HEALTH SERVICES
RESOURCE CENTRE
BRIEFING PAPER NO. 4
ON
SOME RECENT TRENDS IN
LOCAL SERVICE DELIVERY
IN COMMUNITY CARE
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1. INTRODUCTION

Community care is both a concept which is much debated and an umbrella term for a wide range of services. Hunter and Judge (1988) argue that the community care concept implies a shift in the balance of care from institutions to community facilities and from health to social services. Key features of community care include a firm focus on the local community and on integration of the work of multidisciplinary teams which serve that community. Major target groups for community care policy include the elderly, the mentally handicapped and the mentally ill.

Hunter and Judge point to a lack of clarity about community care and its objectives, which are variously defined as: discharging people from long stay hospitals; preventing admissions to hospitals; unblocking acute beds; cost containment; developing new services; providing domiciliary rather than residential care. A recent official British definition of community care objectives cited by Griffiths (1988), which focused on non-institutional care and on integration of services, was the following:

- to enable an individual to remain in his own home, wherever possible, rather than being cared for in a hospital or residential home; and

- to integrate all the resources of a geographical area in order to support the individuals within it.

A simple definition of community care services which I am proposing in this paper is:

"those services which are provided in the community where people live and outside hospitals or other institutions"

Since the McKinsey Report, the services in the health boards' Community Care Programme include personal health care, preventive services, environmental protection and welfare services.

Recent major policy documents, e.g. on services for the mentally ill or the elderly, have placed a clear emphasis on the local community at sub-area level and on the work of multi-disciplinary teams at that level. The report on psychiatric services, Planning for the Future (December 1984) recommended that psychiatric services be organised on the basis of sectors of 25,000 - 30,000, to be served by psychiatric teams (Par. 4.13). Health Board psychiatric services have since been organised on the basis of this sectorisation model. The more recent report on services for the elderly, The Years ahead (October 1988) recommended that services for the elderly too be organised as far as possible in districts serving a population of roughly 25,000 - 30,000
people. Such services were to be provided by district teams coordinated by a district liaison nurse (Pars. 3.12 - 3.14).

Why the new emphasis?

Why is there this new emphasis on service delivery at sector level i.e. at a more local level than the community care area, and on the work of teams at this level?

Three major reasons may be suggested here. The first is a growing interest in getting as close as possible to the point of service delivery in order to ensure effective, high-quality care. The second reason is a growing recognition of the value of non-statutory and informal support networks in the community (e.g. the family and the neighbourhood). A third and allied factor is the view that it is at local level and in the context of people of different disciplines working together that these networks can be most effectively mobilised.

My aim in this paper is to examine different types of local community where care is provided and different types of teams in Ireland and Britain. I also propose to consider some general issues in teamwork and service delivery which arise at local level in community care.

What follows is a brief outline of the structure of the paper:

Section 2: will look at the British experience of community care at local level, including significant new developments like neighbourhood nursing teams.

Section 3: will look at the Irish experience of community care with particular reference to developments at sub-area level, including the work of sub-area teams, and to a growing emphasis on target groups in Ireland. The Irish experience will be examined in the context of general community care problems and opportunities in Ireland.

Section 4: will go on to consider general issues in local service delivery, especially teamwork issues, which include the conditions for successful teams and obstacles to the development of such teams.

Section 5: will conclude the paper by bringing together some of the key points and arguments made.
2. THE BRITISH EXPERIENCE

2.1 Decentralisation

A focus on the local community and on the development of locally integrated services are basic themes in community care and are also very important aspects of decentralisation. Decentralisation and community care may be said to be closely linked. Indeed, the Audit Commission's report on community care in Britain (1986) saw decentralisation as central to community care.

It is useful therefore to examine the British experience of local service delivery in community care in the context of a wider interest in decentralisation. Hambleton (1988) identifies three dimensions in decentralisation: a decision-making dimension related to the decentralisation of power; a service integration dimension to do with bringing services together at local level; and a political dimension to do with the degree of public or political involvement in the local services. He lists among the objectives of decentralisation a desire to improve public services, to strengthen local accountability and to reallocate services to neglected or priority groups.

The Griffiths reforms introduced by the Conservative Government in the mid-1980s, and particularly the introduction of general management, can be seen as favouring the first dimension of decentralisation. Unit General Managers were given the tasks of clarifying management structures and accountability and of getting close to the consumer: tasks which appear to be compatible with a neighbourhood orientation. The general management approach provided for clear lines of authority and, potentially at least, for decentralisation of decision-making. It is more questionable whether it facilitated the second dimension of decentralisation i.e. the development of integrated community services focused on particular target or priority groups. Hunter and Wistow argue that such integrated care requires not general management but a team management approach based on consensus. Others take the view that the multi-disciplinary team approach favoured in the 1974 health service reforms proved unwieldy and ineffective in practice and required to be replaced by a simpler management structure. In relation to the third dimension of decentralisation (increasing public or political involvement) Griffiths argued that management should give priority to finding out how well the service was being delivered locally by obtaining the views of patients and the community and then by acting on this information.
Areas to which services decentralised

To what size and type of area have services been decentralised in Britain? "Neighbourhoods", "patches" or "localities" in the British context are generally areas with a population of 10,000 - 25,000 people on which service delivery is concentrated. The focus at least in theory is not on those providing the service but on the needs of the population in this defined area and on the provision of comprehensive services by people of varied expertise. A DHSS circular in 1987 stated that some local and health authorities had decided as a matter of principle that their services were best managed at the most local level that was sensible and had devolved management responsibility to the neighbourhood level.

One example of decentralisation to the neighbourhood is the process known as "locality planning". The Audit Commission's Report (par. 163) refers to such a process in the Exeter Health Authority, where there are six local planning groups involving local professionals as well as interested members of the public. As the Report notes, the local planning group identified need for community-based care in its own patch and develops plans which are then submitted to a central development group.

Two important reports on professional organisation in the 1980s made recommendations very much in line with the neighbourhood or patch approach. The Community Nursing Review, or Cumberlege Report, of 1986, recommended that community nursing services should be organised in units small enough to be sensitive to the needs of a population of between 10,000 and 25,000 but large enough to make best use of the skills and experience of the staff concerned. In 1982, the Barclay Report developed the concept of community social work i.e. where the focus was on the community to be served rather than on the specialist qualifications of individual social workers.

Types of local team in Britain

Turning now to the types of local team which exist in community care in Britain, there are three main sets of teams: neighbourhoods nursing teams, primary health care teams and teams aimed at particular target groups.
2.2 Neighbourhood Nursing Teams

Neighbourhood nursing teams are a fairly recent phenomenon in community care in Britain and owe their development to an important recent report on community nursing, the Cumberlege Report. This report stated that there was scope for making better use of nursing skills and that the effectiveness of the primary health care team needed to be improved. Its main recommendation was that community nursing services be planned, organised and delivered on a neighbourhood basis. Community nursing services in this context were those provided by district nurses, health visitors, school nurses, midwives and community psychiatric and mental handicap nurses.

The British Government's White Paper on Primary Health Care (Promoting Better Health) endorsed the general thrust of the Cumberlege recommendations but did not accept the neighbourhood nursing approach as the single blueprint for service organisation (see par. 7.7). The Report also said (par. 7.9) that the Government attached considerable importance to the strengthening of the primary health care team (PHCT).

In a circular issued at the same time, the DHSS suggested that neighbourhood nursing might be particularly appropriate in inner city areas: "If the pattern of general practitioner services in such areas is one of a large number of small overlapping practice areas, it may be unrealistic to expect comprehensive linkage with community nursing staff and for the time being working in primary health care teams may be no more than a long-term objective". It was clear, however, from the circular that the establishment of such teams was an important long-term objective.

A survey of district health authorities in January 1988 found that 60% of the authorities which replied had introduced neighbourhood teams or were planning to. The number of nurses per team ranged typically from 15 to 25 and the size of the neighbourhoods from 20,000 to 30,000. The ratios of community nurse per head of population varied from around 1:700 to 1:1700. The figures may be compared with the ratio recommended in the Cumberlege report of between 1:1000 and 1:2500. Health visitors, district nurses and school nurses were the core staff in the teams. (Patching-in no. 5, King's Fund Centre, July 1988).
The development of neighbourhood nursing teams has caused controversy. General practitioners have expressed particular concern about this development. GPs consider that the establishment of such teams makes GP-nurse cooperation more difficult and is in conflict with a policy commitment to primary health care teams. Nursing opinion, on the other hand, or at least that expressed in the Cumberlege Report, is that under current arrangements nursing skills are being under-used and that patient needs, especially in the inner city areas, are not being met. It has been noted that the GP's average list of 2,000 patients may be scattered over a very large population in the cities: and that on the other hand, as Cumberlege noted, there may be 15-20 GPs caring for 50 households in a block of flats. These features of GP organisation, which are rooted in a free choice of doctor by patient and of patient by doctor, do not facilitate cooperation with nurses who serve particular catchment areas.

As noted above, the British Government has cautiously welcomed neighbourhood nursing teams but in the context of an overall commitment to primary health care into which any neighbourhood organisation of community service must fit. The White Paper on Primary Health Care stated (Par. 7.9) that the Government attached particular importance to the strengthening of the PHCT. The 1987 circular cited above stated that the Department favoured only those organisational changes and developments which contributed to the development and effectiveness of PHCTs; which took full account of the local pattern of general practice, organised on the basis of practice lists with overlapping practice areas in order to ensure choice of GP; and which recognised that community nursing staff would continue to be linked to general practice as part of primary health care teams.

2.3 The Primary Health Care Team

The World Health Organisation (1973) has defined the primary care team as "A non-hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive care practicable".

A British Working Group on the Primary Health Care Team, which was established in 1978 and reported in 1981, defined the team as "an interdependent group of GPs and their secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his/her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service". (See DHSS circular letter DS/H10/139, 22nd January 1979).
The Working Group recognised that other professional and lay skills and voluntary services are involved in the wider setting of primary health care but decided to confine its deliberations in the first instance to the narrower team concept suggested in its definition.

It is noteworthy that the Working Group did not include social workers in the team. There has been some discussion about social worker attachment to primary health care teams and some experiments in such attachments but social workers are not usually formal members of the team. In Britain, social workers are employed by local rather than district health authorities. However, the recent White Paper on Primary Health Care, Promoting Better Health, endorsed a suggestion that some social workers might work from the same premises as the family doctor.

As noted above, this White Paper stated that the British Government was committed to the continued development of primary health care teams, which provide "higher quality of care and wider choice for patients" (Par.3.45). The White Paper said that such teams were working well at present but might benefit from a wider membership e.g. through the inclusion of social workers.

Some anxiety has been expressed about the implications of proposals in the more recent White Paper on the NHS, Working for Patients (1989). This White Paper did not examine community care in a broad sense but its proposals in relation to general practice aroused controversy. In particular, the proposal to introduce GP practice budgets provoked the criticism that GP budget holders might be discouraged from accepting "unprofitable" patients, e.g. the elderly or chronically ill: a development clearly not in line with a primary care team philosophy.

2.4 Teams Aimed at Particular Target Groups

As well as services for localities or geographical communities, there has also been much interest in what might be called communities of interest focusing on particular target groups e.g. the handicapped or the elderly. Some decentralised services focus on just such communities. A "Patch Committee" which operated in Pimlico in London and reported in 1988 focused in its work on three groups: the elderly, the homeless and ethnic minority groups. In this section, the work of teams in the area of mental handicap is examined.

According to the Audit Commission Report (par. 163), multi-professional Community Mental Handicap Teams (CMHTs) combine the work of psychiatrists, psychologists, social workers, community psychiatric nurses (CPNs) and occupational therapists. The social worker and CPN tend to be full-time with the other professionals available on a sessional basis.
CMHTs have a particularly important role when mental handicap hospitals close. Richard McCarthy (1985) has described the role of such teams in a district of London (Lewisham and North Southwark), where a large regional mental handicap hospital was scheduled for closure in 1986. There was cooperation between housing associations, voluntary organisations and district health authorities in the provision of shared and supported housing for adults with a mental handicap in the community. It was decided to use ordinary housing to provide a series of cluster schemes and group homes. The role of the CMHTs was seen as providing a full range of support services including twenty-four hour cover to the new housing projects being developed. (Design for Special Needs no. 36, January - April 1985).

Nigel Malin (1987) has reported on the NIMROD service in Cardiff, which is a community-based service for people with a mental handicap in ordinary dwellings. The service covers a catchment area of 60,000 people and this area is divided into four sub-catchment areas.

Some of the problems facing community care staff in mental handicap have been outlined by Hunter and Wistow. They noted the assumption of the Department of Health that, apart from some short-term bridging funds, the reduction of hospital populations through patient transfers should be accomplished from within existing resources. Hunter and Wistow referred however to the inadequacy of resources in many existing hospitals and also to the demand for services from people who have never entered the hospital system. They add that there is some evidence that resources transferred from long-stay hospitals are as likely to remain in the health service as to be transferred into the local government sector: "Consequently, the local authority role in providing locally based services may be less substantial than DHSS policies have traditionally anticipated". (p.105).

2.5 Problems at local level in Britain

This survey of the British experience concludes with a brief examination of the practical situation, and particularly of problem areas, in Britain.

These problem areas include organisational and financial fragmentation and, to a lesser extent, difficulties in inter-professional cooperation. These difficulties are often linked to what is seen as the lack of a clear overall policy on, or strategy for, community care.
In relation to the organisational and financial areas, the haphazard and unplanned development of residential care is a key issue. The Audit Commission Report noted that long-stay hospital provision is often replaced not by community-based services but by residential homes. Such residential places are separately funded by social security without reference to local authority social services plans. In addition, as a result of government measures to control expenditure, local authorities which increase spending in real terms on community care lose part of their grant. The Audit Commission Report argued that "perverse incentives" were thus operating in the system in favour of residential homes and against community care. This report also highlighted the problem of inadequate funding e.g. for the transition phase when institutions are being scaled down and community services developed.

The Griffiths report on community care also criticised the split in responsibilities between local authority social service departments and the social security system. Griffiths argued that local political and managerial responsibility needed to be underpinned by a suitable financial system. He proposed a switch in financial responsibilities for community care from both social security and health authorities to local authorities. In a response to Griffiths sixteen months after his report, (July 1989), the British Government accepted his main proposal i.e. that local authorities be given primary responsibility for community care. The Government envisaged that local authorities would be 'enablers' rather than direct providers of care. Some other Griffiths proposals, e.g. a special community care grant and a Minister for community care, were not accepted.

Finally, reference is made elsewhere in this paper to inter-professional difficulties or differences in perspective. What may be noted here is that the Audit Commission Report discussed issues which arise in relations between the primary health care team and community care services. In theory they were complementary: the primary care team looked after medical problems and the community care personnel looked after accommodation, rehabilitation and training, care and support. In practice, however, there could be overlap and conflict, especially in the context of limited resources. The report referred in particular to a potential conflict of interest for nurses, whose role straddles both services.
3. **THE IRISH EXPERIENCE**

Any examination of community care in Ireland must refer to the general context of expenditure cutbacks in the health services. Resource constraints clearly apply in community care as in other services and have serious implications for levels of service and staffing. The current financial context would also rule out any prospect of dramatic policy or organisational innovation at local level in community care.

This part of the paper outlines the work of sub-area teams in Ireland at present and considers their possible future contribution to the development of services.

### 3.1 Local service delivery and sub-area teams at present

This section provides a general outline of the current situation at sub-area level. Some further details on the situation in each health board, based on an informal survey carried out in 1989, are provided in Appendix A.

The principal features of service delivery and teamwork at local level are:

- Structures at local level are relatively informal. In many cases, there are no district care teams as such but informal teams whose composition varies with the target group being served. Such teams serve principally as fora for discussion and may meet relatively infrequently e.g. every few months. The informality of structures means that objectives are not usually very clearly defined.

- Sub-area teams generally function at a purely operational level i.e., staff cooperate in providing services to particular patients or families but have no control over resources or the perception that they constitute a team in any formal sense.

- Services are increasingly organised at local level by target or priority group e.g. the elderly, the handicapped, the mentally ill or children at risk. This trend is very much in line with the policy recommendations of recent reports, such as those already cited on the elderly and handicapped. (See p. 1).

- Resource constraints have a major impact at local level. Thus staff shortages or lack of resources for the cost of meetings may either impede the establishment of formal sub-area teams or contribute to a diminution in their presence or importance.
Health board procedures and methods of operation are quite centralised. In matters relating to financial management and control, for example, there is relatively little delegation to community care areas or sub-area level. Local teams do not have control over their own budgets. One result of this is that coordination of services at programme or management team level can seem more important than local coordination.

The involvement of GPs with sub-area teams is generally fairly limited. Teams which have sought such involvement have often found that GP attendance at team meetings has been very irregular. Some hold the view that the recent change in the GPs method of payment may facilitate GP-community care cooperation in future. In general, GP-community care coordination is seen as a major issue and difficulty.

There is an increasing recognition of the importance of close links with voluntary organisations and community groups but these links are not always well structured. There is general acceptance of the need for good cooperation with local community groups but not a strong emphasis on the active participation of such groups in service planning and provision.

In view of the fairly informal reality outlined above, it is difficult to be precise about the current objectives of sub-area or district care teams in Ireland. The objectives outlined below do not apply to any particular health board but summarise some of the objectives listed across several health boards. These objectives included:

- to act as fora for discussion of common problems and areas of interest;
- to build links between the different professions and between those who deliver and those who organise the service;
- to identify needs in the sub-area;
- to develop links with the voluntary sector;
- to review the functioning of the health service in that sub-area;
- to improve communications with personnel outside the health board e.g. GPs;
- to integrate services provided in the particular sub-area for priority or target groups.
3.2 Future Direction of Sub-Area Teams

The discussion which follows on the possible future contribution of teams is based on the assumption that such teams will be given a clear role and purpose and a well-defined position in the community care structure. The future role of teams will also depend on the general direction which community care takes in the coming years. In this context, the recommendations and influence of forthcoming reports such as that of the Working Party on Community Medicine will obviously have considerable relevance. It must also be frankly stated, however, that there is little prospect of significant development at sub-area level if the major problems currently experienced at area level—which are largely outside the scope of this paper—are not resolved.

The possible contribution of sub-area teams is in three areas:

(1) organisation
(2) planning and evaluation
(3) resource allocation

3.3 Organisational contribution

(a) Coordination of Services

There has been much discussion in recent years about organisational problems and issues in community care, particularly in relation to the health board programme structure and to the operation of community care teams and to the future role of the director of community care.

One much debated problem, highlighted for example in the NESC report, is that of coordination across programme boundaries. Taking the example of services for the elderly, the NESC report noted that in some regions, all three programmes were involved in service provision and suggested that services were characterised by inflexibility between residential and community facilities.

In relation to the psychiatric services, Planning for the Future (14.9) advocated close working links between the different programmes but recommended the continued existence of a separate psychiatric programme. Its view was that a separate programme was needed to bring about the transition to community-based psychiatry. When this transition was over, structures would be re-assessed. Whatever its merits in theory, the existence in practice of a separate psychiatric sector team structure with area boundaries different to those of community care is not conducive to effective cooperation across programme boundaries.
As a result of problems in the programme structure, some recent reports have advocated its abolition. The 1986 consultative document, Health - The Wider Dimensions and the 1988 report on services for the elderly, The Years Ahead, both recommended a change from a programme based structure to a geographically based administration of services. In advocating organisation on a geographical or territorial basis, The Years Ahead recommended that administrative responsibility for the delivery of a service should be located as close as possible to the operational level i.e. to district level. (Pars. 3.11 and 3.12). At this district level, the district liaison nurse would then have the function of coordinating services for the elderly (Par. 3.13).

A major potential contribution of sub-area teams clearly lies in this area i.e. that of improved coordination of services at, or very close to, the operational level at which such services are actually delivered. This coordination process should include the improvement of cooperation with key personnel operating outside the formal health board structure e.g. GPs.

On this last point, Health - The Wider Dimensions recommended (5.3) demonstration projects in a number of areas which would harness the complementary skills of GPs and other community based workers in tackling particular health problems. The earlier Working Party Report on the GMS had called (Par. 3.65) for "clear channels of communication" between the GP and other local personnel.

(b) Development of the team approach

Another potential organisational contribution of sub-area teams is to develop the multi-disciplinary team concept originally set out in the McKinsey proposals.

The aims of the team, as envisaged in the McKinsey reports, were:

- to integrate the work of professional and administrative staff;

- to involve professionals fully in decision-making and the management of resources;

- to encourage the development of a client-centred rather than a more fragmented provider-centred approach;

- to facilitate access to the service for the individual client;

- to facilitate a process of delegation within the health board which would ensure good contact with local communities.
Various reports on community care—for example the 1987 NESC Report and the 1982 Inbucon review—found that the multi-disciplinary team approach was not working as intended at community care area level. NESC referred for example to the absence of genuine multi-disciplinary planning i.e. planning incorporating the prior specification of resources, objectives and priorities by the team. According to NESC, evaluation and planning of services for particular target groups was damaged by the ineffective functioning of the community care team.

What contribution might teams at sub-area level make to the development of the team concept generally in community care? It may be suggested that properly established local teams enjoying a significant degree of discretion could do much to involve the different professions in managing and planning services. Such an involvement would, in its turn, help to revive and strengthen the multi-disciplinary team concept which has formed the basis for the current health board organisation of community care.

3.4 Contribution to planning and evaluation of services

The importance of need measurement and of information in planning and evaluation was central to the McKinsey structure and recommendations. Ten years later, the Inbucon report suggested that need in the Irish community care services tended to equate to presented demand and that there remained very significant information problems and gaps in community care. The NESC report in 1987 argued that the present level of information on community services was grossly inadequate and referred in particular to deficiencies in information on the take-up of services by socio-economic group and by district. It suggested that these deficiencies severely hampered decision-making on resource allocation in community care.

The future contribution of sub-area teams in the area of planning and evaluation could be:

- to build up an effective local information base;
- to develop information on particular target or priority groups;
- to involve the different professions more effectively at local level, and as a team, in planning and evaluation.
3.5 Contribution to resource allocation

There is clearly a close link between planning and evaluation, on the one hand, and resource allocation on the other. In contributing to more effective planning and evaluation of services, sub-area teams would also therefore be facilitating a more equitable allocation of resources.

Sub-area teams could also have a role in quantifying resource targets in community care. It has often been argued that a general policy commitment to community care must be matched by the commitment of resources to the community. In advocating the redirection of central resources towards community care, the NESC report argued that this reallocation of resources should be expressed as specified, quantified targets. While the NESC comments referred particularly to the national level, they are also valid at a local level. Within the process of reallocation of resources to community care, sub-area teams could have an important role to play in quantifying targets at local level. In principle at least, the existence of a solid team structure at local level ought to facilitate resource allocation decisions at this level.
4. TEAMWORK ISSUES

This section looks at teamwork issues in general and in a service delivery context. As not every collection of people at work is a team, it is useful to begin by distinguishing between teams and other types of working groups. Nichol (1983) notes that a team is not simply a committee where people cooperate but rather an integrated unit geared to a common purpose. This is at the other end of the continuum from individual work involving limited contact with colleagues. Integration of separate activities lies in between.

Individual work with limited contact — Coordination — Integration of separate activities — Team: Integrated Unit with a common purpose — Collaboration

Some concept of creative interaction is thus essential to most definitions of teamwork. Nichol suggests that team development is about harnessing the potential of people to work cooperatively, creatively and committedly for organisational goals. Booth (1981) distinguishes between coordination and collaboration. Coordination, he suggests, means working independently but in harmony while collaboration means working together.

Irish district care teams have been at the more individualistic end of the individual-team continuum i.e., more geared towards coordination than collaboration.

4.1 Conditions for successful teams

The most important condition for any successful team is that of clarity of purpose. Hunter and Wistow stress that structure is not a substitute for purpose and that policy objectives must be clarified:

"The indisputable need for appropriate enabling structures should not obscure the prior and ultimately more important need to be clear about the purpose such structures are intended to serve. The tendency at local level for planners to devote more attention to the fine detail of collaborative mechanisms than to the often more contentious questions concerning desired service patterns is an example of this deficiency" (P.166),

Crucial questions which arise in relation to purpose are: What is the purpose of the service being provided? Which needs is it designed to meet? Is a team structure necessarily required in order to meet those needs and to achieve that purpose? If a team is thought to be required, what are the tasks of the team and is the combination of skills on the team appropriate to the tasks?
The clarification of purpose is the fundamental condition for the establishment and successful operation of a team. Once a team has been established, important conditions for its successful operation include effective communication, clear role definitions and adequate resources.

Some of these conditions can be met from within the team and others (e.g. adequate resources) require support from outside. Many writers emphasise the importance of support from top management to local teams. Cooperation, in other words, needs to be operating not only at the point of delivery of service but also at higher levels. An understanding of team needs by service managers is also essential to its effective functioning.

4.2 Problems and difficulties in teamwork

Before looking at the potential value of teams in the Irish context, it is worth discussing some problems associated with teams. A major point here is that team building and group maintenance processes — as distinct from other forms of contact between people in a group context — are extremely demanding and time-consuming. As Nichol has noted, considerable training in teamwork is necessary if teams are to be successful. It is not always easy to reach the proper balance between process issues (how the team operates), content issues (the team’s tasks) and structural questions (its organisational context).

Major problems in teamwork include issues of leadership, 'power' and 'identity'. These issues are reflected in different professional statuses and values, as well as different problem definitions, role perceptions and views about leadership of those involved in the team. In some respects, power and identity may be seen as opposite sides of the same coin, with power problems (e.g. leadership problems) all the more acute when there is anxiety about work roles in a team context. Huntington (1982) saw medical-social work conflict in terms of identity problems: "The sensitivity of the two groups about their status and knowledge base, leads to tension, particularly in areas of work where weakness is experienced. If one's own weaknesses are then denied and displaced on to the other group, relationships can be virtually destroyed". (p.542). Those comments can clearly apply to a much wider context than to doctor-social worker relationships alone.

The difficulties involved in building successful teams indicate that teams are not required in each situation. Sometimes a courteous and cooperative approach, as distinct from teamwork as such, may meet the needs of a particular situation. Critchley and Casey (1984) suggest however that where there is more uncertainty about the work which has to be done and the needs which have to be met, (which is often the case in community care) there is more need to share and therefore more need for teamwork.
4.3 Implications for Service delivery

In applying this discussion of teamwork issues directly to the service delivery context, it is worth recalling the principle emphasised above i.e. that structure is subordinate to purpose. The implication of this principle is that the objective of teams, and particularly of sub-area teams, is to meet individual or community needs rather than to produce services or to create structures. New structures are not desirable for their own sake but only if they meet community needs.

In the Irish context, therefore, the crucial question which arises is the following: is the creation of formal sub-area teams necessary if community needs are to be met?

In answering this question, it is useful to recall some of the key community care objectives which have already been listed. These include the identification of patient needs and the planning and evaluation of services designed to meet those needs by the different professionals involved in community care; the concentration of resources on particular target groups; and the integration of services at local level. Multi-disciplinary teams clearly have significant potential for contributing to the realisation of these objectives.

Any realistic examination of community care, however, must also identify significant barriers to the establishment of effective district care teams. These include the serious problems already associated with community care teams and a general lack of delegation to the local level within health boards.

In the absence of wider community care reform, it is difficult at the moment to envisage or recommend the establishment of a new formal structure at local level. At the same time, there is clearly an urgent need for innovative approaches to service delivery at local level in community care and for a continuing commitment to a high quality of care.

If district care teams did come to be established in a relatively structured way, what form should they ideally take? On the basis of the discussion in this paper, it is possible to make some suggestions as to how such teams should operate and be structured:

- The identification at the outset of team purpose is very important. In this context, the establishment of priority or target groups might be useful.
- Teams require coordinators but there might be a different coordinator for different target groups.
- Regular, well organised team meetings are very important.
Teams should attach considerable importance to developing stronger relations with GPs and voluntary organisations. Over time, some of these personnel might join teams.

Delegation of decision-making from the centre is very important but teams also require encouragement and support from senior management.

Ideally, over time, teams need to have some control over their own budgets if they are to develop in a dynamic way at local level.
5. **CONCLUSION**

This survey of local service delivery in community care indicates that there is a great variety of experience at local level in Ireland and Britain. It is nevertheless possible to identify some important trends:

- an increasing emphasis on the identification of **target groups** at local level;
- services are increasingly seen as complementary to informal networks, especially in a climate of limited resources;
- the importance of coordination across programme and other boundaries is emphasised;
- **GP** - community care coordination is seen as an important issue at local level.

The basic requirements for successful teams may be summarised as a clear **purpose**, significant **delegation** to the local level and the provision of adequate **resources**. By the same token, current difficulties, such as lack of clarity about the purpose of local teams, a lack of delegation to local level and inadequate funding for community care, may be seen as major barriers to the establishment of successful teams.

In view of current difficulties, it may be suggested that a very significant development of local district teams in any formal sense is most unlikely in the near future. As already suggested, the future of such teams will depend greatly on more general developments in community care or community medicine.

As suggested in the last section, however, to make this point is not to argue that local service delivery must stand still until there are major policy initiatives or structural reorganisation in community care. Even outside the context of such initiatives, there is a clear necessity for imaginative and determined approaches to meeting community care needs at local level in Ireland.
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DISTRICT CARE TEAMS AT PRESENT

There are no nationally established norms in relation to district care teams and there is therefore a considerable fluidity and diversity in the different health boards. There is, in fact, a considerable variety of experience over time and by health board in the organisation of the community services at district level. District care teams exist in a relatively formal sense in some boards. In others, there are teams oriented towards particular target groups (e.g., the elderly or the mentally handicapped) rather than geographically based district care teams as such. In some boards, district care teams were established in the past but no longer exist.

In the North Western Health Board, there are not district care teams in the formal sense. The health board's community care areas are sub-divided into six sub-area, four in Donegal and two in Sligo-Leitrim. The field staff in these sub-areas may be considered as informal district care teams.

In addition, there are teams of staff focusing on particular client groups e.g., the elderly and the mentally handicapped. In relation to services for the elderly, matrons of small hospitals act as district coordinators and there is also an area coordinator at community care area level. Services for the mentally handicapped are organised by community service units covering populations of roughly 20,000 people and the community psychiatric services are sub-divided into different sectors, served by sector teams.

In the South-Eastern Health Board, there are not district care teams as such but there are teams oriented towards particular target groups e.g., geriatric assessment teams and mental handicap intervention teams. There are ad hoc arrangements at the local level with area medical officers being responsible for areas of around 25,000 population and particularly for school services and for development clinics for children. District care teams were tried in the past but there was a difficulty related to the irregular attendance of the people who were not health board employees - e.g. GPs - at the meetings. For teams to be set up in the future, and to work successfully, the present staff shortage in the health board would have to be remedied and the active involvement of GPs and voluntary organisations would be required.
In the North-Eastern Health Board, district care teams have never been set up on a general basis because of shortage of staff and particularly of directors of community care and of area medical officers. In the Louth community care area, however, there are two district care teams based at Carrickmacross and Ardee. The teams members include the local health board staff as well as GPs and representatives of voluntary organisations. Meetings which occur once a quarter are chaired by a non-statutory person and are seen as useful fora where problems of mutual interest can be discussed.

In the Western Health Board, there were once district care teams but these were disbanded a few years ago. These teams operated at a very local level. There were fifteen in Galway, twelve in Mayo and four in Roscommon. They included public health nurses, GPs, community welfare officers and voluntary organisations and met once every two months. The aim of the teams was to develop a multi-disciplinary approach and links between different disciplines as well as between those who delivered and those who organised the service. They also had the objective of defining the needs of the locality, reviewing the functioning of the health services in the locality and of submitting proposals to the community care team.

In the Midland Health Board, the two community care areas are both divided into three different sectors of roughly 20-30,000 people. Organisation is by client group - there are sectoral teams for the mentally handicapped and the elderly as well as one examining child abuse. The Directors of Community Care and the Senior Area Medical Officers play a central role in the teams. Attempts are being made to develop contact with GPs and to review the work of voluntary organisations which receive money from the health board. While organisation of teams is by client group, there are also monthly meetings which include a general review of services.

In relation to services for the elderly, the liaison nurse between the hospital and community services plays an important role. She is also involved in the organisation, on a pre-planned basis, of relief beds for the elderly, i.e. temporary beds which provide relief for people caring at home for elderly relatives.

In the Eastern Health Board, community care areas and teams were established relatively late and it has never been found necessary to set up sub-area teams in any formal sense. The restricted area of the EHB, as compared to much larger regions, may also be seen as a factor militating against the establishment of district teams.
There are teams of doctors and nurses which care for the elderly as well as ad hoc sub-area teams which deal with problems such as the sexual abuse of children.

In the Mid-Western Health Board, district care teams have existed since the mid 70s. There are now 3 community care teams and 14 sub-area teams: 5 in Limerick, 5 in Tipperary/Limerick and 4 in Clare. Each team serves a population of 25,000 to 30,000 people and includes the usual range of health board community care staff. There is also contact with community psychiatric nurses and voluntary organisations. The area medical officers and the public health nurses are in contact with the GPs. In time, it is felt GPs, pharmacists and the psychiatric services might be incorporated into the teams.

There has been active consideration for some time of district care teams in the Southern Health Board. Such teams were established in the early 1980s. These had a strong community orientation. They were seen as linking the provision of services and the development of a community. Among their objectives was to improve the self-sufficiency of the less well-off and to build a partnership between the community and the health board. They were also aimed at involving local non-professionals in discussions where appropriate. They included local priests, voluntary workers and teachers and discussed a wide range of community issues and problems. Questions of confidentiality could sometimes cause difficulties in a broad-based group. GPs did not participate in these teams, which have now lapsed. There is multi-disciplinary involvement in the family resource centres at Togher and Mayfield and active interest in the establishment of district care teams in the amalgamated North and South Lee community care areas.

NOTE: This information is based on an informal survey carried out in mid-1989.