors were employed by one organisation and working with another. The project addressed the structural aspects of the problem, and transferred the management of the district nurses and health visitors to the GPs

as far as possible. However, this did not address long-standing causes of tension between the professions of medicine and nursing, and the unequal status between them.

The project demonstrated that collaboration between health professionals could not be presumed. This has important implications if the effective delivery of community care is dependent on practitioners working together for assessment and the provision of care. The issue then is, how can joint working between health service practitioners be ensured? There is an assumption that GPs, district nurses and health visitors will have a full understanding of one another's roles and responsibilities and ways of working, but this was not always the case within the practices in the study. The GPs in one study assumed that the health visitor would be able to meet them at their morning coffee break and communicate about patients, though this was the time when the health visitor was out visiting.

What made a positive difference for collaboration between health care practitioners included being based in the same premises, which made communication and informal contact easier. Transferring the management of district nurses and health visitors to GPs was not a particular success and raised as many problems as it solved. However, releasing the community staff from those obligations set by nurse management, such as paperwork and district-wide commitments, did mean that they could concentrate on the priorities of the practice, rather than try to operate with two sets of priorities. This implies two things: firstly, that no one can serve two 'masters', especially when their aims are in conflict; secondly, that establishing a set of shared goals promotes

collaboration. This is confirmed by West and Field who emphasise the importance of involving all team members in setting objectives and also in measuring performance against them⁵.

THIS STUDY: ITS CONTEXT AND CONTRIBUTION

This study belongs to the body of literature which has looked at relations between health and social services. In considering collaboration at different levels of the health service and the Social Services Department, it was necessary to bring together four streams of literature on joint working: on theoretical analyses of collaboration, on joint planning between the agencies, on social worker attachment to general practice and on primary health care teams.

The study of planning for community care belongs in the context of research undertaken in the late 70s and early 80s of processes of collaboration between health and social services, which found that collaborative activity had not met the expectations of policy makers, but that these expectations had been too high. The research found that this conclusion still held. "Collaboration" is very much a feel-good term used by politicians in a deliberately vague and ambiguous way, as a means of avoiding hard intellectual choices. Implementing it - whatever it is - is much more complicated. Collaboration between health and social services was not something that happened automatically because it was seen as good for clients or necessary for implementing community care. Other considerations could get in the

⁵ West and Field, 1995, p. 121.

way. One major impediment to joint working was the instability created, firstly, by the reorganisation of the agencies that came about as a result of the new legislation and, secondly, because of the frequent changes of Director in the Social Services Department.

One purpose of the research was to see whether the NHS and Community Care Act had changed the dynamics between the agencies. The study demonstrated that the Government was doing two contradictory things at the same time: exhorting collaboration while setting up structures that made collaboration ever more difficult. Collaboration was required for some of the processes introduced by new legislation. There was some evidence in Sunderland of closer working between the agencies over some of these, such as the production of the community care plan, though in other aspects, collaboration was less good, such as assessment and care management and joint training.

As already noted, the evaluation of the social worker attachment supported many of the previous studies which showed the value of this kind of working. There was little evidence of the tensions described by Huntingdon in the relationship between the social worker and the general practitioners in the project. The real value of this study, however, was in placing social worker attachment in the wider setting of the relationship among the agencies and recording the development of social worker attachments in Sunderland after the evaluation ended. This gave a great deal more insight into the difficulties of collaboration at different levels than the original project, and was only possible because of the researcher's position as an insider. Social

worker attachments of the type described in this study are unlikely in general practices for the foreseeable future. The NHS and Community Care Act has changed the nature of social work, putting the emphasis on assessment and care management rather than on therapeutic intervention. It is also unlikely that cash-strapped SSDs will expend scarce resources on costly attachments. There is still a need for social workers and GPs to work together. This study shows how difficult it is to make that happen, not at the level of the individual social worker and individual practice, but between operational management and the collective body of GPs.

The literature on Primary Health Care Teams points to the obstacles to developing effective teams. The Direct Management Project attempted to address one of the structural complications, by integrating district nurses and health visitors, who are employed by community units (now NHS Trusts), more fully into the teams with which they work. The evaluation identified as many problems with this model as benefits, thereby confirming the complexity of PHCTs and the hindrances to making them cohere. The account of the development of this model after the evaluation also demonstrated the difficulty of collaboration at a project management level: not between health and social services as with the social worker attachment, but between different parts of the health service. Collaboration is as necessary within the health service as it is between the health service and social services. Like the social worker attachment project, the Direct Management Project also showed the need for collaboration at different levels.

The project also showed the different ways in which language was understood by

different groups. So "management" for district nurses and health visitors meant professional support through training and mentoring and operational oversight in terms of rostering and employment policies and procedures. For GPs, the concept had overtones of control, telling the nurses what to do and how to do it. This shows how profoundly different the world is from different professional perspectives. This dissonance does not promote harmony. Collaboration requires an acknowledgement and transcendence of these difference.

Taken as a whole, the three parts of the case study show how difficult it is for organisations to work together. Relationships between individuals in the studies tended to be more collaborative than relationships between corporate bodies, but this research clearly demonstrates that it is important to see the relationship between those individuals in the context of relationships between organisations.

The study used a framework for collaboration to measure the factors which promoted or hindered collaboration. This was developed from work by Davidson and augmented by findings from the literature. What it does not show is how successful collaboration actually is. Measuring collaboration is not easy. It is difficult to measure something so intangible. It is not possible to assess how collaborative organisations are in general: it is only possible to evaluate collaboration over particular projects. The nature of collaboration between organisations is constantly shifting according to the individuals involved and the nature of the enterprise around which collaboration occurs. A scoring system is available for primary health care teams, but this cannot be used for joint working between agencies, as it only applies

where individuals are working together.

The next four sections pick up particular issues of the study and discuss their implications: the nature of equality and power in collaborative relationships, factors which promote or hinder collaboration, an analysis of the Framework used in this study for measuring collaboration, and the future for collaboration and research into collaboration.

EQUALITY AND POWER

The idea of equality was identified in the literature as an important pre-condition of collaboration in teams (see pages 143-145 and 163-164). The issue is essentially one of power. When one person or one profession is perceived as holding more power than another, can the relationship between them be described as collaboration? The question of power takes in the debate about professional dominance and male dominance. These issues arose in the Direct Management Project: the very nature of the project raised these ideas. However, they did not emerge overtly as an issue in the social worker attachment. The social worker was accepted as another professional within the practice, though it was recognised that the social worker was on the GPs' territory. A project with a GP working in a social services area office is almost inconceivable. It appeared that collaboration with GPs is only possible on the GPs' terms. Though Sheppard does not come to this conclusion, that is the lesson of his study. He refers only to the profound refusal of GPs to initiate contact with social

workers and CPNs, which is put down to the GPs' assumption of leadership⁶. GPs cannot be forced to collaborate; they can only be encouraged. They will only do it if it suits them, and does not cause too many problems or have too high a cost. Nevertheless, they are key players in health and welfare services in the community, and there is a need for them to work with other providers of care, for the sake of patients and to enable other workers to do their jobs. The ethos of collaboration tends to assume an ethos of equality which does not exist. To the extent that the first requires the second, collaboration is built on a chimera. Professional equality between medicine, nursing and social work will not come about in the foreseeable future. The issue then is how pragmatic collaboration can take place which recognises and takes account of the uneven balance of personal power.

If the balance of power is such an issue for collaboration between individuals, what place does it have in collaborative dynamics between organisations? The theoretical literature on the exchange model and political economy model recognises that an imbalance of power is almost inevitable. The NHS holds more power than local authority SSDs, if this be measured by the funding at its command, the service it provides to almost the whole population and its popularity with the public. However, the SSDs did become more powerful in the early 1990s, partly as a result of their new responsibilities in community care and the transfer of funding in the form of Special Transitional Grants. The nature of power held by individuals within the agencies was also different. NHS managers have greater freedom to act than the LA officers who have to submit policies and proposals to committees of elected representatives. As

⁶ Sheppard, 1992, p. 435.

planning for community care progressed, the SSD in Sunderland came to act with greater authority. The balance of power was an element in inter-agency relations, but it was never so overt or so personal as in relations at the field-worker level.

FACTORS WHICH PROMOTE OR HINDER COLLABORATION

The framework used in this research to measure collaboration is based on that proposed by Davidson, who implies that the signs in each category (environment, organisational characteristics, collaborative process) need to be right before collaboration can occur⁷. As I have used the framework in this study, the collaborative omens have not always been propitious. The turbulent environment of major legislative and organisational change did not facilitate good working relations between health and social services. The dual pressures of increasing demand on services and financial stringency made agreement more difficult about where appropriate boundaries lay between the responsibilities of the agencies. Formal and informal process for joint working at the strategic level have been established over twenty years, and worked reasonably well in Sunderland. The health authorities and local authority shared common boundaries, which meant that they did not have to dissipate their collaborative energies over other health and local authorities. However, GPs were not bound by statutory boundaries, which could make planning for general medical services difficult. Furthermore, the centre of attention for GPs was the patients on their list (or the patients who turned up in the surgery), rather than the population as a whole. Collaboration was seen, at all levels, as being in the

⁷ Davidson, 1976, pp. 122-123.

interests of clients, though there was less certainty about the benefits to the organisations or individual workers. GPs, in particular, were willing to collaborate if collaboration came to them, but less enthusiastic if it meant they had to behave differently. At the practitioner level, efforts to clarify understanding about roles, responsibilities and ways of working did facilitate good relations between the social worker and the practice. However, with relations among health care workers, these factors were assumed even where they were deficient.

The research showed that collaboration is immensely difficult at a time of internal change, when organisations have to concentrate on their own structures and on re-establishing their own identities, rather than on external relations. Leach argues that organisations strive for greater autonomy once their survival is assured⁸. This study suggests that they withdraw from collaboration when their survival is threatened, because it is too demanding, when time and energy have to be directed towards self-preservation. The government introduced community care policy with its emphasis on collaboration at the same time as it required immense organisational change, thereby jeopardising the very behaviour that it commanded. If policy makers are to insist on collaboration as a way of overcoming the difficulties that government itself creates, they should assume the responsibility for making collaboration possible, or at least of not putting extra barriers in the way.

If collaboration is to take place, it has to be properly funded, and this applies to

⁸ S N Leach, "'Organisational Interests' and Inter-organisational Behaviour in Town Planning", *Town Planning Review*, 1980, 51, pp. 286-299, p. 2.

collaborative projects as well as joint working in planning. Joint Finance is well-established, but it is not without its difficulties. There is a tendency for government to assume that collaboration, like so many other developments it requires⁹, is revenue-neutral and that any costs must be absorbed by those bodies which implement them. Collaboration also takes time and effort. The recent limitations on management costs in the NHS may mean that there are fewer officers available in Health Authorities for joint working with Local Authorities.

Collaborative projects at fieldworker level which bring workers out of one setting and put them together in another will almost always be more expensive than providing services according to separate functions, although this thesis does not examine costs in a systematic way. The additional expense arises from setting-up costs (accommodation, furniture, equipment), running costs (administration), the cost of time spent collaborating and the cost of providing a service to a wider client base than normal. This may be justified by intangible factors, but the advantages of these projects are very difficult to quantify. In the Social Worker Attachment, the clients and carers generally felt that they had benefitted from the project. But the patients served by the Direct Management Project were unlikely to identify many direct advantages: this assumption was reflected in their lack of involvement in the evaluation. The benefits expected there were more subtle, and to do with better understanding among the participants and improved communication.

Six questions about collaboration were put at the end of Chapter Four. The first is

⁹ For example, charters, care programme approach.

about the usefulness of the framework as a measure of collaboration. It is helpful as a means of drawing out the key factors which promote or hinder collaboration. It showed that many of the elements found within the literature to be necessary to or helpful for collaboration were absent in Sunderland during the early 1990s, though some factors conducive to collaboration were to be found. Thus in the environment, the level of turbulence did not promote collaboration. The new legislation contributed to this turbulence, and introduced two opposing forces: a considerable pressure to collaborate and organisational changes that made collaboration difficult. This lack of coordination in policy was a hindrance to collaboration, which was exacerbated by financial pressures and increasing demand on services. There is further discussion of the framework later in this chapter, when the framework will be revised and developed to take account of the lessons of this research and other observations.

The thesis aims to study collaboration at different levels, and the second question asks if this would lead to a better understanding of the nature of collaboration. This has shown that there is a difference between collaboration at the strategic level, over plans and funding, and collaboration at the fieldworker level about delivering care. The quality of collaboration within a project can be very different to collaboration between organisations about the project.

The third question asks about the effectiveness of inter-agency and intra-agency coordination in Sunderland during the research period. In terms of the structures for inter-agency collaboration, the mechanisms for collaboration in Sunderland had been strengthened: this strengthening ranged from the joint planning processes to the means

of joint working at field level, such as the assessment and care management procedure, the hospital discharge procedure, and the social worker attachments. However, none of these were working at their optimum level; though the attachments worked well where they had been established, it was difficult to extend them, and to establish relationships between practices and social services where they did not exist. As for collaboration, the turbulence created by the organisational changes and the frequent changes of Director meant that collaboration was less than effective. As for outcomes, Sunderland did have, by the end of the research period, a framework for delivering community care. Parts of it may have been weak, but all the parts were in place.

Judging the quality of intra-agency collaboration is less easy. There was less recognition that effort was required to ensure that the different parts of the health service worked well together; indeed, in the early days of the reforms, the emphasis was on the need to draw them apart. Joint working among different parts of the health service takes place within a structure characterised by medical professional dominance and male dominance. As far as the process was concerned, assumptions were made in the Direct Management Project about the nature of joint working and the roles and responsibilities of the various players which were not challenged. There was little attempt to clarify understanding and test out perceptions. Some benefits were starting to emerge by the end of the project, but they were limited. The research showed that different parts of the health service have different aims and objectives which take precedence over collaboration.

The fourth question asks whether collaborative working can only occur if circumstances in all dimensions of the framework are favourable. Can collaboration take place among committed fieldworkers in spite of the agencies, or can robust structures and systems compensate for a lack of commitment from individuals? In pragmatic terms, collaboration occurs, despite the difficulties, in an imperfect and haphazard manner. Though a great deal is known now about improving collaboration, the costs of achieving quality collaboration appear to be too high to be pursued wholeheartedly. Collaboration is a tool which can help agencies achieve their goals. Health and social service agencies have too much on their agendas to pursue collaboration as a goal in itself. If it were possible to measure collaboration and the costs of collaboration, it might be possible to identify the point at which the cost outweighs the benefits. In the present state of knowledge, this is but a dream.

The answer to the question of the impact of the NHS and Community Care Act 1990 is that it made collaboration both more necessary and more difficult. It created more boundaries than it dissolved, particularly within the health service. It required tremendous organisational change, which was a great impediment to joint working by making agencies concentrate on their own structures, and by introducing new players and personalities which altered the dynamic of relationships. It made the separate cultures of health and social services even more distinct and perplexing to each other, by implementing different interpretations of the purchaser/ provider split.

The final question, about the implications of collaboration on outcomes for clients, cannot be answered within this thesis. The clients of the social worker attachment

appreciated this model of working. In the Direct Management Project, it was recognised that patients were unlikely to identify any direct benefits. Similarly, the public would probably find it difficult to point to any direct benefits of collaboration at the strategic level. It is not possible, therefore, to say whether the effective coordination of planning or integrated service delivery is more important for client outcomes. As well as any impact on client outcomes, there is also a need to identify whether collaboration leads to more cost-effective services and a more satisfying way of working for professionals.

A FRAMEWORK FOR MEASURING COLLABORATION

At the end of Chapter Four, a Framework was drawn up from the literature indicating the factors deemed to be significant to facilitate collaboration at different levels. It is worth recalling how the Framework was devised. Three of the twelve boxes arose from work by Davidson, namely those in the environment, characteristics and collaborative mechanisms columns at the Strategic level. The items listed in those boxes come from Davidson, the theoretical literature and the studies on collaboration at the strategic level. I added the other two levels (operational and practitioner) and the fourth column on collaborative attitudes. The items in these boxes were drawn from the literature relating to collaboration at the relevant level. There are gaps in the boxes at the operational level, because this was not a focus of the literature review and because there is less literature available.

The Framework was used in subsequent chapters to measure collaboration in the

different parts of the case study. This showed that many of the factors found in the literature to be desirable to promote collaboration were absent or deficient in Sunderland, though many of these factors were not within the control of the agencies locally. Such factors at the strategic level as compatible structures, accountability framework, funding and geographical boundaries were established nationally, and of these only the coterminous boundaries promoted collaboration.

At the practitioner level, the successful social worker attachments were ascribed to good preparation: agreements about how the team would work, roles and responsibilities, access to records and methods of communication. These are all elements of the columns relating to "characteristics of the team" and "collaborative mechanisms". One proposed attachment which failed did so because of a lack of preparation in these areas. Communication was important in both projects, particularly in relation to formal meetings and informal encounters. Other factors were less significant within these studies, such as joint training. Leadership was not an issue in the Social Worker Attachment, but was more problematic in the Direct Management Project. Both the social worker attachment scheme and the Direct Management Project ran aground in their later history at the operational level.

The previous section in this chapter included a discussion of the usefulness of the Framework. This section reflects on how the Framework can be developed as a result of this research, looking through the experience of the Social Worker Attachment as this covered all three levels, strategic, operational and practitioner.

The listed items in the boxes in the "environment" column are the same at all three levels. What is different is the environment in which each level is set. Strategy is developed against the backdrop of national and local politics: in this case, the development of community care policy. These are less significant for operational management, though the context of the strategic plans of the organisation is important. In other words, operational management is less concerned with an environment that calls for the development of community care policy nationally, but is involved in how community care policy will work in practice in Sunderland. At the field work level, the environment is even more local: it is about how community care will work in my/our area of responsibility. Each level is set in the context of the level above it.

The factors at the three levels of the "characteristics" column are all different, at least on the surface. This is partly due to the language employed in the literature relating to each level. For example, the form of membership of practitioners within a team is an issue of accountability, both within the team and to employing organisations. Similarly, accountability lies behind the issues of shared ownership of projects by operational management and the need for clear and explicit understanding about areas of responsibility and lines of accountability. Agreements at operational and practitioner levels about how projects will operate and how teams will work are agreements about domain, as is the issue of legitimacy at the operational level. The item on "culture in which coordination / collaboration is valued" appears in the table at the strategic and practitioner levels, but not explicitly at the operational level, though it is implied by the item on "commitment from the agencies". A collaborative

culture is also significant at the operational level, and should be included there.

What is different at the various levels is the degree of control the agencies have over the characteristics that shape them. Most of the characteristics at the strategic level are established beyond the control of the agencies. The agencies have more control to determine the characteristics of individual projects. This is not invariable. In the case of the Social Worker Attachment, the characteristics of general practice are established by the nature of the GP Contract, the long history and development of General Practice, and the domination of medicine as a profession. These are not easily influenced by collaborative ventures.

"Compatible structures" is a significant characteristic at the strategic level, and applies horizontally to the structures of the agencies. The experience of the Social Worker Attachment showed the need for compatible structures vertically within organisations. After the reorganisation of the SSD, the model of the generic social worker did not fit well with the new divisions of service. Allowance was made for this, but the tension remained. Projects need to have a clear niche within the structures of the organisation which "own" them.

Following this discussion, the factors at the different levels begin to look similar, as the revised table on the following page shows. The only item at the operational level that cannot be subsumed within the more abstract categories identified at the strategic level is clarity of purpose.

	CHARACTERISTICS OF THE ORGANISATION / PROJECT / TEAM
STRATEGIC	Compatible structures between agencies Accountability framework Domain Funding: (i) pressures, (ii) earmarked for collaboration enterprise Culture in which coordination / collaboration is valued Geographical boundaries
OPERATIONAL	Compatible structures: project / agencies Accountability: shared ownership, clear and explicit understanding of areas of responsibility and lines of accountability, agreed systems for monitoring and evaluation Domain: equal legitimacy of participating authorities is fostered and recognised, explicit and detailed agreements on funding, personnel and administrative issues Funding: common fund Culture in which coordination / collaboration is valued : Commitment from the agencies signified by stable representation from officers of an appropriate and commensurate rank Clarity of Purpose: collective aims and objectives, separate aims and objectives, focus and ambition
PRACTITIONER	Accountability: Leadership, nature of membership, e.g. attachment Domain: Leadership, clear and explicit agreements about how the team will work, shared understanding of roles and responsibilities Culture in which coordination / collaboration is valued

The items in the third column on collaborative mechanisms can also be grouped to some extent. Again, this shows that some factors are important at more than one level, but others are only significant at one level. For example, in the literature, joint training is promoted as an important means of fostering collaboration at the practitioner level. Though it is does not appear in the literature as a means of promoting collaboration at the other levels, the Department of Health and SSI are using it as a technique and I have observed several examples of training events and workshops where attendance by multi-agency teams is encouraged (e.g. SSI workshops on Children's Services Plans in 1995).

A number of items appear at the strategic level which do not appear at other levels. Of these, it is clear from this research that perceived benefits to clients should appear at the practitioner level: there was a very strong feeling among those who participated in both fieldwork projects that what mattered was the clients and working together mattered because it meant a better service for clients.

The operational management of the two fieldwork projects was probably a weak element, and the insights they offer into factors which promote collaboration at this level are limited. Both projects were steered through my own project committee¹⁰, the Primary Health Care Project Team, with some work delegated to particular groups or individuals. A separate group was set up to manage the rolling out of the Direct Management project. Thus, formal processes were in place for the management of the projects. Even if they were not particularly successful in rolling out the projects, these formal processes were probably necessary.

These projects do suggest some problems to be avoided. For example, no one person was responsible for the success of the extension of the projects. There may have been greater success had someone been given responsibility for managing the implementation of the projects. Different understandings emerged of the implications of the evaluation: for GPs, it demonstrated the value of social work in the therapeutic setting of general practice; for SSD managers, it showed that the project extended the service to people who would not otherwise receive a service, and was therefore a

¹⁰ The Social Worker Attachment had already begun when the Primary Health Care Project commenced, but once the group was in place, it assumed responsibility for the development of the project.

drain on resources. These interpretations were not made explicit to the different parties and became a barrier to progress. This reflects the importance of taking account of the expectations of different stakeholders in research¹¹, but also in project management. One major cause of dissension in rolling out the Direct Management project was funding, though this was also of some concern in the Social Worker Attachment. The LMC took the view that the evaluation had demonstrated that the model required more resources than those which existed under the former model of attachment, and would not cooperate with extending the scheme until the problem of securing adequate resources for district nursing and health visiting had been addressed. This points to two things: firstly, that projects need to be properly funded. Secondly, and more interestingly, was the use of cooperation as a bargaining tool. The GPs wanted more resources in community nursing anyway. The project gave them a tool to bargain with, and they were prepared to manipulate the situation to get what they wanted. This is related to some extent to the previous discussion on expectations. As well as the need for a shared understanding of expectations, there is a need to address the problem that stakeholders might manipulate a situation to achieve other related ends.

The items which are now added to the "collaborative mechanisms" box at the operational management level are somewhat tentative. The research points to them rather than demonstrating them. Even when the tentative nature of these items are taken into account, it does appear that something different is required at the operational level to implement and manage new projects.

¹¹ Smith and Cantley, 1985.

	COLLABORATIVE MECHANISMS
STRATEGIC	Formal processes for joint working Informal processes Authority Funding Perceived benefits to the organisations Perceived benefits for clients Costs of collaboration
OPERATIONAL	Formal processes for managing the project Funding Identified project manager Expectations are made explicit / managing the stakes
PRACTITIONER	Formal processes for joint working: records, meetings, accommodation, communication, protected time Informal processes: encounters in corridor and staff room Perceived benefits for clients Joint learning / training

The column on collaborative attitudes was not one of the categories within Davidson's typology. It was added by the researcher because of the many references to these factors in the literature¹². Collaborative attitudes are the personal responses to the culture of the organisations in which collaboration takes place. The three key collaborative attitudes found in the literature are commitment, trust and understanding of systems and processes of the participating agencies. These are also relevant to the operational level. From my own experience, the ability to see issues from the point of view of the other agency is essential for collaboration, which is an aspect of understanding. Hunter and Wistow say that entrepreneurial and networking skills are important for managing projects¹³. In my experience, networking skills are also

¹² E.g. Nocon, 1989; Hunter and Wistow, 1989; Huntingdon, 1981, p 182; Joint Working Group, 1981; Ovretveit, 1990; David Good, "Individuals, Interpersonal Relations, and Trust" in Diego Gambetta, ed., *Trust: Making and Breaking Cooperative Relations*, (Oxford: Basil Blackwell, 1988).

¹³ Hunter and Wistow, 1989, p. 16.

important at the strategic level: knowing who does what and how and being able to deal with people personally is crucial. These insights arise not so much out of the case study itself, but from six years practical experience of working at the interface between health and social services.

Equality has already been discussed in this chapter. This item only appears at the practitioner level. Following the earlier analysis and the evidence of the case study, this item should be changed to "ways to manage existing inequalities" (between professions, sexes and so on). This is in the interests of pragmatism, recognising that equality is not going to happen quickly and that individuals need to work together in spite of their differences. There is, of course, a danger here, that by developing strategies to promote collaboration even when the players are not equal, this will reinforce the inequalities. As we saw in Chapter Four, the theoretical literature acknowledged that the balance of power between agencies was not equal and that this would affect collaboration between them (see pages 110-111). There is also a need to manage the difference in power at an agency level, but this is not a matter so much of collaborative attitudes as the need for government to create the conditions which will enable agencies to work together even though power is not equally divided between them.

This discussion results in the following changes to the fourth dimension of the Framework, relating to collaborative attitudes:

	COLLABORATIVE ATTITUDES
STRATEGIC	Commitment Trust Understanding and willingness to learn Networking skills
OPERATIONAL	Commitment Trust Understanding Entrepreneurial and networking skills
PRACTITIONER	Commitment Trust Understanding: insight into systems of others, insight into one's own occupational system Ways of managing inequalities

One tension contained within the Framework is that between individual actors and corporate bodies. This does not apply so much to the column on environmental factors, as this is about external forces. The column on characteristics relates to bodies of people, but at the practitioner level, there is more room for an individual and personal response. This is also true of collaborative mechanisms. The column on collaborative attitudes is very much about the response of individuals. To some extent, this could be an artefact caused by my adding the fourth column to the table. The items within the fourth column could be subsumed within the item on culture in the "characteristics" column. However, the tension between organisational systems and individual and personal factors raises some important issues. How successful is collaboration when it takes place in a culture which promotes it but the participants play only lip service to it, compared with an environment in which the systems contain barriers to it but the participants are committed to joint working? Are both not needed if collaboration is to succeed? And if the two dimensions are not fully present, what factors are essential, and to what degree, to enable collaboration to take

place at all? These questions, which have emerged from this study, require further research. My own feeling, arising out of this research and from six years experience of working at the boundary between health and social services is that both are important. Collaboration can be constrained by deficient systems and processes and it can be limited by individual players who are half-hearted or antagonistic. It will be most effective where the culture of organisations encourages collaboration and the participants are committed to it.

This section has examined the Framework column by column and has proposed a number of changes. The whole of the revised table is set out on page 406. Whereas the first table gave the impression that different factors were necessary at the different levels, it is now clear that many factors needed at one level are also needed at another, though these abstract factors will be applied in a different way according to the context. This raises the question as to whether there is any value in looking at the different levels within the Framework. In my opinion, it is important to take account of all the levels in the Framework: firstly, because the multiple layers are important for an understanding of collaboration, and, secondly, because some factors only appear at one or two levels, and it may be that these factors are particularly important for an understanding of collaboration at that level. Further research is needed to test the robustness of the Framework and to examine the factors that are unique.

REVISED FRAMEWORK FOR COLLABORATION

	ENVIRONMENT	CHARACTERISTICS OF THE ORGANISATION / PROJECT / TEAM	COLLABORATIVE MECHANISMS	COLLABORATIVE ATTITUDES
STRATEGIC	Level of turbulence Legislation Policy co-ordination Political pressure to collaborate Economic forces Level of demand on services	Compatible structures between agencies Accountability framework Domain Funding: (i) pressures, (ii) earmarked for collaborative enterprise Culture in which co-ordination / collaboration is valued Geographical boundaries	Formal processes for joint working Informal processes Authority Funding Perceived benefits to the organisations perceived benefits for clients Costs of collaboration	Commitment Trust Understanding and willingness to learn Networking skills
OPERATIONAL	Level of turbulence Legislation Policy co-ordination Political pressure to collaborate Economic forces Level of demand on services	Compatible structures: project / agencies Accountability: shared ownership, clear and explicit understanding of areas of responsibility and lines of accountability, agreed systems for monitoring and evaluation Domain: equal legitimacy of participating authorities is fostered and recognised, explicit and detailed agreements on funding, personnel and administrative issues Funding: (i) pressures, (ii) earmarked for collaborative enterprise Culture in which co-ordination / collaboration is valued: Commitment from agencies signified by stable representation from officers of an appropriate and commensurate rank Clarity of Purpose: collective aims and objectives, separate aims and objectives, focus and ambition. Accountability: Leadership, nature of membership, e.g. attachment Domain: Leadership, clear and explicit agreements about how the team will work, shared understanding of roles and responsibilities Culture in which co-ordination / collaboration is valued	Formal processes for managing the project Funding Identified project manager Expectations are made explicit / managing the stakes	Commitment Trust Understanding Entrepreneurial and networking skills
PRACTITIONER	Level of turbulence Legislation Policy co-ordination Political pressure to collaborate Economic forces Level of demand on services		Formal processes for joint working: records, meetings, accommodation, communication, protected time Informal processes: encounters in corridor and staff room Perceived benefits for clients Joint learning / training	Commitment Trust Understanding: insight into systems of others, insight into one's own occupational system Ways of managing inequalities

THE FUTURE FOR COLLABORATION AND RESEARCH INTO COLLABORATION

In a rapidly changing environment, what is the place for collaboration between health and social services? One considerable challenge to collaborative relationships was emerging at the end of the research period with the issue about continuing care. Throughout the 1980s, the number of continuing care beds in hospitals had been run down as the number of beds in private nursing homes increased. For those without sufficient income of their own, these places had been funded by an open-ended budget in the Department of Social Security, and demand had risen exponentially. In 1993, the budget was transferred to Social Services Departments, and also became cash-limited. SSDs were required to undertake financial assessments of clients requiring publicly assisted placements in nursing homes and residential care homes, and those with the means were required to contribute towards their care. Continuing care that had once been free now had a cost to the client. Responsibility for continuing care had shifted from the health service to some extent, and, given the actual and potential resource implications, both health and social services had an interest in ensuring that the boundary moved away from them. Conflict between them was inevitable, as Whitehead had predicted¹⁴. The issue erupted when the Health Service Commissioner upheld a complaint that Leeds Health Authority had failed to provide a service to a stroke patient which meant that the patient's wife had to pay the costs

¹⁴ Margaret Whitehead, "Is it fair? Evaluating the equity implications of the NHS Reforms", in Ray Robinson and Julian Le Grand, eds., *Evaluating the NHS Reforms* (London: King's Fund Institute, 1993) pp. 208-242 (pp. 231-239).

of the nursing home¹⁵. A year later, the DoH issued guidance requiring all health authorities to set out policies for continuing health care with explicit eligibility criteria¹⁶. Though health authorities were obliged to secure local authority acceptance of the policy and criteria, there was no onus on local authorities to give it, which gave them considerable power in the negotiations. A study of collaboration in the setting of the development of continuing health care policies would make a valuable contribution to our understanding of relations between health and social services, to show whether this aspect of community care policy fanned the flames of discord between health and social services, or whether it brought to the surface fundamental problems in the relationship that already existed.

A related issue concerns the changing perceptions of the nature of health care. One aspect of health service policy not discussed in this thesis is that of changing practices in acute care and the shift towards the so-called "primary care led NHS". Hospitals are increasingly seen as providers of treatment, rather than providers of care. Changes in clinical practice have led to reduced lengths of stay in hospital, and the number of hospital beds has fallen dramatically. These changes have arisen from incremental developments and local initiatives rather than from explicit policy decisions¹⁷. There is an expectation that primary care, community health services and social services will meet the care needs of those returning home after treatment. This has considerable implications for community care. Furthermore, as Wistow

¹⁵ Health Service Commissioner, 1994.

¹⁶ DoH, 1995a, HSG (95) 8.

¹⁷ Wistow, 1995a, p. 234.

says,

the redefinition of the hospital's role as one increasingly concerned with short-term, technologically driven interventions is potentially at odds with notions of good practice in discharge, which need time to conduct holistic assessments of need and to make choices about future lifestyles and living circumstances.¹⁸

There is a need to look further at these shifting boundaries and the implications for collaboration in the care of vulnerable people in the community.

The nature of collaboration, particularly for SSDs has changed. Not only are they required to work closely with the health service, but they are also expected to work with the independent sector and groups of users and carers in planning and developing services. This issue was not addressed in this thesis, but any future study of collaboration will need to take account of this new dynamic.

The health service has always been a divided organisation, not so much a "national" health service as a federation of separate services. The social services began separately and were united by the Seebohm reforms. After the reforms of the NHS and Community Care Act and subsequent legislation, the health service is still divided, though the boundaries are now different. The purchaser/provider split has not riven the SSDs as deeply as it has the health service. However, as SSDs provide less in the way of direct care services and buy more services from independent

¹⁸ Gerald Wistow, "Coming apart at the seams", *Health Service Journal*, 2 March 1995, pp. 24-25 (p. 25).

providers, they may experience the same sort of problems in collaborating with providers that the health service experiences now. Though the mixed economy of care may have other benefits, it is a risk to collaboration, and may be worth exploring with this in mind.

Further analytical and theoretical work is also required on the levels and types of collaboration. This thesis has shown that there is a link between collaboration at different levels of health and social service. Quite a lot is known about collaboration at each level separately, though perhaps less is known about collaboration at the joint management level. Every one of the three bodies of literature has developed in isolation from the others. There is a need to integrate these separate strands, and to analyse and define the nature of the relationship among them.

New approaches to collaboration are being developed. There are even "New Age" solutions to the problem of collaboration¹⁹, which would imply that there are spiritual dimensions of the issue that have not yet been addressed in the mainstream literature.

LESSONS FROM THE RESEARCH PROCESS

Finally, there is the question of the lessons to be learned from the process of doing the research, and the implications for the researcher. If I were to be sent back to

¹⁹ M Scott Peck, *The Different Drum* (Arrow Books, 1987); *A World Waiting to be Born: The Search for Civility* (London: Rider, 1993).

1991, to the start of this research, knowing what I do now, what would I do differently? This is, of course, a false question, because the research only came about because I was employed as a researcher to evaluate a number of projects. I would not probably have chosen the Direct Management Project, but would have wanted to investigate collaboration in relation to the hospital discharge policy. On the other hand, the project did show the difficulty of collaborative relationships within the health service, which has added a richness to this study. I would have built an economic analysis into the evaluation of the Social Worker Attachment Project. That might not have had much impact on a study of collaboration, but it might have meant that the expectations of the agencies and the GPs became less elevated. One of the strange experiences of this research has been my own influence on the collaborative dynamic between the health and social services in Sunderland because of the work I was doing. The byword of this study is "I know, because I was there".

One concern expressed in the discussion of research methodology in Chapter Two was the use of evaluative studies for a different purpose from the one originally intended. In the event, this approach has been justified. The evaluation of the social worker attachment was highly favourable to the project. When it was considered in a wider context and not just as an isolated arrangement, it helped to show up fundamental difficulties in collaboration, not between individual social workers and individual GPs, but between GPs as a group and social services as a department. This analysis was assisted considerably because I was able to record the development of social worker attachment after the end of the original project. Demonstration projects do have limitations as the subjects of research: they are set up to succeed. Researchers

are advised to look beyond the project at the wider setting and, if possible, in a wider time-frame. This experience may illustrate the difference between evaluation and research. The evaluation found the attachment of a social worker to a general practice to be a successful method of joint working; the research identified considerable problems in collaboration between GPs and social services.

As far as the implications are concerned, I learnt a great deal about "doing research" and writing a sustained and coherent piece of work. As a mature part-time student with a demanding full-time job and a pair of teenage children, I may not have had the time or energy of a young scholar, but I found that skills I had learnt or acquired in life were valuable to the research and made me more efficient with the time I had: principally my typing, word-processing, time-management and organisational skills. Writing a thesis is a bit like running a small hospital, marshalling the separate elements to create a coherent and functioning whole. Above all, I learned about persistence. As for employment, I found that people were starting to label me an "academic" and assume that I was incapable of doing anything other than research and writing papers. Studying for a PhD is not necessarily an advantage in management.

MOVING TOWARDS PRAGMATIC COLLABORATION

This section draws out the key lessons of this research for different parties involved in promoting or studying collaboration. It proposes that we should aim for pragmatic collaboration, joint working that takes account of the messiness and contradictions inherent in the way health and social services - and the other bodies involved in the

delivery of community care - work. At the same time, we need to move towards bringing the structures closer together and building in incentives for joint working, so that the balance of costs and benefits in collaboration is favourable.

The main message for the Department of Health is that it must take account of its responsibility for creating the climate for collaboration. This means consideration of the implications of policy for collaboration, particularly in relation to the mixed messages that ensue from the Department. Another responsibility of the DoH is to create the structures of the organisations which then need to work together. As we have seen, the incompatibility of structures and systems impede collaboration. There is a need to adapt and alter the structures to make collaboration easier. One area of particular concern in this regard is primary care: the way general practice is structured makes collaboration very difficult, and there are few incentives for GPs to collaborate. It may be that current government initiatives in primary care²⁰ will result in some changes, though the need to encourage GPs to collaborate does not appear to be one of the aims of this process.

Similarly, the message for senior managers of health and social service agencies is that their responsibility is to create the culture in which collaboration can take place between the organisations at a local level. If there is no commitment to collaboration from the leadership, then collaboration will be limited. Creating the culture means developing an expectation that people from the different organisations will talk to each

²⁰ NHS Management Executive, *Choice and Opportunities* (London:HMSO, 1996); *Primary Care: Delivering the Future* (London:HMSO, 1996).

other about what is going on, take account of each other's interests and plan and develop services together. It means creating opportunities for joint working and clarifying processes to enable this to take place. There is a need to take account of vested interests and the ways in which projects can be sabotaged in the pursuit of these interests: in other words, political awareness is required.

This research has demonstrated the importance of looking at collaboration throughout the organisations involved, at different levels within them. Collaborative projects arise out of the context of collaboration (or lack of it) at the strategic and operational levels. When projects are established, it is important to take account of the context at different levels. The framework can be used as a guide or checklist of issues that need to be considered. Though practitioners may work well together, the long term viability of collaborative projects is dependent on collaboration at other levels.

There is a similar message for researchers here: that collaborative projects need to be considered within a wider context. There are dangers in extrapolating general policy from a successful collaborative project without an awareness of how the project fits in to the wider aims of the organisations involved and the interests of different stakeholders. This research has shown the value of being able to observe the extension of a scheme following the evaluation of the initial pilot, which led to important and revealing findings.

CONCLUSION

In this thesis, I have explored the nature and effectiveness of collaboration between the health and social services in Sunderland in the early part of the 1990s. I surveyed the problems with the concept and practice of collaboration. The research considered collaboration in the context of the NHS and Community Care Act. It described the impact of the Act on inter-agency relations. It examined projects designed to strengthen collaboration between health and social services and among different parts of the health service, and explored the circumstances which promoted or hindered it and analysed some of its problems. It concluded that a pragmatic approach to collaboration was the best way forward of working with what is possible rather than on insisting on the ideal. It was not possible to answer one of the questions set at the beginning of the research, namely whether better collaboration would make community care policies work better. There is an assumption that this is the case, but it is untested, and this research did not result in any evidence to prove or disprove it. It remains an important question, and an area in which further research would be profitable.

When I began writing this thesis, I was optimistic about collaboration. As the years went by, I became more and more despairing: collaboration was a rhetorical device, a rainbow to cross a chasm, and a rainbow with no pot of gold at that. I end this work as a pragmatist. Collaboration may save money in the long run, though this is not proven, and certainly requires initial investment. Collaboration may not be possible in its pure form, but it is necessary and can happen in some form. The

boundaries may have shifted as a result of the NHS and Community Care Act, but they are real. The bridges across them are shaky and incomplete. In some places they may only exist as precarious planks. I very much doubt that collaboration could even deliver all that has been promised for it in cost-effectiveness, satisfaction for the players and an integrated service for clients. Where it is expedient, it will happen after a fashion, if the costs are not too great. It needs to be striven for: there is a place for promoting the vision of collaboration to engender aspiration. It will happen more often where structures, cultures and values of organisations promote and encourage collaboration. This is less likely where organisations are concentrating on organisational change and are beset by increasing demands, new demands and services, financial strictures and professional rivalries and intransigence. What is hopeful is that human endeavour is a continuous process, and there will always be new insights, new research and new understanding.

INTERVIEW SCHEDULES

I JOINT PLANNING FOR COMMUNITY CARE

You've read the paper - is this an accurate representation of what took place? Is there anything missed out? Do you feel that anything has been misunderstood?

Do you have or know of any other documents which could be useful?

What do you understand when you think of collaboration in planning - how would you define it? How do you identify collaboration - how do you know when you've got it? What was your perception of the collaboration between the agencies, between individuals, that went into the process of planning for community care? How well did the agencies collaborate in developing community care policy and implementation plans? What sort of collaboration should there have been?

In your view, is collaboration an important element in planning for community care? Why? Why not? Where does it come on the scale of 'important things'?

In your opinion, what were the outcomes that emerged from the whole process of planning for community care? - What were the successes? And what were the failures, from your point of view?

There are also some specific queries:

Why were the JCPTs brought to an end? Why were they ineffective?

Did the planning system change because of community care, or would it have changed anyway?

Why was Joint Planning Group thought to be necessary?

II SOCIAL WORKER ATTACHMENT PROJECT

a. Clients/Carers Questionnaire

Subject

CLIENT / CARER

MALE / FEMALE

<65 / 65>

Referral

Did you ask to see the social worker, or were you referred by someone in the practice?

SELF / GP / HV / PRACTICE NURSE / DN / MIDWIFE / CPN/ ADMIN
/ OTHER

Were you surprised to be referred to a social worker in the practice? YES / NO

Were you happy to see a social worker? YES / NO

Seeing the Social Worker

Why did the social worker see you?

DON'T KNOW

BECAUSE THE DOCTOR/NURSE THOUGHT IT WAS A GOOD IDEA
PROBLEM RE

Did you find the social worker helped you? YES / NO

If not, what do you think was the reason for this?

COULDN'T GET ME WHAT I WANTED

PROBLEM TOO BIG

DIDN'T LIKE HER

DIDN'T WANT A SOCIAL WORKER INVOLVED

OTHER

If so, how was she helpful?

TALKING OVER WORRIES

AIDS / ADAPTATIONS

FINANCIAL / MATERIAL PROBLEMS / ADVICE

COORDINATING SERVICES

OTHER

Was there any difference for you in seeing the social worker rather than the doctor or nurse?

Was there any specific help that the social worker was able to offer that was different from the doctor or nurse?

TALKING OVER WORRIES

AIDS / ADAPTATIONS

FINANCIAL / MATERIAL PROBLEMS / ADVICE

COORDINATING SERVICES

OTHER

If there wasn't a social worker in the practice, where would you have gone to resolve your problems?

AREA SOCIAL WORKER

HOSPITAL SOCIAL WORKER

ADVICE CENTRE

DSS

FAMILY / FRIENDS

DISTRICT NURSE

PRACTICE NURSE

HEALTH VISITOR

GP

LOCAL COUNSELLOR

NOWHERE

OTHER

Understanding of Social Work

What did you know about the work of social workers before?

Do you feel that you have a better understanding of social workers now? YES / NO

If you had difficulties in the future which you thought a social worker could help with, would you feel happy about seeing a social worker again? YES / NO

Comparing Practice / Other Social Worker

Have you seen a social worker in the past? YES / NO

Where?

What did that social worker do for you?

Was there any difference in seeing the practice social worker?

SPEED

ACCESSIBILITY

RESULTS

WIDER RANGE OF SERVICES

MEMBER OF KNOWN TEAM

STIGMA

Do you think there are any advantages or disadvantages to having a social worker in the practice?

ADVANTAGES

DISADVANTAGES

Information

Did you get sufficient information from the social worker about what was happening? YES / NO

Carers

Do you feel that your needs as a carer were taken into account?

YES / NO

If not, why not?

Comment

Are there any other comments you would like to make about seeing the social worker in the practice?

b. Practice Members' Questionnaire

Referrals

[The questions in this section were applied to 5 cases for each referrer]

What did you expect the social worker to do in response to the referral you made?

If the social worker hadn't been there, how would you have dealt with the case?

Did you feel that the involvement of the social worker helped the situation?

Did the client receive: a more comprehensive package of care
 a more integrated service
 a broader range of services
 other

because of the social worker involvement?

What sort of feedback did you receive on the progress the social worker made with your referrals? Was it sufficient? What sort of feedback do you want and how do you want to receive it?

Did the patients give you any feedback following their referral to the social worker? What did they feel about it (scale 1 [unhappy] - 10 [ecstatic]).

Were there any situations where you made a conscious decision not to refer to the social worker? To whom did you refer the patient?

Social Worker Attachment

Are there any areas of work that the social worker might have been involved in if the project had lasted more than 6 months?

What were the positive features of social worker attachment?

What were the negative features of social worker attachment?

Did having the social worker in the practice save you time?

Would you like to see social worker attachment as a permanent feature of the practice?

If another practice was interested in social worker attachment, what advice would you give them about arranging this within the practice?

Perceptions and Experiences of social services

Were there any notable problems or benefits in referring patients to social services before the practice attachment?

Did having an attached social worker rectify these, or create other problems?

What did you think social workers did before the project?

Has your perception/understanding changed as a result of the project?

Any other comments?

III. DIRECT MANAGEMENT PROJECT

a. Pre-Project Questionnaire

Do you feel that you are part of a 'primary health care team'?

Could you tell me what you define as a primary health care team?

Who is in your team? (Anyone else?)

How do you regard relationships between members of the primary health care team now?

Who would you say make the policy decisions in your team? Why do you say that? Is that the case most of the time? (If not, who else?) How do you feel about that?

Can you give me a specific example of a time when the team really worked well together? Tell me about it.

Can you give me a specific example of a time when you felt the team was not working? Tell me about it.

Do you ever discuss your work with:

GPs	District Nurses
Practice Nurse	Health Visitors
Practice Manager	Admin staff
Other (who?)	

Do you ever discuss the work of:

GPs	District Nurses
Practice Nurse	Health Visitors
Practice Manager	Admin staff
Other (who?)	

with them?

[QUESTIONNAIRE ON TEAM FUNCTIONING - see below]

District Nurses and Health Visitors only ...

How long do you spend on the practice premises each week? How long do you spend in the practice when you know the GPs are there?

How often would you expect to meet the GPs at:

Practice meetings

Ad hoc meetings to discuss referrals

Ad hoc meetings to discuss ongoing patients

Chance meetings (in the corridor/staff room)

When you are discussing a patient with the GP, who usually makes the decision about the future management?

GP / Self / Both / depends on the circumstances of the case

Do you ever have concerns about tasks you are required to carry out? How would you deal with these concerns?

General Practitioners only ...

How often would you expect to meet the HVs at:

Practice meetings

Ad hoc meetings to discuss referrals

Ad hoc meetings to discuss ongoing patients

Chance meetings (in the corridor/staff room)

How often would you expect to meet the DNs at:

Practice meetings

Ad hoc meetings to discuss referrals

Ad hoc meetings to discuss ongoing patients

Chance meetings (in the corridor/staff room)

When you are discussing a patient with the HV, who usually makes the decision about the future management?

GP / Self / Both / depends on the circumstances of the case

When you are discussing a patient with the DN, who usually makes the decision about the future management?

GP / Self / Both / depends on the circumstances of the case

b. Mid-Project Questionnaire

After 5-6 months of the Directly Managed Staff Project, what do you think are the benefits of this kind of working?

What are the drawbacks/problems?

Has your role changed over the last six months as a result of the scheme? In what way?

Have you noticed that the quality of service improved at all? In what way?

Can you think of any examples of patient care where the pilot has meant that things worked better, or worse?

How do you regard relationships between members of the primary health care team now? Have they improved or deteriorated over the six months? In what way? Is this because of the pilot or are there other factors involved?

Can you give me a specific example of a time when the team really worked well together? Tell me about it.

Can you give me a specific example of a time when you felt the team was not working? Tell me about it.

Research has shown that primary health care teams work in different ways. Which of the following statements best describes your team?

- A. Members of our team work independently and do not need or get the opportunity to meet, talk or write to one another.
- B. Members of our team sometimes meet, phone or correspond to discuss problems, but generally work independently.
- C. Members of our team meet regularly (either at meetings or informally), and keep other members informed about their work.
- D. Members of our team meet regularly, discuss referrals and share information about patients, occasionally share the care of patients, and generally have the same objectives in relation to their work.
- E. Members of our team meet often (both at meetings and informally), discuss referrals and share information about patients, sometimes share the care of patients, have common agreed objectives, and support each other in their work.
- F. Other (Please State):

In general, how do you feel about the way the primary health care team is working?

Very satisfied

Satisfied

Neither satisfied nor unsatisfied

Unsatisfied

Very unsatisfied

[QUESTIONNAIRE ON TEAM FUNCTIONING - see below]

General Practitioners only ...

How often would you expect to meet the HVs at:

- Practice meetings
- Available in common room at known time
- Chance meetings (in the corridor/staff room)
- Other:

How often would you expect to meet the DNs at:

- Practice meetings
- Available in common room at known time
- Chance meetings (in the corridor/staff room)
- Other:

When you are discussing a patient with the HV, who usually makes the decision about future management?

GP / HV / Both / depends on the circumstances of the case

When you are discussing a patient with the DN, who usually makes the decision about future management?

GP / HV / Both / depends on the circumstances of the case

Do you ever make comments to the HVs about their work?

Do you ever make comments to the DNs about their work?

Do you ever make comments to the PN about her work?

What does it mean for you to manage district nurses and health visitors? What has been your role in relation to:

- Day to day management of staff
- Child protection (health visitor)

In what other ways has the project affected you or the practice?

What outcome would you like to see for the project?

Are there any other comments you would like to make about the project?

District Nurses and Health Visitors only ...

How long do you spend on the practice premises each week?

How long do you spend in the practice when you know the GPs are there?

How often would you expect to meet the GPs at:

Practice meetings

Ad hoc meetings to discuss referrals

Ad hoc meetings to discuss ongoing patients

Chance meetings (in the corridor/staff room)

When you are discussing a patient with the GP, who usually makes the decision about the future management?

GP / Self / Both / depends on the circumstances of the case

Do you ever make comments to the GPs about their work?

Do you ever have concerns about tasks you are required to carry out? How would you deal with these concerns?

What does it mean for you to be managed by GPs? What has been their role in relation to:

Day to day management of staff

Child protection (health visitor)

In what other ways has being managed by GPs affected you or the way you work?

What outcome would you like to see for the project?

Are there any other comments you would like to make about the project?

c. Final Questionnaire

How has the Project been going since I last spoke to you?

After 11-12 months of the Directly Managed Staff Project, what benefits of this kind of working have you noticed recently?

What drawbacks/problems are you experiencing now, as a result of the project?

Has your role changed over the last twelve months as a result of the scheme? In what way?

Has the quality of service changed at all? In what way?

Can you think of any other examples of patient care where the pilot has meant that things worked better or worse?

How do you regard relationships between members of the primary health care team now? Have they improved or deteriorated over the six months? In what way? Is this because of the pilot or are there other factors involved?

Can you give me a specific example of a time when the team really worked well together? Tell me about it.

Can you give me a specific example of a time when you felt the team was not working? Tell me about it.

Overall, what is your verdict on the project?

Would you recommend this model of working to another practice / GP / DN / HV?

What advice would you give to another practice / GP / DN / HV wanting to set up a scheme? What are the features that would make it successful?

AND NOW, I'S LIKE TO ASK SOME QUESTIONS ABOUT TEAMWORK.

Do you feel that you are part of a 'primary health care team'?

In the first round of interviews, I asked people who was in their primary health care team. It was clear the people regarded membership of the team in different ways: core members, members of the wider team, people who ought to be members, and people who used to come to meetings. How would you categorise these people?

	CORE TEAM	WIDER TEAM	OUGHT TO BE MEMBER	USED TO BE A MEMBER	NOT A MEMBER
GPs					
District Nurses					
Health Visitors					
Practice Nurse					
Receptionists					
Practice Manager					
Midwife					
CPN					
Terminal Care / Macmillan Nurse					
Social Worker					
School Nurse					
Clergy					
Dietitian					
Chiropodist					
Pharmacist					
Counsellor					
Voluntary Agencies					
Psychologist					
Bath Nurse					
Home Help					
Cleaner					
Other:					
Other:					

Research has shown that primary health care teams work in different ways. Which of the following statements best describes your team?

- A. Members of our team work independently and do not need or get the opportunity to meet, talk or write to one another.
- B. Members of our team sometimes meet, phone or correspond to discuss problems, but generally work independently.
- C. Members of our team meet regularly (either at meetings or informally), and keep other members informed about their work.
- D. Members of our team meet regularly, discuss referrals and share information about patients, occasionally share the care of patients, and generally have the same objectives in relation to their work.
- E. Members of our team meet often (both at meetings and informally), discuss referrals and share information about patients, sometimes share the care of patients, have common agreed objectives, and support each other in their work.
- F. Other (Please State):

In general, how do you feel about the way the primary health care team is working?

- Very satisfied
- Satisfied
- Neither satisfied nor unsatisfied
- Unsatisfied
- Very unsatisfied

[QUESTIONNAIRE ON TEAM FUNCTIONING - see below]

Are there any other comments you would like to make about the project?

QUESTIONNAIRE ON TEAM FUNCTIONING¹

Thinking in more detail about the way your team functions, please could you answer these questions (circle or tick the number which best represents how you feel about the team):

A. To what extent do I feel a real part of the team/

1	2	3	4	5
Completely a part all the time	A part most of the time	On the edge, sometimes in, sometimes out	Generally outside, except for one or two short periods.	On the outside, not really a part of the team

B. How safe is it in this team to be at ease, relaxed and myself?

1	2	3	4	5
I feel perfectly safe to be myself; they won't hold mistakes against me.	I feel most people would accept me if I were completely myself, but there are some I am not sure about.	Generally, you have to be careful what you say or do in this team.	I am quite fearful about being completely myself in this team.	A person would be a fool to be his/herself in this team.

C. To what extent do I feel "under cover", that is, have private thoughts, unspoken reservations, or unexpressed feelings and opinions that I have not felt comfortable bringing out into the open?

1	2	3	4	5
Almost completely under cover	Under cover many times.	Slightly more free and expressive than under cover	Quite free and expressive much of the time	Almost completely free and expressive.

D. How effective are we, in our team, in getting out and using the ideas, opinions and information of all team members in making decisions?

1	2	3	4	5
We don't really encourage everyone to share their ideas, opinions and information with the team in making decisions.	Only the ideas, opinions and information of a few members are really known and used in making decisions.	Sometimes we seek the views of most members before making decisions and sometimes we disregard most members.	A few are sometimes hesitant about sharing their opinions, but we generally have good participation in making decisions.	Everyone feels his / her ideas, opinions and information are given a fair hearing before decisions are made.

¹ See Pearson, forthcoming, and Dyer, 1987.

- E. To what extent are the goals the team is working towards understood and to what extent do they have meaning for me?

1	2	3	4	5
I feel extremely good about the goals of our team.	I feel fairly good but something are not too clear or meaningful.	A few things we are doing are clear and meaningful.	Much of the activity is not clear or meaningful to me.	I really do not understand or feel involved in the goals of the team.

- F. How well does the team work at its tasks?

1	2	3	4	5
Coasts along, makes no progress.	Makes little progress, most members working to own agenda.	Progress is slow, spurts of effective work.	Above average in progress and pace of work.	Works well, achieves definite progress.

- G. Our planning and the way we operate as a team are largely influenced by:

1	2	3	4	5
One or two members.	A small group of members.	Shifts from one person or small group to another.	Shared by most of the members, some left out.	Shared by all members of the team.

- H. What is the level of responsibility for work in our team?

1	2	3	4	5
Each person assumes responsibility for getting work done.	A majority of members assume responsibility for getting work done.	About half assume responsibility, half do not.	Only a few assume responsibility for getting work done.	Nobody (except perhaps one) really assumes responsibility for getting work done.

- I. How are differences or conflicts handled in our team?

1	2	3	4	5
Differences or conflicts are denied, suppressed, or avoided at all costs.	Differences or conflicts are recognised, but remain mostly unresolved.	Differences or conflicts are recognised and some attempts are made to work them through by some members, often outside team meetings.	Differences and conflicts are recognised and some attempts are made to deal with them in our team.	Differences and conflicts are recognised and the team usually works through them satisfactorily.

COMMUNITY CARE - POLICY AND GUIDANCE
SELECTED LIST : DECEMBER 1986 - SEPTEMBER 1995

Audit Comm.	Making a Reality of Community Care	Dec 86
Nat Audit Of	Community Care Developments	Oct 87
R Griffiths	Community Care: Agenda for Action	Feb 88
DoH	Caring for People	Nov 89
CI (90) 3	Care in the Community	Jan 90
CI (90) 20	All Change - From Hospital to Community Care	Oct 90
DoH	Comm. Care in the Next Decade & Beyond	Nov 90
SSI	Assessments Systems and Community Care	May 91
DoH	Care Management & Assessment	Jun 91
LAC (91) 12	Getting the Message Across	Jun 91
EL (91) 81	Progress Review Issues for SSI/RHAs	? Jul 91
LAC (91) 16	Secretary of State's Direction - Section 46 of the NHS & Community Care Act 1990: Community Care Plans	Sep 91
LAC (91) 14	Health-Related Social Work. NHS and Local Authority Collaboration - Provision of NHS services to Local Authorities and of health-related social work services to the NHS	Oct 91
LAC(91)19	Specific Grant for the development of social care services for people with a mental illness	Nov 91
DoH	Training for Community Care: A Joint Approach	91month?
Audit Comm.	Community Care: Managing the Cascade of Change	Feb 92
EL (92) 13	Implementing Caring for People	Mar 92
BMA	What's Happening to Community Care?	Jul 92
LAC(92)12	Housing and Community Care	Sep 92
EL (92) 65	Implementing Caring for People	Sep 92
FDL 92/83	Care in the Community / Caring for People	Oct 92
DoH	Press release: Virginia Bottomley announces government support for Community Care	Oct 92
EL (92) 42	Health services for people with learning disabilities (mental handicap)	Oct 92
LAC(92)15	Social care for adults with learning disabilities (mental handicap)	Oct 92
EL (92) 67	Memo. on the Financing of Comm. Care arrangements after April 1993 and on individual choice of res. accom.	Oct 92
FDL(92)83	Care in the Community/Caring for People	Oct 92
BMA	GPs & Community Care	Oct 92
EL (92) 82	Community Care Special Transitional Grant	Nov 92
HSG(92) 43	Health Authority payments in respect of Social Services functions	Nov 92
DoH	Implementing Community Care: Getting it Together: Strategies for Implementation	Nov 92
LASSL(92)12	Community Care - Special Transitional Grant Conditions and Indicative Allocations	Dec 92
LAC (92) 21	Social Services Training Support Programme : Financial Year 93/94	Dec 92
CI (92) 34	Implementing Caring for People: Assessment	Dec 92
HSG(92)50	LA contracts for residential & nursing home care: NHS aspects	Dec 92
HSG(92)54	DHA consent to people entering nursing homes with LA financial support	Dec 92
LAC(93)4	Community Care Plans (Consultation) Directions 1993	Jan 93
FHSL (93) 9	General Practitioners and "Caring for People"	Feb 93
CI (93) 5	Community Care Plans: a preliminary analysis of a	Feb 93

	sample of English Community Care Plans	
EL (93) 18	Implementing Caring for People	Mar 93
EL (93) 21	Community care - arrangements for people in independent sector residential care and nursing homes on 31 March 1993	Mar 93
EL (93) 22	Implementation of Caring for People - Communications	Mar 93
EL (93) 48	Community Care Implementation & Monitoring	May 93
DoH	Training for the Future: Training and Development Guidance to support the implementation of the NHS and Community Care Act 1990 and the full range of community care reforms.	May 93
CI (93) 36	Community Care - Informing Users and Carers	Dec 93
EL (93) 119	Community Care	Dec 93
NHSME	A Study of Hospital Discharge Arrangements - Report by Nuffield Institute	Jan 94
DoH	First Impressions; enclosing 6 reports: Analysis of a Sample of Community Care Plans, Special Study of Purchasing and Contracting, Implementing Comm. Care for Younger People with Physical and Sensory Disabilities, Mental Health Services, Assessment, 31 December Agreements	Feb 94
LAC(94) 12	Community Care Plans (Independent Sector Non-Residential Care) Direction 1994.	Mar 94
EL (94) 57	Community Care Monitoring for 1994/95	Jul 94
DoH	Impressions of the First Year; enclosing 7 further Special Study reports: The Role of the GP and Primary Healthcare Team, Community Care Packages for Older People, Care Management, 'It's our Lives', Training and Development, Community Care for People with HIV and AIDS, Residential Care Decisions.	Jul 94
DoH	4 further reports: The F Factor, Social Care Markets, Home and Away, Care Management	Nov 94
DoH	Housing and Homelessness	Nov 94
SSI	Moving On: Report of the National Inspection of Social Services Department Arrangements for the Discharge of Older People from Hospital to Residential or Nursing Home Care.	Jan 95
HSG (95) 8 / LAC (95) 5	NHS Responsibilities for Meeting Continuing Health Care Needs	Feb 95
EL (95) 39	Community Care Monitoring : Report of 1994 National Exercises	Mar 95
HSG (95) 45	Arrangements between health authorities and NHS Trusts and private and voluntary sector organisations for the provision of community care services	Sept 95

HEALTH AND SOCIAL CARE SERVICES

IN THE COMMUNITY

INTRODUCTION

This section sets out the health and social care services available in the community in Sunderland in the early 1990s.

Use is made in this account of Health Service Indicators. These are comparative data, published by the Department of Health, which enable comparisons to be made with performance regionally and nationally. This means, for instance, that the performance of Sunderland FHSA is compared with that of all 96 FHSAs in England and Wales. For any indicator, all the FHSAs are ranked from lowest to highest on a percentage basis. Health Service Indicators are particularly useful in indicating "outliers", which are the local statistics occurring within the top or bottom twenty per-cent of the range. These are the areas where the local figures are at greatest variance with the norm. Though there may be good reasons for this, they help to show the areas which may warrant further investigation.

FAMILY PRACTITIONER SERVICES

General Medical Practice

GPs provide a general medical service to the community, including diagnosis, treatment, referral to specialist care, rehabilitation, management of chronic sickness and terminal illness, and ill-health prevention. On 1 October 1993, there were 142 General Practitioners in Sunderland, working in 53 practices. On the whole, practices in Sunderland were relatively small in terms of the number of doctors: 45% of practices had 2 or 3 doctors. Only a small percentage (15.5%) of Sunderland doctors were female, which was substantially less than the percentage of women GPs in England (28%) and in the Northern Region (26%) at 1 October 1992¹. A significantly greater proportion of Sunderland doctors (33%) was born in India, Pakistan, Sri Lanka and Bangladesh than in the Northern Region (13%) or England (16%), with a correspondingly lower proportion of doctors born in Great Britain².

The United Kingdom has a unique system which ensures (almost) universal access to medical care, by which nearly everybody is registered with a GP. Only a small proportion of the population is not registered - homeless people, travellers, and some people who have moved home recently. The average number of patients on a doctor's list varies throughout the country. Though the average list size had been declining for many years, Sunderland GPs had more patients per doctor than in the Northern Region

¹ Department of Health, 1993e, Table E&W01 R01.

² Department of Health, 1993e, Table E&W05 R01.

or the country as a whole (Table C.i). Sunderland's position relative to the Region and England and Wales became worse in 1993. Difficulties in recruiting GPs to Sunderland continued during 1994 and 1995, so that by 1996, Sunderland was the most under-doctored area in the country³.

TABLE C.i: AVERAGE NUMBER OF PATIENTS PER GENERAL PRACTITIONER, COMPARING SUNDERLAND WITH NORTHERN REGION AND ENGLAND AND WALES (As at October 1st)⁴

	No. GPs	Average List Size	Average for Region	Average for E & W	% S'land over Region	% S'land over E & W
1981	125	2,402	2,237	2,145	7.4%	12%
1983	130	2,233	2,137	2,108	4.5%	5.9%
1985	135	2,212	2,076	2,059	6.6%	7.4%
1987	146	2,086	2,002	2,010	4.2%	3.8%
1989	145	2,094	1,945	1,971	7.7%	6.2%
1991	143	2,043	1,895	1,947	7.8%	4.9%
1993	142	2,115	1,878	1,892	12.6%	11.8%

The 1990 GP Contract led to a significant increase in the number of practice nurses, practice managers and administrative staff employed by GPs, though there were still fewer than in other parts of the country.

³ John Hacking, "Weight watchers", *Health Service Journal*, 2 May 1996, pp. 28-30.

⁴ Figures from Sunderland FHSA; DHSS, *Statistical Bulletin on General Medical Practitioners in England and Wales 1976-1986*, FPCL 135/88 7 October 1988, and for 1977-1987, FPCL 154/89 7 September 1989; NHS Management Executive, *General Medical Services Basic Statistics, 1 October 1989*, and *1 October 1991*; Central Statistical Office, *Regional Trends*, volumes 18, 20, 22, 24, HMSO.

During the period, Sunderland had eleven health centres, which accommodated a total of 31 general practices and four branch surgeries as well as a range of community health services. The oldest of these health centres was opened by Aneurin Bevan in 1955, and was the eighth health centre to be opened in Britain after the NHS began. The number of health centres in Sunderland was unusually high. For this reason, GPs in Sunderland were slow to make use of the cost rent scheme to build their own premises; the first practice to move into its own premises did so in 1985. By 1994, 14 practices had purpose-built premises, another two were planned, and a further eight had made substantial improvements to their main or branch surgeries. Thus, 40% of practices had new or improved surgeries and 58% were based in health centres. No practices in Sunderland were accommodated in premises regarded as being below minimum standards⁵ as defined in "the Red Book" which sets out the terms of contracts with GPs⁶. The standard of practice accommodation was, therefore, good when compared with other inner city areas. Nevertheless, the surgeries were often too small for the amount of activity taking place in general practice and the numbers of staff included in the Primary Health Care Team (PHCT).

⁵ DoH, *Health Service Indicators 1991/92*, Computer package, XM98.

⁶ Department of Health, *Statement of Fees and Allowances payable to General Medical Practitioners in England and Wales*, § 51.10. Minimum standards include:

- (a) ease of access to and within premises;
- (b) properly equipped treatment room;
- (c) access to toilet and washroom facilities;
- (d) adequate internal waiting areas;
- (e) premises are clean and in good repair;
- (f) adequate security for records, prescription pads, drugs;
- (g) where minor surgery is undertaken, the premises and equipment should be adequate.

The number of practices with computer systems had increased steadily from 65% in 1991 to 79% in 1994⁷.

Only five practices were recognised as training practices, with accreditation to take on GP trainees. GP trainees are fully trained doctors learning the specialty of general practice. Practices could only be accredited for training if they reached certain standards.

Other Family Health Services

The GP surgeries had good access to pharmacies, which offered a range of services in addition to dispensing prescriptions. These additional services included pregnancy testing, the supply of oxygen equipment, the visiting of residential homes, participation in the needle exchange scheme, though not all pharmacies provided all services.

The Health Service Indicators show that the number of prescriptions and the cost of prescriptions was very high, with Sunderland ranked at 91 and 99 respectively⁸ among the highest prescribing areas, though it was General Medical Practitioners who influenced this figure rather than pharmacists themselves.

The number of dentists in Sunderland was low for the size of population and was the

⁷ Sunderland Health Commission, IM&T Department, Personal communication, 1994.

⁸ DoH, *Health Service Indicators 1991/92*, computer package, XP43 and XP03.

second worst in the Region⁹. The addition of 26 dentists would have been required to enable parity with England and Wales¹⁰. Special schemes to enable dentists to start or extend practices in areas of need had limited success. Dental health in Sunderland was poor. A smaller proportion of children were registered with a dentist; the number of children considered dentally fit on registration was low¹¹; and the number of older people registered for continuing care was also low. Sunderland had the highest number of tooth extractions in the country. 34% of dental patients received exemption or some remission from charges, compared with 26.4% in the Northern Region and 23.2% in England and Wales. Only 12 other areas (of 98 in total) had a higher proportion of patients receiving help with charges.¹²

The number of opticians was also low. The Health Service Indicators rank Sunderland 13 for the ratio of opticians to the population, though this ranking has gone up from an even lower level (5) in the 1989/90 Indicators¹³. The number of sight tests in children was low¹⁴. However, expenditure on the General Optical Service was high,

⁹ C L Carmichael, "A 10-year comparison of General Dental Service care in the Northern Region 1979-1989", *British Dental Journal*, August 10/24 1991, pp. 97-101.

¹⁰ *Ibid.*

¹¹ DoH, *Health Service Indicators 1991/92*, computer package, XD50.

¹² Dental Data Services, *GDS Annual Statistics, Adult Treatment April 1992-March 1993*, Dental Practices Board, July 1993.

¹³ DoH, *Health Service Indicators 1991/92*, computer package, XE21.

¹⁴ DoH, *Health Service Indicators 1991/92*, computer package, XE42.

with Sunderland being ranked at 81¹⁵.

COMMUNITY HEALTH SERVICES

Community health services are predominantly nursing services, but also some medical, paramedical and support services which are provided in the community. Until 1974, most of these services were provided under the aegis of the Local Authority, but then came under Health Authority control. They have tended to be the "cinderella" services, with less visibility and political clout than the more exciting acute hospital services.

However, these were the very services that needed to be built up if the aspiration to provide care in the community was to become a reality.

In this account of community services in Sunderland, the services have been grouped by clientele or by type of service offered: services for children, for women, for people with learning disabilities or mental illness, older people and terminal care, paramedical services, equipment services, and community outreach services. Numbers of staff have been given where possible. However, some figures relate to funded establishments, while others are staff in post. The NHS Trusts in Sunderland also provide services to Seaham and Murton, and staff working in these towns are included in the figures.

Services for Children

Child Health Service: The Child Health Service incorporated a number of elements:

¹⁵ DoH, *Health Service Indicators 1991/92*, computer package, XE01.

- pre-school service, including community child health surveillance through the clinical medical officers and the vaccination and immunisation programme
- school health (medical checks, vaccination and immunisation, health promotion)
- the child development unit (which assesses special needs and provides therapy)
- specialist nursing, including paediatric liaison and child protection

The demands on the service were changing as the responsibility for child health surveillance shifted towards general practice. In 1994, the community service still carried out 30% of child health clinics and 25% of vaccination and immunisation uptake.

Health Visiting: Most health visitors provided a visiting and child surveillance service to young families. Most health visitors were attached to general practices, and worked mainly with patients registered with the practice. Some health visitors had special roles, such as working with the Child Development Unit, the Bangladeshi community, or Pennywell Neighbourhood Centre.

In the Northern region, there were 2.2 health visitors (health visitors and school nurses) per 10,000 population in 1992¹⁶. The 1993 rate for Sunderland is 2.01 (health visitors only).

¹⁶ Central Statistical Office, *Regional Trends 29*, HMSO, 1993, table 7.22, p. 106.

Services (mainly) for Women

Family Planning: The community Family Planning Service provided a district-wide service offering contraception, well woman clinics, psychosexual counselling, vasectomy counselling, young person's advisory clinic, domiciliary service, post-termination contraceptive counselling and cervical cytology. The Sunderland service was unusually extensive, with 23 - 25 clinics are held each week, making family planning available somewhere in Sunderland from 8.30 am to 8.00 pm each week day and Saturday mornings. Since the 1990 GP Contract, more family planning was carried out in general practice, which made it necessary to review the way the service was provided overall. There was also a recognition that the needs of young people were not met adequately.

Community Midwifery: Community Midwives provided a service to pregnant women and very new mothers, holding antenatal clinics in GP surgeries and visiting new mothers at home until the baby was ten days old. A named midwife worked with each practice. A midwife was always available on-call, 24 hours a day.

Services for People with Learning Disabilities or Mental Illness

Community Nurses Learning Disabilities: This service provided care for people with learning disabilities who lived in the community. Their role had changed from undertaking treatment plans to proactive involvement in health care. Their work included:

- Helping people with learning disabilities to gain access to mainstream health care - encouraging them to make use of the services they needed, accompanying them to hospital/clinics
- Running clinics to carry out health screening
- Advising professionals in the mainstream health services on how to handle individual clients (e.g. feeding)
- Flexi Day Care Service - to help people with "challenging behaviours" to use facilities in the community and empower them to have some control over their lives. The Sunderland service was recognised as being particularly good.
- Some residential care.

Community Psychiatric Nursing: There are three parts to the CPN service:

(1) Acute/Rehabilitation

The CPNs worked with clients aged 16 - 64 suffering from the residual effects or onset of mental illness, or experiencing the disabling or distressing effects of mental health problems or critical life events. They also targeted positive mental health education to known risk groups. This service made around 17,600 contacts with clients in a year.

(2) Elderly Mentally Ill

One team of CPNs provided support to the elderly living at home who are under the care of a consultant psychogeriatrician. This service made around 8,000 contacts a year.

(3) Community Addiction Team

The Community Addiction Team provided a specialist, multi-disciplinary service to clients with problems related to substance abuse and their families. This service made over 8,000 client contacts a year.

The CPNs were not attached to general practice in the way that district nurses and health visitors did, but worked geographically in professional teams. They sometimes attended practice meetings.

The number of CPNs in England tripled between 1981 and 1991. There were 0.78 CPNs per 10,000 population in England in 1991 and 0.65 in the Northern Region¹⁷. In Sunderland in 1994, there were 0.94 CPNs per 10,000 (G and H grades). It is not clear whether this indicates that Sunderland is better served with CPNs, or whether it is part of the general trend of increasing numbers of CPNs and the difference is due to the span of dates.

Clinical Psychology: There are four sections within this department, representing the client groups it served: adult health, learning disabilities, older adults and child and family.

- The adult service took referrals from consultants (acute medical and surgical specialties as well as Psychiatry) and GPs. The service was over-subscribed. It could take 370 new patients a year, but the demand for the service was much

¹⁷ Central Statistical Office, *Regional Trends* 28, HMSO, 1993, p. 79.

greater. The demand was regulated by the waiting list: if it was too long, doctors did not refer. The service saw patients with long-term, complex anxiety problems, behavioural problems, eating disorders, chronic pain, sleep problems, depressions, problems relating to sexual abuse. Patients were usually seen for 6 - 9 appointments, and the section made over 2,600 total contacts a year.

- The service for people with learning disabilities worked mainly with staff in specialist services who supported the client group, but also provided a service directly to clients, individually or in groups, and their families and carers. The service addresses psychological problems arising from the learning disability, challenging behaviours, problems of anxiety or low self-esteem, and interpersonal problems. This section saw around 150 new patients a year, with over 1,500 total contacts.
- The service for older adults saw 140 new patients a year, with over 500 total contacts.
- The child and family service saw 130 new patients and made nearly 600 total contacts in a year.

Services for Older People and Terminal Care

District Nursing: The District Nurses cared for patients in their own homes and provided a treatment room service in health centres and some GP surgeries. There

were two parts to the service: the day-time service and the evening service. Both operate 7 days a week. The day-time district nurses are attached to general practices, and work mainly with patients registered with the practice. The evening service, which is available until midnight, covers the whole district.

In the Northern region, there were 2.92 district nurses (grades G-I) per 10,000 population in 1992¹⁸, which was higher than any other English region. The 1993 rate for Sunderland is 2.22. Though this was lower than the 1991 regional rate, it was higher than the rate for England.

Marie Curie Nurses: This service provided nursing support to patients who were dying of cancer, mainly during the night, but occasionally during the day.

Paramedical Services

Chiropody: The Chiropody Department provided a district wide foot care service to the elderly, children, diabetics and people with disabilities. Clinics were held in health centres, hospitals, and social services establishments, and a domiciliary service was also provided. Some sessions were also held alongside general practice diabetic clinics. Sunderland spent more on chiropody per head of population than the national average.

Dietetics: In addition to providing a dietetic service within the hospitals, a new

¹⁸ Central Statistical Office, 1993, p. 106, table 7.22.

service was developed during the research period whereby dietitians worked in general practices, mainly alongside diabetic clinics, but also providing a general service to people with obesity or requiring dietary advice because of a medical condition. GPs could also refer directly to the hospital service.

Occupational Therapy: Very little community Occupational Therapy was provided by the health service. A half-time community paediatric occupational therapist worked in the Child Development Unit, schools and patients' homes. A full-time Community Liaison OT worked with adults in their own homes. This post was originally funded through Joint Finance to provide a liaison between occupational therapists in the hospital service and in social services. The Community Liaison OT worked with people who were temporarily disabled (for instance, following orthopaedic surgery), people who were elderly and frail, people who had been discharged from hospital because they were medically fit but still had social needs, and also provided OT support for palliative care. It had been envisaged that the worker would carry out therapeutic treatment in the home (for instance, with stroke patients), but the demand for this was so great that very little of the need could be met. The worker aimed to provide safety on discharge from hospital.

Physiotherapy: The physiotherapy service included the hospital physiotherapy departments, which accepted open access referrals from GPs and an outreach service at a Health Centre. In addition, there was a community service for adults providing a service to MS sufferers, domiciliary physiotherapy and support in the event of crises of mobility, Spastics Society workshops and adults with learning disabilities. The

paediatric community physiotherapy service worked in schools, nurseries, children's centre clinics, child development unit and patients' homes.

Speech Therapy: This department offered a speech therapy service to patients in hospital (mainly adults) and to clients in the community (mainly children) with communication difficulties. Sessions were held in health centres, schools and hospitals throughout the district. The District Audit Service found the speech and language service to be "well-managed but poorly resourced"¹⁹. Sunderland had the lowest staffing ratio in the Northern Region.

Community Dental Service: This service developed from the old school dental service. It is responsible for screening school children, providing a dental service to people with special needs, such as learning disabilities, medically compromised children and adults (e.g. heart problems, diabetics), extractions under anaesthetic for children, services for older people, including a service to residential homes, long-stay patients and home-bound older people, dental health education and epidemiological research. The service made 30-40,000 contacts a year in the early 1990s, but was declining at the end of the research period.

Equipment Services

Home Loan Equipment Service: This service made equipment available for patients

¹⁹ District Audit Service, Management Letter to Members 1992/93.

to use at home to help them while they are recovering from illness, or suffering from a terminal illness, in response to assessments made by nursing staff, physiotherapists or occupational therapists. In 1992/93, 8,762 articles were loaned out, from zimmer frames and commodes to specialist beds and suction machines. Demand on the service increased as a result of the changing philosophy of hospital care and earlier discharge, and Community Care. Since April 1993, for instance, there was a notable rise in demand for certain items, particularly commodes. The system depended on the return of equipment so that it could be loaned out again.

Wheelchair Department: The Wheelchair Department provided a wheelchair service to 5,314 users in Sunderland and North Easington. It trained district nurses, health visitors, physiotherapists and occupational therapists to assess needs for wheelchairs and ran clinics for specialist assessments. The department arranged domiciliary assessment visits and attended the special schools regularly to reassess children's wheelchair needs. The department supplied wheelchairs, special seating and accessories, and was responsible for maintenance, replacement and reassessment. In the year 1992/93, the department issued 1,336 new wheelchairs.

SOCIAL SERVICES

From 1993, the three client care divisions of the Social Services Department (SSD) served children and families, people with disabilities, and older people. Each division included workers who assessed the needs of clients and manage their care, as well as those who were responsible for the direct provision of services. By 1994, The

Department was reviewing the services it provided and thinking about the best way of providing support. It was expected that some residential units would close and other services would change, to ensure a greater choice of community care services. The figures given below, therefore, are accurate at the time of publication of this report, but are likely to be out of date very rapidly.

Children and Families: The services provided by this division included:

- assessment of the needs of children and their families through 13 teams of social workers;
- a range of family support services to help parents care for their children at home;
- A fostering and adoption service;
- Social work advice;
- residential care options for those children who cannot be looked after by their own families;
- An After Care service which assists and supports young people to live independently after leaving care;
- Day Nursery type services in Home from Home settings and Family Centres;
- Support for children with disabilities and their families, including day care, respite care and residential care, home adaptations, equipment and a sitting service.

The number of places in LA childrens' homes had fallen from 195 in 1991 to 95 in 1994. At the same time, fostering places have been increased. There were also 12

respite care places for children with learning disabilities. Day care was provided to around 360 children aged under 8 in LA establishments. In addition, 291 children used the home from home service. The division was also responsible for registering day provision for children, which included 313 child minders, 41 playgroups, 8 creches and 10 private nurseries, as well as youth clubs, play and holiday schemes.

People with Disabilities: This division provides services to adults with physical disabilities, sensory disabilities, learning disabilities, mental health problems, drug and alcohol problems and HIV and AIDS. The services include:

- assessment of the needs of people with physical disabilities, sensory disabilities, learning disabilities, and mental illness through 8 teams of social workers;
- Support for people at home, including Home Care Support, Meals on Wheels, adaptations to the home;
- Equipment to help people who are disabled;
- Day care;
- Short breaks;
- Sheltered accommodation;
- Residential care;
- Services for people with sensory disabilities, e.g. interpreting service;
- Services for people with AIDS, including the support of 2 AIDS Liaison workers, a directory of services for people with HIV/AIDS.

There were 118 LA residential places for people with learning disabilities, with new facilities planned. There were 512 day care places for this client group, including 42

special care places. In addition, 69 people with learning, physical and sensory disabilities were employed in a sheltered workshop making furniture. There were 120 day care places available daily for people with a physical disability.

Older People: The services provided by this division include:

- assessment of the needs of older people through 11 teams of social workers;
- Support for people at home, including Home Care Support, Meals on Wheels, adaptations to the home;
- Equipment to help people who are disabled;
- Day care;
- Short breaks;
- Sheltered accommodation;
- Residential care.

In a six month period in 1993, the teams carried out nearly 4,000 assessments, not including requests for bus passes and disabled parking permits.

The Older People's Division commissioned 2,030 Meals on Wheels and 968 Luncheon Club meals per week. Around 5,000 contacts to provide home care were made each week. Most of these (78%) took up to one hour, though a small number (1%) took over two hours. The first round of Local Authority Performance Indicators placed Sunderland at the top of the metropolitan councils for the percentage of older people

helped to live at home²⁰. This was because home care was free and provided to a large number of elderly residents. The number of Local Authority residential places for older people had gone down considerably, from 775 places in 1991 to 442 in March 1994. This policy was encouraged by the Government, which structured community care legislation in such a way that it was generally less expensive for the Social Services Department to place people in private homes than in Local Authority homes.

THE INDEPENDENT SECTOR

Voluntary and private organisations offered a wide range of activities and services. They also existed to represent a particular client group, to campaign or raise awareness about an issue, to raise funds, or to provide mutual support and self-help. Organisations provided advice, support and services to a broad spread of client groups, including: children, women, older people, people with a physical or sensory disability, people with a mental illness, people with learning disabilities, people suffering from or caring for others with a particular disease or condition, people who have suffered loss or bereavement or from abuse or violence²¹.

The independent sector was in a good position to respond to gaps in service provision and develop new services to meet needs in the community, and the government was keen to encourage this.

²⁰ Audit Commission, *Local Authority Performance Indicators* Vol 1 Education services, social services and total expenditure (London: HMSO, 1995) p. 25.

²¹ City of Sunderland Social Services Department, *Your Guide to Community Care Services in the City of Sunderland*, December 1993.

SCORING SYSTEM FOR TEAM FUNCTIONING

The questions on team functioning were developed by Pauline Pearson¹ from work by Dyer².

To each of the nine questions, a range of five possible responses is offered. At one end of the scale is a statement which indicates a high level of collaboration and at the other a statement indicating lack of teamwork. The statements move from negative to positive and from positive to negative in different questions, so that respondents have to think twice about which statement they choose.

The scoring system allocated five points for each statement chosen at the positive end of the scale and one point for each statement at the negative end. The points were multiplied by the number of choices made at each of the five points in the scale and divided by the total number of responses, thus giving an average for the team or other category by which respondents had been grouped. Average scores for each of the nine questions were added together to give a total score. The maximum possible score using this method is 45 and the minimum is 9. The scores allocated to each response are given in Table Di.

TABLE Di: SCORING SYSTEM

STATEMENT	1	2	3	4	5
QUESTION					
A	5	4	3	2	1
B	5	4	3	2	1
C	1	2	3	4	5
D	1	2	3	4	5
E	5	4	3	2	1
F	1	2	3	4	5
G	1	2	3	4	5
H	5	4	3	2	1
I	1	2	3	4	5

¹ Pearson (in press).

² Dyer, 1987, p. 123.

Responses by Practice

Scores for responses to the questions in the first and third round of interviews were calculated twice, once including the administrative staff (receptionists, secretaries, computer operators) and once excluding them. This enabled a fair comparison with the second round of interviews, when administrative staff were not questioned.

TABLE Dii: FIRST INTERVIEWS: RESPONSES BY PRACTICE, INCLUDING ADMINISTRATIVE STAFF

PRACTICE >	A	B	C
QUESTION NO.			
A	4.1	3.6	4.2
B	4.3	4.6	4.7
C	3.8	3.7	4.0
D	3.9	2.9	4.2
E	3.6	3.6	4.3
F	4.2	3.5	4.7
G	3.8	2.9	4.6
H	4.8	3.9	5.0
I	3.9	3.7	4.4
TOTAL	36.4	32.5	40.1

When the administrative staff were excluded from the calculations, Practice A's score increased, that of Practice B went down, and Practice C stayed very much the same.

TABLE Diii: FIRST INTERVIEWS: RESPONSES BY PRACTICE, EXCLUDING ADMINISTRATIVE STAFF

PRACTICE >	A	B	C
QUESTION NO.			
A	4.6	3.6	4.2
B	4.4	4.5	4.5
C	4.0	3.6	4.0
D	4.5	3.1	4.3
E	4.0	3.1	4.2
F	4.3	3.0	4.5
G	4.0	2.6	4.3
H	4.9	3.1	5.0
I	4.4	3.8	4.3
TOTAL	39.1	30.7	39.3

In the second round of interviews, the scores of Practices A and C decreased by 14% and 9% respectively, while Practice B's score increased by 10%. When the scores of all three practices are added together, the overall score decreased from the first to the second interview by 5%.

TABLE Div: SECOND INTERVIEWS: RESPONSES BY PRACTICE

PRACTICE >	A	B	C
QUESTION NO.			
A	3.6	4.0	4.0
B	4.0	4.4	4.3
C	4.0	4.1	3.4
D	4.0	3.6	3.9
E	3.5	3.5	4.0
F	3.5	3.3	4.0
G	3.5	3.4	4.5
H	3.9	4.0	4.0
I	3.8	3.5	3.7
TOTAL	33.6	33.8	35.8

TABLE Dv: FINAL INTERVIEWS: RESPONSES BY PRACTICE, INCLUDING ADMINISTRATIVE STAFF

PRACTICE >	A	B	C
QUESTION NO.			
A	3.9	3.6	3.6
B	4.2	4.4	4.0
C	3.4	4.0	3.6
D	4.1	2.8	2.7
E	4.0	3.8	3.4
F	4.0	3.6	4.1
G	3.7	2.5	2.8
H	4.5	4.2	4.9
I	3.8	3.3	3.1
TOTAL	35.6	32.2	32.2

The views of the administrative staff do have some impact on the practice score in some practices. When they are not included in the scores, Practice A's total is increased by two points, Practice B's score is virtually unchanged, and Practice C's result is a reduction of nearly two points.

TABLE Dvi: FINAL INTERVIEWS: RESPONSES BY PRACTICE, EXCLUDING ADMINISTRATIVE STAFF

PRACTICE >	A	B	C
QUESTION NO.			
A	4.4	3.9	3.6
B	4.4	4.2	3.7
C	3.9	3.8	3.3
D	4.0	3.1	2.5
E	4.4	3.7	3.0
F	4.0	3.3	3.8
G	3.9	2.6	2.5
H	4.5	4.1	4.8
I	4.1	3.4	3.3
TOTAL	37.6	32.1	30.5

The issues over which the lowest scores were achieved included question D, about how effective the team is in using the ideas, opinions and information of all team members in making decisions. Practice A, in which the doctors perceive the Primary Health Care Team as a meeting to discuss clinical issues, scored highly; the other practices did less well. Pilot staff had a higher perception of the team's effectiveness in this regard than the practice managers and practice nurses.

A related question, G, about the people who influence planning and the way the team operates, also attracted poorer scores. Practice A scored less well here than for question D, which probably reflects the perception of the PHCT as a clinical gathering. Underlying the scales is a perception of "teaminess" on all fronts.

The comparison of the team scores over the study period does not include the views of the administrative staff, as they were not interviewed during the second interview. The table shows that Practice A started with a high score, which dropped dramatically at the second interview and rose again at the final interview, ending only 1.5 points below the original score. Practice B started with a relatively low score, which increased by 10% half way through the project and dropped back a little at the end, ending 1.4 points ahead of the original score. Practice C started with the highest score which has fallen at each stage, ending 9.4 points (24%) below the original score.

TABLE Dvii: COMPARISON OF PRACTICE TEAM SCORES (EXCLUDING ADMINISTRATIVE STAFF) OVER THE STUDY PERIOD

	A	B	C
FIRST INTERVIEW	39.1	30.7	39.3
SECOND INTERVIEW	33.6	33.8	35.8
FINAL INTERVIEW	37.6	32.1	30.5

A similar pattern is seen when the final scores for the whole practice are compared with those of the first interview. There are marginal changes in the scores in Practices A and B, and a significant reduction in Practice C. Practice A drops 0.8 points, Practice B drops 0.3 points, and Practice C falls 7.9 points.

TABLE Dviii: COMPARISON OF PRACTICE TEAM SCORES (INCLUDING ADMINISTRATIVE STAFF) OVER THE STUDY PERIOD

	A	B	C
FIRST INTERVIEW	36.4	32.5	40.1
FINAL INTERVIEW	35.6	32.2	32.2

Responses by Employment Status

Though this system enables comparison between groups and over time, scores could be skewed if the total number of responses to a question is small. For this reason, the following tables show responses by employment status (GP, GP employed, pilot staff) rather than profession, as the number of Health Visitors, Practice Nurses and Practice Managers is each small.

As might be expected, GPs had a higher opinion of the functioning of their teams than other groups, and staff employed by GPs had a more positive perspective than the pilot staff, who, in the past, were less integrated into the practice team. However, in response to the question on levels of responsibility, employed staff gave a more positive response than GPs

TABLE Dix: FIRST INTERVIEWS: RESPONSES BY EMPLOYMENT STATUS

	GPs	GP EMPLOYED (INCL. ADMIN)	GP EMPLOYED (EXCL. ADMIN)	PILOT STAFF
A	4.7	3.8	3.7	3.8
B	4.8	4.5	4.2	4.4
C	4.2	3.8	4.0	3.6
D	4.5	3.3	3.8	3.5
E	3.8	4.1	4.7	3.0
F	3.8	3.9	4.3	3.6
G	4.3	3.7	3.8	2.9
H	4.3	4.8	4.7	3.9
I	4.7	3.9	4.3	3.7
TOTAL	39.1	35.8	37.5	32.4

There is very little change in the scores for GPs and for pilot staff between the first and second interviews. The score for GP employed staff (excluding administrative staff) fell by 14%.

TABLE Dx: SECOND INTERVIEWS: RESPONSES BY EMPLOYMENT STATUS

	GPs	GP EMPLOYED	PILOT STAFF
A	4.1	3.8	3.7
B	4.7	4.0	4.0
C	4.7	3.2	3.8
D	4.4	3.7	3.5
E	4.4	3.7	3.3
F	4.0	3.4	3.3
G	4.3	3.8	3.2
H	4.0	3.3	3.5
I	4.3	3.2	3.5
TOTAL	38.9	32.1	31.8

When the scores are analysed by employment status, the highest result is achieved by the doctors, who are 10 points ahead of the pilot staff. The score for all the practice staff is a little higher than the scores for practice employed staff excluding the administrative staff, which indicates that in general terms secretaries and receptionists have a higher view of how the team is functioning than practice managers and practice nurses.

TABLE Dxi: FINAL INTERVIEWS: RESPONSES BY EMPLOYMENT STATUS

	GPs	GP EMPLOYED (INCL. ADMIN)	GP EMPLOYED (EXCL. ADMIN)	PILOT STAFF
A	4.8	3.4	3.5	3.7
B	4.8	4.1	3.7	4.0
C	4.7	3.7	3.7	3.2
D	4.3	2.9	2.0	3.0
E	4.5	3.7	3.2	3.6
F	4.2	4.1	4.0	3.3
G	4.3	3.0	2.8	2.4
H	4.8	4.5	4.7	4.1
I	4.3	3.2	3.5	3.4
TOTAL	40.7	32.6	31.3	30.7

When scores are compared over time, the doctors' score dips slightly half way through the study period and picks up a little at the end, with the final score 1.6 points above the original. The final score for the pilot staff is 1.7 points below the original. The most significant change is among the GP employed staff, excluding administrative staff, where the final score is 6.2 points (16.5%) below the original, with the biggest reduction in the score occurring between the first and second interviews. When the administrative staff are included, the decrease is only 2.8 points (8%).

TABLE Dxii: COMPARISON OF EMPLOYMENT GROUP SCORES OVER THE STUDY PERIOD

	GPs	GP EMPLOYED (INCL. ADMIN)	GP EMPLOYED (EXCL. ADMIN)	PILOT STAFF
FIRST	39.1	35.8	37.5	32.4
SECOND	38.9		32.1	31.8
FINAL	40.7	32.6	31.3	30.7

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GLOSSARY OF ABBREVIATIONS

CATI	Computer Assisted Telephone Interview
CCP	Community Care Plan
CNLD	Community Nurse in Learning Disabilities
COT	Community Occupational Therapist
CPN	Community Psychiatric Nurse
DHA	District Health Authority
DHSS	Department of Health and Social Security (replaced by separate departments in 19xx)
DoH	Department of Health
DSS	Department of Social Security
FHSA	Family Health Services Authority
FPC	Family Practitioner Committee (replaced by FHSA in 1990)
GP	General (Medical) Practitioner
IM&T	Information Management and Technology
JCB	Joint Commissioning Board
JCC	Joint Consultative Committee
JCPT	Joint Care Planning Team
JIG	Joint Issues Group / Joint Implementation Group
JOG	Joint Officer Group
JPG	Joint Planning Group
LA	Local Authority
LMC	Local Medical Committee

MISG	Mental Illness Specific Grant
MS	Multiple Sclerosis
NHS	National Health Service
NHSE	National Health Service Executive
NHSME	National Health Service Management Executive
OPCS	Office of Population Censuses and Surveys
PAD	Primary Assessment Document
PHC	Primary Health Care
PHCT	Primary Health Care Team
RHA	Regional Health Authority
SSI	Social Services Inspectorate
SSD	Social Services Department
TU	Trades Union
UGM	Unit General Manager

