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Implementing Assessment and Care Management:

Learning from local experience 1990-1991

by Virginia Beardshaw
with MAIN participants

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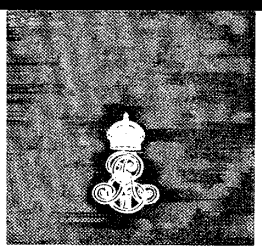

Contents

Virginia Beardshaw is Director of the King's Fund's London Initiative.

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Acknowledgements

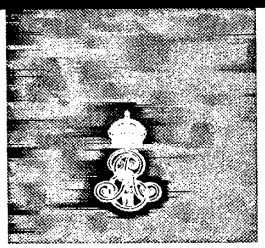
This report is the result of an eighteen month collaboration between senior officers of eleven English local authority social services departments on the issues, dilemmas, conflicts and rewards associated with the implementation of the assessment and care management arrangements outlined in the government white paper *Caring for People* and the NHS and Community Care Act 1990.

These officers came together to form the MAIN network, with support from the Social Services Inspectorate of the Department of Health and from their individual social services departments. The King's Fund, which facilitated the formation and workings of the group, gratefully acknowledges this help, as well as the valuable contribution of the individuals who participated in MAIN.

The authorities who worked together within the network are very different, covering as they do the full range of rural and urban environments in England and an equivalent spectrum of political orientations. The degree of information sharing and mutual learning achieved within the network accordingly reflects the best collaborative traditions of the British public sector.

David Towell and Roger Blunden of the King's Fund and Lynda Hoare of the Social Services Inspectorate facilitated MAIN's work, and collaborated with me on the preparation of this report. I thank them for their help. In addition, thanks are due to Linda Moore and Carmel McColgan for their administrative and secretarial help in supporting the network and preparing this manuscript, and to Ann James and Tessa Jowell for their useful comments on it.

Virginia Beardshaw, September 1991



Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their lives.

Caring for People: Community Care in the Next Decade and Beyond, 1989.

1. Introduction

This report concerns the implementation of assessment and care management* within eleven local authority social services departments in England in 1990 and 1991.

In the spring of 1990, a group of senior social services managers responsible for developing assessment and care management within their authorities formed themselves into MAIN — a mutual aid implementation network. MAIN's work was supported by the Social Services Inspectorate of the Department of Health as part of its programme of 'Caring for People' implementation projects, and was facilitated by the King's Fund. The establishment of the network was linked to the Fund's earlier work for the Social Service's Inspectorate's assessment and case management project group, which had been established to lead and monitor the implementation of the provisions of the National Health Service and Community Care Act 1990 within English local authority social services departments.[1]

This report summarises the issues raised and the approach taken by the MAIN network's member authorities as they began the process of introducing assessment and care management within their social

* As a result of representations made during consultations on the Department of Health's draft policy guidance, the term 'care management' is now used in place of the earlier 'case management', which featured in the white paper 'Caring for People'.

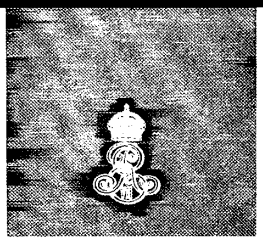
services departments. It is intended to inform others with responsibility for assessment and care management about the network's approach, and some of the strategies and tactics which its members found helpful. MAIN participants are listed in Appendix 1 to this report, along with their contact addresses and telephone numbers, which readers can use to obtain further information.

The MAIN Network

Assessment and care management are critical elements of the current programme to reform the delivery of services for people with disabilities which was established in the white paper *Caring for People* and the National Health Service and Community Care Act 1990. The ways in which local authority social services departments develop and introduce these processes will be important to the success of the community care reforms as a whole.

The MAIN network's aim was to provide its members with opportunities to share experiences and provide mutual support for the process of evolving their authorities' approach to this key part of the reform programme. At the same time, the intention was for it to act as a sounding board to permit the Social Services Inspectorate and others at the centre to test out ideas and learn from a range of local situations. The network was designed to include participants from a range of county councils, metropolitan boroughs and London boroughs so that ideas and approaches from a variety of different settings could be discussed and tested among participants.

MAIN met for five two-day sessions. These were held in May, July and September 1990 and April and September 1991.



2. THE ROLE OF ASSESSMENT AND CARE MANAGEMENT IN COMMUNITY CARE

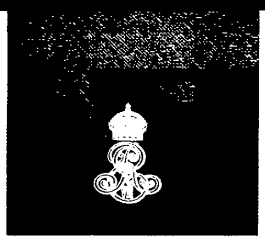
Caring for People, and the legislation that flows from it, gives local authority social services departments four key responsibilities to undertake in fulfilling their role as lead agency for community care:

- needs assessment;
- design of service packages;
- organisation of service delivery from a variety of providers in the statutory, voluntary and independent sectors;
- monitoring the quality and cost effectiveness of services.

Each of these responsibilities has an important bearing on the processes of assessment and care management. The guidance and other documents produced by the Social Services Inspectorate's advisory group on care management and assessment define both of them, and give detailed advice and guidance on local implementation strategies[2].

Dilemmas and conflicts

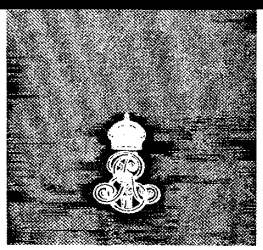
Assessment and care management will occupy a pivotal position in the new service system. The two processes will mediate between the needs of individual people with disabilities and their carers, and the resources and services available for their support in the community or in residential care. In essence, assessments will determine eligibility and establish needs. Care management is a method which social services departments can use to organise the inter-related tasks of needs assessment and the design, management and monitoring of care centred on individual requirements.



As such, assessment and care management are about two distinctly different things. They are about tailoring services around individual needs *and* about resource rationing.

In practice, too, assessment and care management processes are likely to reflect a tension between *Caring for People*'s twin objectives of increasing the self determination and independence of people with disabilities by maximising the choices available to them and their carers at the same time as taking account of 'the local availability and pattern of services'.

Assessment and care management could become mechanisms through which resources — for example, financial support, staff time, buildings — become used in a more flexible way to support people with disabilities in the community. This should mean a new emphasis on 'starting where the user is' in terms of needs assessment, instead of simply fitting people into existing services. These changes will, however, need to reflect continuing resource constraints within social services departments. More precise 'targetting' of services is almost certain to mean that some people receive fewer services — or nothing at all — at the same time as others receive help more precisely geared to their requirements. Moreover, the introduction of assessment and care management will involve a major change to the organisational culture in which service provision takes place. The extent to which both processes can be meshed productively with wider service planning, development and purchasing on the one hand, and the development of client-centred information and financial support mechanisms on the other will influence how far social services departments change from old-style blanket provision to support that more precisely meets individual need.



In the course of MAIN's work it became clear that support and leadership at a very senior level from within social services departments was vital if the implementation of assessment and care management processes is to be effective. In particular, participants considered that there was likely to be considerable conflict between the tailoring of packages to individual need and the imperative — in the case of directly provided or volume contracted services — to hold down unit costs by maximising resource usage. This dilemma was strongly associated with network members' concern about how historically committed resources — for example, residential and day care directly provided by local authorities — could be 'unlocked' and made available in parallel with the gradual implementation of care management.

The Implementation Timetable

Caring for People: Community Care in the Next Decade and Beyond was published in November 1989, and its main recommendations were incorporated into the National Health Service and Community Care Bill which began its passage through Parliament in January 1990. The Act received the Royal Assent in June of the same year.

In the field, local authorities began to prepare for the community care reforms early in 1990. In many places, these early efforts built on thinking and small-scale innovations which had developed during the 1980s. By the first meeting of the MAIN network in May, many social services departments had designated lead officers with responsibility for developing the new structures and approaches that would be needed. At that time, authorities were working to a timetable in which the community care changes paralleled the NHS reforms. The aim was to have the new structures broadly in place by April 1, 1991. Many social services departments placed particular priority on agreeing assessment procedures for elderly people in need of support and on developing an approach to community care

plans with NHS colleagues.

On 19 July 1990 the then Secretary of State for Health, Kenneth Clarke, announced a two-year delay to the full implementation of the reforms in a statement to the House of Commons. Local authorities were instructed to continue to bring in the changes, but at a slower pace. In particular, the transfer of responsibilities for elderly and other people entering state-supported residential care was put back until April 1993. As a result, funds to pay for board and lodging in residential care will remain within the social security budget until that time.

The effect of the delay in implementation on MAIN participants was immediate. At the network's inaugural meeting in May, it was clear that the participating authorities found the initial deadline of 1st April 1991 an extremely challenging one, especially in the light of their parallel responsibilities for the implementation of the Children Act 1989 by October 1991. For many authorities, too, the introduction of the Community Charge from 1 April 1990 was resulting in an astringent financial climate in which the assumption of major new responsibilities seemed a particularly daunting task. Despite these difficulties, however, most of the participating social services departments had felt on their mettle to make progress with the reforms, in order to prove that they could fully assume their role as community care lead agency.

It is fair to say that MAIN members were initially discouraged and dismayed by the postponement. The network's meeting on 16-17th July was overshadowed by rumours that an announcement of a major delay in implementation was imminent, and when participants met on 13-14th September it was clear that some authorities' plans had not recovered their momentum.

There was a general uncertainty about the revised timetable for the reform package, and the extent of the political will behind it. Many Departments within the network were uncertain about how much priority to place on community care. Moreover, the financial constraints imposed by local authorities' need to limit their community charge demands, along with continued turbulence within social services departments over arrangements for the implementation of the Children Act, meant that the changes outlined in *Caring for People* were in danger of slipping down the agenda both within MAIN's participating social services departments and within their sponsoring local authorities.

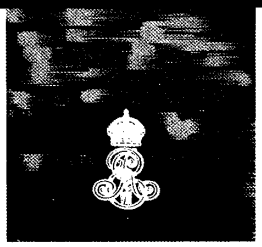
By the time of MAIN's September meeting, it was clear that the vagueness of the revised timetable and the other uncertainties created by the delay in implementation posed particular difficulties for officers responsible for the new arrangements for assessment and care management. Both processes are central to the changed approach to community care, and their successful implementation therefore depends on the extent to which they can be meshed with a number of other changes to the service delivery system. These include the development of a range of service options for users and carers; individualised budget allocations; and user-centred information and financial systems.

Given continued resource constraint, some members found it hard to see where money for 'alternative' service options would come from, particularly in charge-capped authorities. In particular, participants considered that there would be little or no extra money to develop improved domiciliary support. There was the additional concern that private and voluntary homes that were struggling to support people on existing social security payments would get into further trouble and seek assistance from social services departments. This was a particular worry in the light of

some MAIN members' fears that the delay was encouraging some health authorities to continue to bypass social services departments and place frail elderly people in residential care. There was doubt within some authorities about whether or not funding would in fact transfer from social security to local authorities in 1993.

Overall, through the latter half of 1990 and much of 1991 there appeared to be a risk of planning blight and a lack of impetus to embark on the full-scale reform package within social services departments. This persistent problem was complicated by many members' perceptions of the community care reforms being in competition with the implementation of the Children Act 1989 for the resources and talents within social services departments.

Given these problems, however, some participants did welcome the additional preparation and training time granted by the delay. They also recognised that continued social security board and lodging payments for residential care would provide some much needed flexibility within the system. For many of the managers involved, then, the delay opened up the possibility of moving ahead more slowly and pragmatically, with opportunities for experimentation and development that would not have been possible under the original timetable. For many MAIN participants, this of itself represented a heartening opportunity for positive change.



3. Key issues in implementation

At all of the network's early meetings, MAIN members wrestled repeatedly with the 'chicken and egg' dilemma posed by the centrality of assessment and care management to the community care reform package as a whole. In discussion, it became clear that a major cultural shift was required in order to introduce them into social services departments. Incrementalist approaches were possible, and had definite advantages, but carried with them the danger that social services departments would continue in the old service-dominated groove, with the result that the impact of the reforms would become diluted.

This key problem was reflected in the issues for implementation which network members identified and discussed in depth at the network's three first meetings. Another problem which underlay much of the discussion was the tension implicit in the need to target scarce resources at the same time as developing holistic support systems which take account of the needs of people as individuals. Both themes feature prominently in *Caring for People*.

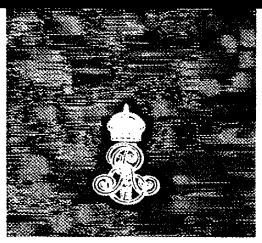
A third structural issue to which participants returned repeatedly was the need for social services departments to stimulate commitment to ensuring better lives for people with disabilities across the whole local authority. Community care objectives needed concerted action from housing, education and leisure departments, as well as from the employment and equal opportunities policies of the wider authority. Support from chief executives' and treasurers' departments was felt to be essential to ensuring a wholehearted corporate commitment to community care.

In summary, MAIN members considered that a shift from conventional forms of provision to tailor-made services of the type outlined in the white paper required simultaneous developments on the following fronts:

1. Moving towards a distinction between purchaser and provider functions within social services departments

At the network's early meetings, members discovered that they held very different perceptions about what a 'purchaser/ provider split' might involve. It became clear through discussion that this reflected a lack of clarity and an absence of any consensus within social services departments themselves. While some of the social services departments represented within the MAIN network were beginning to make changes in the direction of a division between purchaser and provider functions, others were at a very preliminary stage. Some of these differences in approach could be explained by varying political orientations, while others appeared to relate to the different approaches of urban and of rural authorities. Some participants considered that changes were likely to take the form of a very slow and gradual evolution, while others saw it as essential to further development.

In a number of the authorities which had decided to restructure, 'splits' along two dimensions were taking place. The first was a division between adult and children's services, which had been stimulated by the need to implement the provisions of the Children Act 1989 at the same time as those of the NHS and Community Care Act 1990. This frequently occurred at assistant director level within social services departments. The second was a separation which was developing in some places between 'purchasers' of services — the new style 'care managers', or, in some cases, social workers or principal social workers — and 'providers' — typically, home care organisers, and day and residential services managers. This division usually occurred much lower down the organisation, and in many places posed a demanding set of issues for managers implementing the



change, and for staff undertaking new roles (see Section 3).

The London Borough of Waltham Forest was debating the extent to which a wholesale split should be made between purchaser and provider functions. However, a proportion of the Borough's residential homes have already been transferred to not-for-profit organisations, along with some day services. This had already led to an enhanced inspection function within the department to oversee voluntary and not-for-profit provision within the Borough. In Wandsworth, managers are planning to transfer a proportion of the Borough's residential homes to not-for-profit organisations, along with its non-specialist day centres. An experimental contract for evening home care services has been placed with a private sector provider, in parallel with a similar in-house evening home care scheme. The contractor and the authority are collaborating in evaluating both projects.

Humberside social services had developed a detailed plan to reorganise around a purchaser/provider split. Within adult services, care management staff will be organised into 18 district teams of service purchasers. Resources will be managed as clusters or 'resource centres'. Overall management of assessments and resources meets only at assistant director of social services level — an arrangement considered necessary for the creation of a 'marketplace' approach to purchasing.

Devon social services was piloting the separation of provision and assessment in three locations. Beginning this year, care management teams will be established under different management from the in-house service provision. The variations in each locality will be evaluated to establish how radical the separation needs to be.

MAIN participants noted that in many places reorganisations were taking place to cope with the requirements of the Children Act 1989 and the NHS and Community Care Act 1990 for a more specialised form of working, with the danger of fragmentation of services. This held the risk of administrative divisions developing that would not necessarily benefit users.

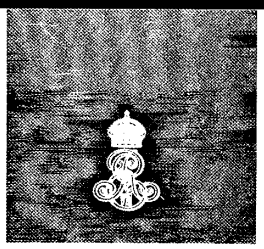
2. Developing clear-cut criteria for targetting services to those most in need

Developing eligibility criteria was proving difficult in many places, and doubts remained about what information to make available to the public. MAIN members also felt that it was important for elected members to understand and agree to any eligibility criteria established, given their political implications.

Despite these difficulties, authorities which faced possible charge-capping had found that having clear-cut eligibility criteria for services was becoming essential for the implementation of both the community care reforms and the Children Act, if budgets were to have any hope of coping with demand. In these circumstances, it was inevitable that fewer people will be eligible for services, but the aim is that those who do will be those with the greatest levels of disability.

Devon social services had identified three levels of priority after extensive consultations:

- **First priority:** Those people who, without the active involvement of the Department, would be in danger of physical or emotional harm.



- **Second priority:** Those people who, without the active intervention of the Department, would be at risk of losing their independence.

- **Third priority:** Those people who, without the active intervention of the Department, would be unable to maintain a satisfactory quality of life.

Devon social services has piloted a differentiated system of assessment in seven districts. The intention was for each client to receive a core assessment at the initial and review stages, which any professional would be equipped to do. This would trigger a further 'professional specific' assessment where needed, and ensure a broadly based, needs-led approach. Devon social services' core assessment guide is reproduced in Box 1.

In Lewisham, work was proceeding on a new integrated assessment system. This builds on existing practice, but with the aim of eliminating the duplication of assessments which happens at the moment. The Borough is finding that the implementation of differentiated assessment is more difficult than it initially appears, and has established a working group to tackle this issue. However, it is clear that the eventual assessment system will be based on an initial screening, which will result in a core assessment upon which specialist assessments will be added where needed. There has been some interest in developing this process across agencies, and integrating it with the introduction of a health and social care record. A pilot project on this began on 1 May 1991, with the aim of ensuring that a folder containing basic information and a record of all services provided will be kept in clients' homes. The intention is to promote better communication between agencies and the sharing of information between them and clients and carers. This new scheme is supported by joint finance.

BOX 1:

DEVON SOCIAL SERVICES ASSESSMENT GUIDE

Core Assessment Guide: Adults

Name ..... No ..... Date .....

- **DON'T FORGET — ALWAYS START WITH PROBLEM/ISSUE**
  — OBTAIN THE CLIENT/CARER PERSPECTIVE
- **THEN EXPLORE CONCERNS ABOUT:—**

MOBILITY/TRANSPORT? **(PLEASE RING APPROPRIATE STATEMENT)**

	1	2	3	4	5	Action/comments
MOBILITY	Independent	With difficulty	With equipment	With help of another	Immobile	
GETTING UP/ GOING TO BED	Independent	With difficulty	Some supervision	With help of another	Bedfast	
SITTING IN AND GETTING OUT OF CHAIR	Independent	With difficulty	Some supervision	With help of another	Unable	
TRANSPORT	Uses own	Public only	Adapted	Needs escort	Housebound	

CHECK ♦ Is orange badge needed? Yes No

DOMESTIC ACTIVITIES?

						Action/comments
HOUSEWORK	Independent	With difficulty	Light only	With help of another	Unable to do housework	
COOKING	Fully competent	Certain meals only	Heats only	Neglects cooking	Unable to cook	
SHOPPING	Independent	Local/small items only	Escorted only	Neglects shopping	Unable to shop	
USE OF MONEY	Competent	Some under-standing/not confident	Needs help sometimes	Needs a lot of help	Not capable	

PERSONAL CARE?

						Action/comments
WASHING	Independent	With difficulty	With equipment	With help of another	Unable	
BATHING/ SHOWERING	Independenc	With difficulty	With equipment	With help of another	Unable	
DRESSING	Independent	With difficulty	With equipment	With help of another	Unable	
EATING	Independent	With difficulty	Needs special preparation equipment	Can manage with help of another	Unable to feed self	
TOILETING	Independent	With difficulty	Catheter/ colostomy equipment	Some supervision	With help of another	
MANAGE MEDICATION	Independent	May need occasional prompt	Fine if regularly supervised	Likely to make some mistakes	Needs constant supervision	

		1	2	3	4
CHECK ◗	FALLS?	None	Only accidental trips	Occasional	Frequent
COMMENTS ◗	CAN PERSON SAFELY BE LEFT	Anytime	For long periods	For short periods only	Not at all

PHYSICAL/MEDICAL?

	1	2	3	4	Comments/action
GENERAL HEALTH	Good	Some problems under control	Some problems needing attention	Needs urgent medical attention	
CONTINENCE URINARY	Full control	Some lapses	Day/night only	Incontinent day and night	
CONTINENCE FAECIAL	Full control	Some lapses	Day/night only	Incontinent day and night	

		1	2	3
CHECK ◗	FATIGUE	None	With maximum exertion	With minum exertion
COMMENTS ◗	PAIN	None	Minimal or under control	Considerable, not under control

SENSORY DIFFICULTIES?

	1	2	3	4	Comments/action
HEARING	No problem	Partial loss	Some difficulty needs attention	Profoundly deaf	
SIGHT	No problem	Partial loss	Some difficulty needs attention	Severe visual problems	

COMMENTS

CHECK

- ◗ Is there a need for special help with communication?
- ◗ Is mobility training needed?
- ◗ Is any input needed from the rehabilitation officer for the

COMMUNICATION? (talking, listening, understanding speech)

	1	2	3	4	Comments/action
ABILITY TO COMMUNICATE	Clear	Some problems, but can understand and communicate needs	Unable fully to understand/ communicate needs	No effective contact	

COMMENTS

LEARNING/WORK/LEISURE?

	1	2	3	4	Comments/action
EDUCATION/ LEARNING	Satisfying	More or greater variety	Not meeting learning needs	No educational/ learning opportunities	
WORK/ OCCUPATION	Satisfying	More work or variety needed	Not meeting occupational needs	No appropriate work	
LEISURE	Satisfying	Greater variety needed	Not meeting leisure needs	No leisure activity	

COMMENTS

EMOTIONAL HEALTH?

	1	2	3	4	Comments/action
MOOD	Normal	Evidence of anxiety or low spirits	Major anxiety/feeling depressed	Profoundly depressed or extremely elated	
MOOD FLUCTUATION	Stable	Some fluctuation in mood	Rapid swings of mood (high/low)	Extreme fluctuation seriously affecting functioning	
SLEEPING	No problem	Wakes early/difficulty in getting to sleep	Sleeplessness affecting functioning	Sleep seriously disturbed/wanders	
ATTITUDE TO SELF	Positive	Some self doubt — in specific areas	General lack of confidence/self esteem	Negative adversely affecting functioning	
SUBSTANCE MISUSE	No problem	Some evidence of misuse	Misuse affecting functioning	Major misuse adversely affecting life	
MEMORY	Good	Forgetful	Poor short term	Poor short and long term	
MENTAL ORIENTATION	Normal	Does not always recognise known people/places	Sometimes wanders and gets lost	Usually completely disorientated	

CHECK	♦	If person confused . . .	For less than 3 months	For more than 3 months
CHECK	♦	Are there any other concerns about mental health e.g. strange beliefs or obsessional compulsive behaviour?		
	♦	To what extent do these affect everyday life and functioning?		

COMMENTS

RELATIONSHIPS/INTERACTION WITH OTHERS?

	1	2	3	4	Comments/action
ACCOMMO-DATION	Own home	Family/other person's house	Sheltered housing	Residential care	
LIVING	With spouse	With family	With other informal carer	Alone	
WITH FAMILY/ PARTNER	Good	Some conflict usually resolved	Major conflict of interests	Breakdown of relationship probable	
WITH OTHERS	Good	Some conflict usually resolved	Major conflict of interests	Breakdown of relationship probable	
WITH CARER	Good	Some conflict usually resolved	Major conflict of interests	Breakdown of relationship probable	
SOCIAL INTER-ACTION WITH OTHERS	Confident	Needs help to develop	Some undesirable personal and social responses	Inappropriate responses/needs help	

CHECK ➧ Are there any concerns about behaviour, e.g. physical/verbal challenge.

In what context and to what degree?

COMMENTS

CARER/NETWORK SUPPORT?

	1	2	3	4	Comments/action
LEVEL OF CARE NEEDED	Very little	Frequent	Most of the day	Night and day	
CARER'S ATTITUDE TO CONTINUING CARE	Happy to continue	Is happy to continue with some changes	Needs much more help to continue	Does not wish to continue	
CARER'S HEALTH	Good	Some problems	Some problems needing attention	Major problems needing attention	
CARER'S SOCIAL CONTACTS	Has full social life	Has full social life with some limitations	Has little or no social life	Has no social life and wants one	
OUTSIDE HELP	Frequent	Contact but help there when needed	Little contact	No one to help	

COMMENTS

CHECK ➧ Is an alarm system needed?

ARE BASIC NEEDS BEING MET?

	1	2	3	4	Comments/action
FOOD/DIET	Good	Diet suspect	Insufficient to maintain good health	Malnutrition	
HEATING	Adequate	Some problems — not dangerous	Some problems — dangerous	Totally inadequate	
HOUSING	Adequate	Needs attention	Unsuitable needs major alterations/rehousing	Homeless	
FINANCE	Sufficient	Finds it difficult to manage	Some financial difficulties	Major financial difficulties	

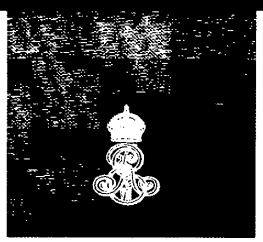
CHECK ♦ Are all the following benefits being claimed?

Mobility Allowance	Yes	No
Attendance Allowance	Yes	No
Invalid Care Allowance	Yes	No
Severe Disablement Allowance	Yes	No
Housing Benefit (Poll Tax relief)	Yes	No
Income Support	Yes	No
Family Credit	Yes	No
Is further benefit advice/support required	Yes	No

FINAL CHECK

		1	2	
♦	**CAN DEPENDANTS BE ADEQUATELY CARED FOR**	Yes	No	**CROSS REFER TO**
♦	**IS THERE ANY EVIDENCE OF ABUSE/ EXPLOITATION**	Yes	No	CHILD GUIDE ?
♦	**CAN PERSON APPRECIATE/ANTICIPATE DANGER**	Yes	No	
♦	**IS THERE A RISK OF SELF HARM**	Yes	No	**IS A SPECIALIST ASSESSMENT NEEDED?**
♦	**THERE A RISK TO OTHER PEOPLE**	Yes	No	**WITHOUT SOCIAL SERVICES INTERVENTION, IS THIS A PRIORITY "A" SITUATION?**
♦	**WILL PERSON/CARER SEEK HELP**	Yes	No	
♦	**IS THERE A RISK OF THE PERSON LOSING INDEPENDENCE**	Yes	No	**WITHOUT SOCIAL SERVICES INTERVENTION IS THIS A PRIORITY "B" SITUATION?**
♦	**IS A MORE INTENSIVE FORM OF CARE NEEDED**	Yes	No	

FINAL COMMENTS



Another authority was developing criteria to distinguish between consumers who will get a complete occupational therapy service; those who would get advice only; and those who would receive neither. This work was being carried out in conjunction with health service occupational therapy managers. At the same time, it is refining its criteria for home care services so as to concentrate on expanding quality provision for its most dependent or vulnerable users.

In Humberside, a banding system for assessment was being developed. When implemented, this would permit an estimated 30-50 per cent of referrals to be dealt with by resource centres, which would assess for 'simple' services only. The aim was to reserve full community care assessments for people with more complex needs.

In Birmingham, the social services department had already established criteria for day care and home care, and these had been approved by the social services committee. Work was going on to extend criteria to services for all user groups, and to develop appropriate information for users and carers.

When considering this issue more generally, a number of MAIN members felt that while social services departments had working eligibility criteria for services like home helps, it was difficult to state simply what these were for fear of excluding people through undue rigidity. A further dilemma was whether more explicit eligibility criteria would imply entitlements, and — if so — how to square this with resource constraints. For some people — those with severe physical disabilities being one example — this might have major cost implications for the department. Packages costing between £40,000 and £50,000 a year were by no means unusual.

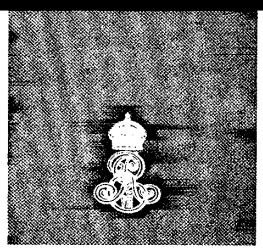
3. Moving from service-led to client-centred screening and assessment systems

Although MAIN participants perceived difficulties in devising screening mechanisms that could operate efficiently without prejudging client need, the concept of 'differential assessment' was proving helpful for many authorities. Several were considering introducing a more substantial reception/information giving function at the point of entry. This would enable them to screen out people who wanted information or simple as-of-right services. The intention is to staff these new posts with experienced and well-trained staff who would not necessarily hold professional qualifications. Clients with more complex needs would be passed to assessment teams for assessment and possible care management.

At the same time, certain participants reported that there was anxiety at middle-manager level in their home departments that 'deprofessionalising' screening might lead to a big increase in demand for services. However, progress could be made, and there was good practice to build on. MAIN participants felt that appropriate training of staff and forms and procedures which reflect a needs-led orientation would result in a better approach.

4. Involving users and carers

MAIN participants saw the new emphasis on client and carer involvement as an opportunity to develop services which were equally accessible to all members of the community. They recognised that discussing plans for services with voluntary organisations representative of different types of service user or particular ethnic groups, religious leaders and small groups of users was part of the process of involvement. No one method of



consultation would be sufficient to do this: instead, a range of approaches needed to be developed if the needs of users and carers were to be brought to the attention of service planners. MAIN members considered that the involvement of users and carers was an essential part of the cultural shift which the community care reforms required.

In Hammersmith and Fulham, the social services department was actively consulting with local community and voluntary groups on the implementation of the new legislation through five one-day conferences. One of these had been reserved for black and ethnic minority organisations. In Camden and in Hampshire, the drafting of community care plans was providing a good opportunity for in-depth consultation with service users and their families and a series of public consultation meetings was also planned. Hampshire's first Community Care Plan was produced in April 1991, and a number of new consultation mechanisms are being used to prepare the 1992 plan, including user groups which have been established for this purpose.

In Wandsworth, individual voluntary organisations representing users and carers and the local Community Care Alliance — an umbrella group of such organisations — have a major role within the service area planning teams which are currently meeting to draft the community care plan in preparation for wider consultation.

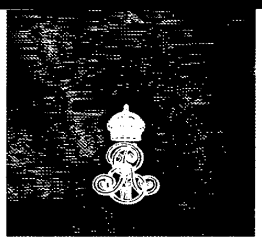
In Birmingham, consultations on care plans were taking place and user and carer involvement was being 'designed into' the new assessment procedures by designating spaces on assessment proformas for users and carers to comment and to agree or to disagree with assessments made. Copies of service plans would be given to users and carers. Three county-wide workshops to

discuss good practice had been organised in Devon, to which users and carers had been invited. The intention was to develop ground rules for user and carer involvement as a result of these meetings. In Waltham Forest a newsletter on the community care plan was being delivered to every household. This included information in minority languages, and offered local people access to a 'hotline' which they could use to ring in with their comments. Walsall social services had had two years' experience of working with a local 'Home Care Cooperative' which the local authority had helped to establish with the aim of helping people with disabilities pool benefit payments received through the Independent Living Fund, Attendance Allowance and the like in order to receive flexible home care support tailored to individual needs.

Participants reported anxiety within their departments about the new emphasis on carers leading to increases in demand for services that could not be met. In most places, the de facto situation was that people with carers received fewer services and had lower priority generally than those living on their own.

5. Building in quality standards and review procedures as assessment and care management approaches are developed

Quality standards and review procedures were felt to be very important, but — once again — a number of participants felt that their authorities were at a very early stage in their thinking. However, it was clear that quality assurance would require the development of standards specifications, control mechanisms, and the review of contracts with private and voluntary organisations as well as 'in house' providers.



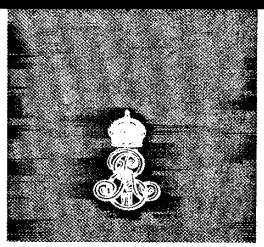
Wandsworth social services department was experimenting with new approaches to service assessment and review criteria for its contracted-out evening home care scheme and a number of other services, including its shopping scheme and mental health resources. The department had already drawn up specifications for the residential care of elderly people in preparation for the transfer of a number of homes to the independent sector. Meanwhile staff in its newly formed quality assurance and service planning division have been working with home care managers and key health authority staff on a 'purchasing brief' for future home care services. In addition, the authority is currently working on specifications for services contracted for individual users.

Other authorities within the network had made some preliminary attempts to set basic quality criteria. In one instance, this included target times for response to referrals, time limits for the completion of assessments and target levels for complaints and appeals. Camden had introduced a quality assurance project in the learning difficulties field in conjunction with local voluntary organisations. Birmingham had adopted a policy on quality, and had conducted quality briefing sessions for every member of staff. Hampshire have also conducted 'total quality management' briefings, and have drawn up several service level agreements with voluntary organisations, along with service level assessment criteria to apply to residential establishments. This work is being informed by consumer surveys. 'Core quality standards' which would apply to all services were being drawn up in Devon, which had already established basic departmental requirements for the quality of assessment and review processes. Waltham Forest had agreed a programme for implementing a quality assurance system by 1993.

6. Devising flexible 'user-centred' information and financial/budgeting systems

MAIN members felt that appropriate management and financial information systems were a crucial part of developing an effective strategy for implementing the community care reforms. At the same time, it was very important that these systems should be designed with the aims of the new community care arrangements in mind. They should not become 'information technology driven'. However, action on this front required a major commitment from treasurers' departments — something that MAIN participants felt might be difficult to achieve in some cases. It would also be important to decide on the appropriate level within the organisation for this information to be made available: some participants felt that it would be counter-productive to involve professional staff in the details of budgeting.

At least one authority represented in the network had decided to go for a simple and inexpensive system using Lotus 123 software. This allows cost centre managers to manage and control budgets, and to build up simple information systems using spreadsheets. Another had found that its budgets could not stretch to cover a major investment in information technology at the same time as a major departmental restructuring exercise, but was piloting local personal computer-based financial information systems with the intention of encouraging the development of 'add on' packages to meet particular service needs. The London Borough of Hammersmith and Fulham were using people with HIV and AIDS as the pilot client group for its information technology package.



Devon social services had also developed a PC-based package, which was being piloted in three districts of the county. This takes dependency and risk data and specifies a broad 'band' of care that can be applied by front line staff without further approval. Each of the five bands has an upper limit for weekly expenditure, which may be exceeded with approval from team managers.

7. Ensuring consistency of approach

The question of the extent to which it was necessary or desirable to ensure authority-wide consistency of approach to clients and particular client groups — and whether information and management systems could be devised to do this — was an issue that concerned network members. This could be a particular problem within large counties with a mixed rural and urban population like Suffolk, Devon and Hampshire.

In addition, network participants felt consistency to be a key issue for the implementation of the community care reforms because they implied rationing in a way that was more explicit than it had been in the past. The need to be seen to be fair was thought to be a necessary corollary to this. It was important for services not to be dependent on where people lived, or on the whims of individual professionals.

However, the new emphasis on quality assurance and contracts was thought by some to be an helpful aid to ensuring consistency of approach within and across client groups. In Humberside, the fact that community care assessments could only be carried out by assessment officers who would all be equipped to take a similar approach was thought to be likely to result in a more consistent approach to service delivery than previous systems.

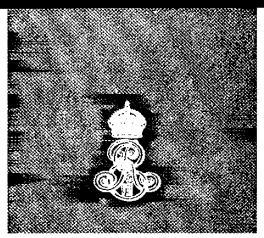
8. Staff skills

Would there, in effect, be a need for new professionals in the reformed system? What role would it be appropriate to ask existing personnel — for example, home care organisers and social workers — to take on under the new arrangements? Participants agreed that it was critically important to answer the question "What do we want staff to do?" before setting out to determine the skills and training needed. Some expected considerable change over the next two years, and felt that new jobs might emerge out of it. With this in mind, it was important not to be drawn into an over-mechanistic approach in which particular qualifications or skills were over-valued, or devalued. It was possible that developments with National Vocational Qualifications might offer a way forward, although many authorities considered that the costs of this approach amounted to a considerable barrier.

9. Working with Elected Members

The community care reforms implied a major shift in the culture of social services departments, along with important changes in practice. MAIN participants felt that it was important to involve elected members in the change process from the earliest stages, so that they understood the strategies and decisions on resources that faced them.

In order to do this, Hampshire social services department had established two members' panels which are set to meet eight times over their two-year lifespan. One covers costs and quality, with a remit which includes the future of residential care, inspection and complaints, and costs and finance. The other centres on assessment and care management, and also covers the



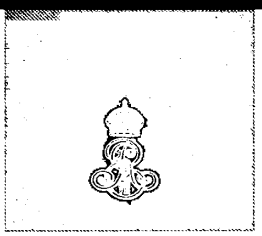
mental illness specific grant, problems relating to drugs and alcohol and community care plans. The groups — which are now about to merge into one — have proved an effective means of encouraging member understanding and 'ownership' of the changes in community care.

In Lewisham, a community care planning group of elected members, senior officers from health and social services and voluntary sector representatives has been established to encourage the development of shared ideas and understanding.

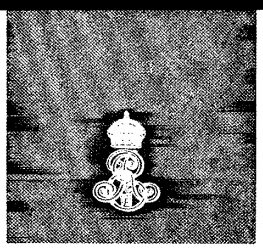
Implementing the new processes

In addition to these general points, MAIN members had particular concerns about the process of assessment and care management.

On assessment, participants felt that information for users to use for 'self-assessment' for simple services was needed. Devon's core assessment did cover this. The question of 'trigger' points for different types of differentiated assessments was a very difficult one: there was little agreement amongst participants about what these might be, or how a system of differentiated assessment might work. There was general agreement that greatly improved training was needed for reception staff so that they could contribute productively to initial screening and sifting, but there was no clear view on how to move into more complicated assessments and on how existing staff — including home care organisers, occupational therapists and the like — could be deployed to do them without replicating existing service-led approaches. Humberside was developing new job descriptions which encompassed an enhanced role for reception staff, and Birmingham was considering developing their own version of this.



On care management, some members felt that budget-holding by care managers was the essential ingredient needed to release the staff creativity required to produce user-led services, although others had reservations about this approach. There was, however, general agreement that few, if any, social services departments within the network had financial and information systems in place that would be equal to the task of this type of budget-holding on an authority-wide basis, although this was beginning to be achieved in some places through pilot projects. In Lewisham, for example, the authority is using the pilot care management scheme to explore the financial and management issues in establishing care management with delegated budgets. The network agreed that there would need to be a considerable degree of clarification of the care management task and role if there was to be real progress. What, for example, was the difference between a care manager and a keyworker? Could health authority staff (for example, district nurses or health visitors) act as care managers on behalf of the local authority in what were primarily social assessments? Would this conflict in any way with their professional roles? In Lewisham, one of the initial findings of the Borough's care management project (see Section 3) is the benefit derived from combining counselling and support with care coordination, especially when supporting carers.



4. Planning and initiating change

MAIN participants agreed that change could take place in two broad ways — one through large-scale systems redesign and the other through a 'virus approach', in which the system was 'infected' through care management projects and other innovative ways of working. Participants felt that it was very important for people operating in the 'virus' mode to have a clear plan and timetable for change, otherwise there was the danger of establishing pilot projects and experiments that would lead nowhere.

As an example of a 'virus' approach, Hampshire Social Services Department was planning to introduce the new assessment process in four areas initially, on a trial basis. A central working group on assessment has been established, with representation from district health authorities and family health services authorities and the social services committee as well as the social services department itself.

The working group has developed basic assessment materials, such as a source guide to issues and attitudes, a referral form for inter-agency use and a core community care assessment pro forma. The four trial areas will be given the task of adapting and developing this basic material as they implement the assessment requirements of the new legislation. Experience will be collected and used to inform the eventual assessment procedures adopted across the county. Training officers will be included in the development process at the trial localities, so that an appropriate training strategy for the county as a whole can be developed. The aim is to 'drive' the development of assessment procedures in the field, rather than in departmental headquarters (see Section 3 for a fuller description of what is involved).

In contrast, Humberside County Council had opted for major restructuring, prior to implementation of the *Caring for People* and Children Act 1989 changes from October 1991. Key features of the changes are a functional split between adult and children's services and a clear purchaser/provider split. This means that domiciliary care will become a 'provider' function managed alongside day and residential services, which will operate as a resource centre. The adult 'purchaser' function will be undertaken by separately managed community care teams consisting of assessment officers and care managers. Assessment officers will be qualified staff; care managers will have special training. Assessments will be comprehensive in that they will deal with all client groups and all requests, including those people who would previously have entered residential care with social security payment funding.

To support these new arrangements in Humberside, budgeting will be devolved to local level and specially tailored information technology and finance systems will be available. It is recognised that there is a need for equity and consistency both geographically and across client groups, and that a system for determining priorities needs to be established. Accordingly, work on priority and eligibility criteria, information technology strategies and information, and training and briefing strategies for staff is continuing on a joint basis with district and family health services authority representatives.

Whether a 'virus' or a systems redesign approach was adopted, MAIN members agreed that it was important for authorities to develop an overall strategy. It would then be possible to begin to make the task of implementation less daunting by breaking it down into a series of 'doable' bits. It would also be possible to attach a timetable to the strategy's constituent parts.

Effective local implementation strategies

In discussion, network participants agreed that there was a need to weave together the following strands of activity to form a comprehensive strategy:

- **Developing shared values and a shared vision about future support to community living.** Both should be informed by direct contact with vulnerable individuals and the development of creative pictures of how we could do better for each of them.

- **Consulting with — and gradually building a better partnership with — users and carers.**

- **Systematic stock-taking of present strengths on which to build, or weaknesses which particularly need to be addressed.** This could be instructive: an audit of assessment procedures in one authority discovered that one person with a medium level of need had had thirteen assessments for care.

- **Building political support for wider changes.**

- **Identifying resource requirements.**

- **Planning phased implementation with links to other key elements of the community care reforms** — for example on policy and planning; organisation; and purchasing.

- **Negotiating inter-agency agendas with colleagues in the health service and the voluntary sector.**

- **Building staff support for change** including personnel arrangements; training opportunities; and managerial support.

- **Building in quality measures throughout**

In addition to these points, it will be important to pilot new ways of working in order to clarify detail, test different approaches, and identify additional streams of activity needed to support the strategy as a whole. These might include managerial decentralisation, systems development and defining new staff roles and skills. In doing so, MAIN members recognised that useful tactics might include:

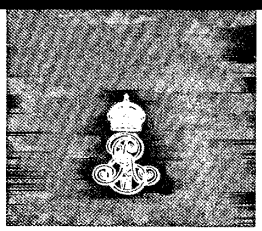
- looking for groups upon which to model new approaches (for example, people with learning difficulties) — in practice, this means testing different things in different areas and comparing results;

- noting, and then building upon, common approaches across authorities;

- building on strengths and existing, successful experiments and pilots;

- improving provider flexibility and responsiveness gradually, for example by improving the calibre of domiciliary support and outreach, which could be done on an incremental basis, if necessary;

- making space for transition in provision, while moving towards the purchasing mode;



- inviting staff to express how they want to change;
- involving staff at all levels and in all functions in experimentation;
- studying and, where appropriate, adapting employment patterns and job descriptions of "non standard" employers in the voluntary and private sectors;
- ensuring that two-way communication with users and carers exists — for example by organising forums which involve them and seek their views — something that was particularly important for people from black and ethnic minority groups;
- using and extending existing formal and informal links with the NHS and voluntary sectors;
- using other local authority initiatives (that is, apart from care management itself) that provide more flexible service alternatives — for example, carer support — and building on them.

Working in the Field

MAIN member authorities have approached the problem of introducing assessment and care management in a variety of ways. Brief descriptions of some of these are included below, to give a flavour of the approaches adopted on the ground.

Devon County Council

Devon social services have responded to the challenges represented by the community care reforms by building on best practice throughout the county. This process had begun well before *Caring for People* was published, following a major restructuring and decentralisation of services that took place in 1987. Devon social

services has implemented a progressive development programme that encompasses:

- **Systematic evaluation of practice at local level**, followed by regular self-monitoring and professional audit exercise.

- **Establishing a 'Charter of Rights' for service users** and ground rules about involving users in decisions about their own care both at assessment and during the planning of service packages (see Box 2).

- **A fundamental review** of the policy and practice of managing in-coming work, publicity, complaints, information and needs-based assessment. This work was undertaken by a series of working groups which included practitioners and middle-managers, and resulted in an integrated set of proposals for service development which achieved wide 'ownership' within the social services department.

- **The development of basic standards for care management on an inter-agency basis.** This included a care assessment approach which has been adopted by many health staff.

- **Innovative Pilot projects** — including the 'Closer to Home' scheme for frail elderly people — which sought to intensify and better coordinate the efforts of social services and health staff work together to support frail elderly people living at home, and later projects which separated care management teams from providers in order to create an 'internal market'.

- **Development of core assessment procedures** based on an assessment guide, which have been developed to apply to all adult

Box 2:

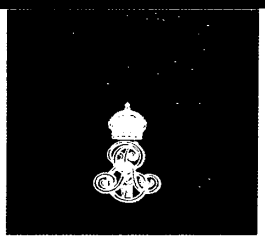
Community Care for the People of Devon

"Charter of Rights" for Clients

Clients have the right to:—

- local and convenient access to Social Services.
- provision that permits and encourages contact with family and friends and which is integrated into the local community the same degree of access to normal community services as everyone else.
- information about the services they are entitled to have by law or by Devon policy and to be informed of the full implications of accepting (or not accepting) services.
- a proper assessment and periodic review of their needs and circumstances.
- consultation and involvement in decisions that affect their lives, particularly those involving risks.
- services of an independent advocate (or friend) when needed who can speak on their behalf.
- privacy for themselves, their belongings and affairs, including the right to receive visitors in private.
- personal dignity, which is respected by others, and to be treated as individuals whatever their problems or disabilities.
- recognition of the full extent of their needs, including their physical, cultural, sexual and emotional needs.
- an environment which is conducive to developing independence and maturity.
- choose whether or not to accept services that are offered with full knowledge of the degree of risk that may result from rejecting services.
- have complaints considered according to agreed and published principles.
- protection from exploitation or being harmed by others or prevented from exploiting or harming others, when in a vulnerable or confused condition by reason of age, illness or handicap.
- care by people who recognise and respond to the needs which help them develop a sense of identity and worth, when in a vulnerable or confused state by reason or age, illness or handicap.

DEVON SOCIAL SERVICES



groups and — in an amended version — to children (See Box 1). This guide has been consciously developed in a 'self-completion' format for users, and one care manager has commented that 'users really appreciate the time and trouble spent in working through the guide together'.

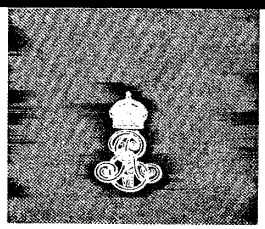
Interestingly, the assessment guide is being extensively used by health service staff in Devon: in one health district it is used by all the primary health care teams. Some of the general practitioners who have used it for their 75+ screening have suggested its introduction across the country.

- **Development of information technology** to support a needs-based assessment approach. This will be accessible in district offices from April 1992.

- **A public statement on policy aims, strategic objectives and priorities** for community care and children's services which was subjected to public consultation and then used for service planning.

Devon social services called their original approach to service delivery 'client centred management', and were pleased that these developments meshed so well with the reforms to community care outlined in *Caring for People*. Currently, client centred management is itself being superseded by new policies aimed at guiding the workings of budget-holding care management teams.

In a paper which aims to link Devon's new client-centred approach to the implementation of the reforms, one of Devon social service's senior managers commented:



'Client centred management . . . was based on the assumption that good assessment and service provision could only be achieved if both users of the service and staff who interact with them have available and share good information about what is happening and that the management of incoming work and the interface with the public is handled in an efficient and businesslike way.

The experience in Devon was that many traditional ways of operating fell short and that clear service standards and operational policies were needed to establish new ways of working. In order satisfactorily to achieve change, moreover, these service standards could not be imposed 'top down'. They had to be developed 'bottom up' to establish the ownership that enables them to take root. We have discovered since that it is even more important to extend the same principles of involvement and ownership to service users.'

London Borough of Lewisham

Lewisham social services intends to use funds from the mental illness specific grant to extend its innovative pilot case management scheme for people with dementia.

The pilot scheme itself is funded by the Gatsby trust, and is being evaluated by the Personal Social Services Research Unit at the University of Kent. Case managers are employed by Lewisham social services department, and the team manager of the mental health (elderly) social work team at Hither Green hospital provides their supervision. They are based in one of the two community teams for the mental health of elderly people based in the borough. The teams themselves are multi-disciplinary: their social workers are employed by Lewisham social services, with other team members employed by the Guy's and Lewisham Trust. Accordingly,

case managers are working closely with the two agencies which provide formal health and social care services for elderly people with dementia.

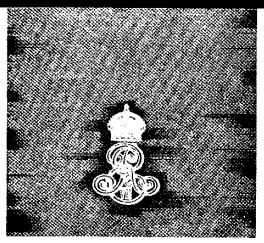
The pilot scheme has a budget of £20,000 a year which the case managers can use to supplement existing services and contribute to more flexible care arrangements for clients of the scheme. This money has proved sufficient to support a small number of clients at home, and has enabled methods of working and procedures for the pilot scheme to be established. The average cost per client to the case managers' budget under the pilot scheme is £50 per week.

The recruitment of helpers to assist people in their own homes is central to the scheme. Case managers use helpers in a way which supplements existing services. Procedures for the recruitment and payment of helpers have been established which are consistent with the Borough's equal opportunities policy. The scheme also provides a range of individual support in addition to the flexible assistance provided by helpers.

With the support of all the other agencies and groups involved, Lewisham social services successfully bid for part of the borough's mental health specific grant allocation. This has provided an additional £60,000 to the case managers' budget, and the scheme has now been to extended to a larger number of elderly people.

Walsall Metropolitan District Council

Walsall social services department restructured early in 1990 to reflect the new relationship between purchasers and providers. Three divisions were created: a purchaser division, a provider division and a quality assurance/inspection unit.



Currently, the plan is to pilot assessment and care management in one area team. Consultation exercises with user groups has taken place on a new philosophy and code of practice document for community care, and for a related assessment and complaints procedure. In addition, the department has established multidisciplinary core planning groups to develop service strategies for the five major client groups. Each has user representation or consultation. An internal community care steering group has been established, and its membership is currently being extended to outside agencies. A comments and complaints leaflet has been devised to encourage feedback from users. A new assessment form is in draft, awaiting full consultation before implementation.

Principal social workers are designated to be budget holders under the new arrangements, and many remain uncertain about their skills in this area. Similarly, home care assistants — who are now expected to take on more personal care — question their level of skill. Both groups expect more training. The department's view is that enhancement of present roles is what is required, rather than a 'new breed' of worker. With this approach in mind, home care organisers are undergoing management development courses, and reception staff are undertaking customer care training to ensure that users are treated courteously.

London Borough of Waltham Forest

Waltham Forest social services has initiated a number of care management pilot projects during 1990-1991. These include two centred on distinctive care groups:

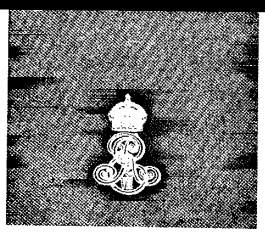
People with Physical Disabilities
During 1990/91 Waltham Forest social services identified funding for additional residential care places for adults with physical

disabilities. However, instead of purchasing places, the money was used to finance an independent living scheme fo six users. Staff were allocated a 'care management' function with assessment and budgetary responsibility for services. Packages of care have been put together which are a mixture of existing services (home helps, meals on wheels) and specifically bought services (for example, personal care workers — often CSV volunteers). In two instances money was been given to the disabled person via a voluntary organisation to employ their own personal care workers. The scheme is currently supporting 5 users living in their own flat.

Senior managers consider that the key to success has been in regular reviews, involvement of users and carers, involvement of staff and closely monitored budgets. In 1992, the Department are opening a housing scheme in Waltham Forest, which will have capacity for 12 people with multiple disabilities. Staff are hoping that some of the scheme's places can be filled with people with physical disabilities currently in residential home outside the Borough. The consequent saving in fees will be ploughed into the scheme to extend its capacity. Managers responsible for home care services are also looking at ways in which money and staff can be used to put together flexible packages of care — evidence that the 'virus effect' of pilot projects may be working here.

Dementia Support Project

This two year project is funded by mental illness specific grant money. The objective is to work flexibly and imaginatively with carers and users to keep people with dementia living at home for as long as possible. The project employs 5 workers and has a pool of money which can be used flexibly according to need. There is a multi-disciplinary support group including a psychologist, consultant psychiatrist, representatives from 2 voluntary organisations and the



Crossroads Care Attendant scheme. The project will be evaluated. The findings will be presented at a seminar to staff and managers responsible for mental health and elderly person services with the objective of getting mainstream services to take on some of the lessons and methods used.

Suffolk County Council

In April 1990 Suffolk County Council established four care management projects at area team level. The locations were determined by the need to reflect variations in the urban/rural mix of communities in Suffolk and to engage staff and managers in each of the existing geographical divisions. Resources were allocated to area teams in Ipswich, Lowestoft, Haverhill and Saxmundham. A total of £383,000 was directed into projects, including £87,000 from East Suffolk Health Authority. The money was used to appoint staff and establish flexi-care budgets. Some of the first year slippage monies were invested in training and team building work, together with the purchase of equipment including computers and software.

The projects were set up as practical experiments in care management and the delivery of community services within a mixed economy of care. They were to:

- Focus resources on the development of customer centred services, particularly — but not exclusively — to older people and carers.
- Experiment with models of care management.
- Examine and try out ways of separating and coordinating the tasks of assessment, purchasing and service provision.
- Develop appropriate systems for needs based assessment.

- Establish guidelines and procedures for local purchasing and contracting arrangements.
- Establish guidelines and procedures for devolved resource management and decision making.
- Negotiate protocols for joint working with local agencies.
- Develop the necessary organisational procedures and information systems.
- Develop financial systems.
- Consider ways of consulting and empowering service users and carers.

The common elements in each of the four projects were the creation of a specific post of 'care manager' and the establishment of a 'flexi-care' budget. A network of local and central support groups was established involving project staff, central planners and specialists in personnel, finance, training and new technology.

Much of the development work around the separation of assessment, purchasing and service provision has been focused around the social services department's home care service. To a greater or lesser degree project teams have moved towards the principle of a single purchasing budget under the control of a social services team manager. A proportion of this budget has been allocated to the major provider services on the basis of a service level agreement. Resources remaining unallocated in this way make up the residual flexi-care budget and can be used to purchase or top-up services around the assessed needs of individual service users or to pump prime the development of new services.

The Haverhill Project

In September 1990, the Haverhill team were the first to appoint a care manager. In less than a year a great deal has been achieved including revising procedures; for allocation, assessment and review; changing budget allocation procedures; establishing a service level agreement with the in-house home care service and entering into agreements with other providers. A protocol has been established with the local health authority and procedures have been established for communication with local agencies. Considerable experience about the pros and cons of purchasing and contracting with the private sector has been gained. The care manager has been involved in development work across all of these areas and in direct work with service users and carers. Unlike the Ipswich project, the care manager undertakes assessments as well as coordinating and assessment process, overseeing the use of the flexi-care budget and designing and implementing care packages.

The frustrations and challenges of the early days of the Project are recalled by the team leader in a recent report:

> 'It was a time of "doing it", learning from mistakes and frequently discovering that one question resolved resulted in six new questions to address. We had to learn not to be overwhelmed . . .'

The Ipswich Project

The Ipswich team appointed their care manager at the end of 1990. Many of the areas addressed are the same as for the other projects although translated here in the centre of an urban area. Links with other agencies are more complex and work pressures quite different to those in the other teams. In Ipswich the assessment work is undertaken by a separate 'assessor' and the care manager's role is focused more around the coordination of the process and the

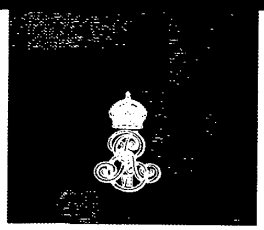
design and implementation of the care package. This has been significant in permitting a more systematic approach to the purchaser provider split than has been possible in the other teams. As in Haverhill the pros and cons of purchasing and contracting with external providers and the links between the purchasing and providing elements of the team's own service have been a major focus of the past six months.

The Saxmundham Project

Saxmundham, like Ipswich, appointed its care manager at the end of 1990. Saxmundham is the most rural of the four projects with a relative dearth of private agencies operating in the area. The focus of the service has therefore been around the development of in-house services and liaison with and promotion of alternative provision. The care manager has been much involved in development work in these areas as well as in the debate around purchasing and contracting, financial systems and the separation of service provision within the social services team. A variation on the Ipswich model is being developed with separate assessors and providers with the care manager coordinating the process and overseeing the flexi-care budget. With a well established community service, Saxmundham has been able to exploit existing links with local agencies.

The Lowestoft Project

Recruitment problems meant that Lowestoft did not appoint its care manager until April 1991. This delayed the process of change but allowed the team to draw upon the work being undertaken by the other projects. The area is different again from the other three and has a specialist team structure. Work is being done around the promotion of service development in the private sector and in contracting, purchasing and financial management. The project has focused particularly on the need to support carers. Existing links



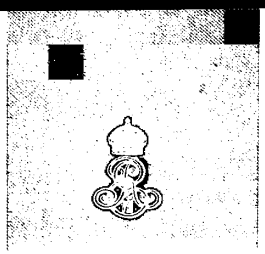
with local agencies have been built upon in the area of assessment and collaborative action. The care manager is involved directly in assessment work and in the coordination of the process as well as in the design and implementation of care packages.

In each of the projects, and in Suffolk social services as a whole a great deal of work remains to be completed, particularly in such areas as: the evolving roles of health and social services in community care; the definition and monitoring of standards; the establishment of competitive in-house provider services; and the development of financial and other information systems. Not surprisingly the work so far clearly indicates a need and a demand for a responsive service capable of providing high levels of care sensitively, to people where they live.

Suffolk social services remains concerned about the extent of that demand in relation to the resources that are available to meet it, both directly in terms of services provided and indirectly in terms of the workforce needed to undertake assessments and monitor the impact of the service. Lessons that have been learned from the projects are informing a departmental reorganisation which will take place in 1992.

Suffolk managers comment that:

> 'The experience of the past year suggests that the nature and impact of the cultural change that teams and individuals have to go through in order to take on the new way of working should not be underestimated. This process takes time and the people going through it need to be supported and helped to assimilate the experience and translate it into action in the workplace. Against these requirements April 1993 is not very far away.'



London Borough of Hammersmith and Fulham

In this small, charge-capped London authority the social services department sees care management as central to achieving real changes for service users. Accordingly, senior managers are seeking to develop a series of pilot projects across its services to adults. Acceptability and evaluation criteria for pilots have been explicitly stated, and staff are being encouraged to volunteer potential pilot projects, with the aim of developing a strong sense of local ownership of individual schemes.

The first pilot project to be agreed centres on people with HIV. Three care budget managers are being designated, and all the more complex requests for service provision will be directed through these staff. They will be responsible for obtaining a 'package of assessments' and for using these to develop personalised care budgets. Individual cases will then be allocated to care managers who will use the care budgets to construct care packages from a 'menu' of services pre-purchased from the AIDS/HIV purchasing and planning unit and supplemented by 'spot purchases' made by care managers from other services available on the 'menu'.

'Service level agreements' have been established as a solution to the organisational difficulty of separating assessors from service providers and providers from purchasers. In essence, the HIV purchasing and planning unit and the service providing divisions of the department have drawn up agreements to cover the whole of the £1.4 million budget for HIV services.

The first phase of Hammersmith and Fulham's AIDS/HIV pilot will consist of a mapping exercise in which care managers will allocate services according to existing criteria. The criteria used will be monitored, and the value of care packages calculated. After three months, costs will be compared with budget allocations for

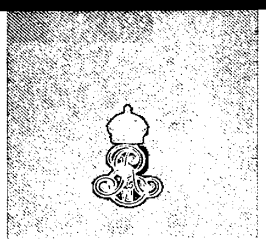
services, and explicit banded budgets will be introduced for the care budget managers. At the same time, service allocation criteria will be relaxed to permit care managers some more flexibility in purchasing from service menus. Care budget allocation and service allocation criteria will be refined as the allocation of care budgets progresses. The aim is to ensure that service provision remains within budget at the same time as the pattern of services comes to more fully reflect users' needs and choices.

Local financial systems and procedural details will be developed as the pilot project progresses. The extent to which service level agreements prove to be a useful device for distancing care managers and their assessment responsibilities from both providers and purchasers will be closely monitored, as will the difficulties and opportunities involved in locating nearly all of the provision for a particular client group within a care management system. A special in-house information technology package has been developed to handle the detailed monitoring required.

Hammersmith and Fulham social services department considers that the success of the pilot care management schemes will emerge through the extent to which users of services feel that they have received an array of services which correspond to their own understanding of their situation. The degree to which staff 'own' changes, and the degree to which the department is able to plan its services coherently, will present useful indications that it is on the right path.

Birmingham City Council

In developing its approach to assessment and care management Birmingham social services has concentrated on assessment processes, on the understanding that they are crucial to successful community care. In undertaking this work, the department has



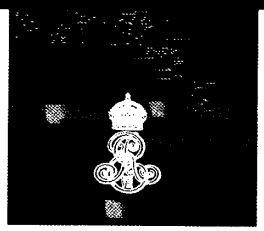
sought to concentrate on users' experience of referral, access and assessment. A major first round consultation with users has already taken place, by means of 'Community Care and You' discussion groups and an associated booklet.

Currently, a further consultation on access and assessment criteria is taking place within and outside the department, and an assessment pro-forma is being piloted with a variety of adult care teams. At the same time, efforts have been made to dovetail financial aspects of assessment with the City's anti-poverty strategy, and a degree of management consensus has been achieved over eligibility criteria for assessments and services.

As a result of these developments, there is a general recognition at senior management level within the department that social services structures could be both more integrated and more 'user friendly' than they currently are. As a result, a major restructuring will take place, and the implementation of care management is 'on hold' in anticipation of it. The City's approach to care management will be informed by approaches developed elsewhere in the country.

London Borough of Wandsworth

Wandsworth social services department began its work on assessment and care management in May 1990. At that time, a small coordinating group arranged an in-house workshop for practitioners and managers in its social work, home care and residential and day care sections in order to draw on staff experience. The meeting demonstrated that considerable enthusiasm for assessment and care management existed locally. A report summarising participants' views and key issues was prepared following the workshop, along with a glossary of terms associated with assessment and care management.

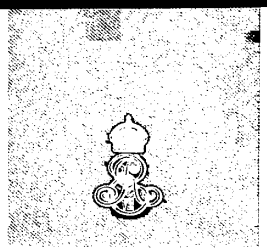


These documents were used in discussions at a seminar which the coordinating group held to discuss assessment and care management with senior managers from the two local health authorities, the FHSA and the housing department. This meeting too revealed positive attitudes towards the implementation of assessment and care management, even though the government's revised timetable had by then been published.

Using information and insights from both meetings, the coordinating group developed proposals for pilot schemes. The social services directorate presented these to the joint care planning team in September 1990. The JCPT agreed to set up a joint health and social services management group to oversee the pilot schemes and to coordinate local research and development on assessment and care management in Wandsworth. Following a major reorganisation of the social services department along broad client group lines, the joint management group met in March 1991.

The pilot programme involves three pilot assessment and care management schemes. The first of these will build on the strengths of existing multi-disciplinary approaches to 'at risk' elderly people, and a proven record of user and carer involvement at one of the social services department's four district offices. The proposal is to second an experienced staff member as a care manager. At the same time, the Borough's finance department is developing financial information systems aimed at supporting care management.

Subsequent trial schemes will centre on people with learning difficulties and people with mental illness. The aim is for the joint health and social services management group to draw on the early experiences of each trial scheme in planning and implementing subsequent projects.



Hampshire County Council

Hampshire social services department is basing its community care reform strategy on lessons learnt from an experimental joint project in which the local authority, Winchester health authority, Andover MENCAP and the Guidepost Housing Association collaborated on the development of a care management service for people with learning difficulties in Andover. Planning for this project began in 1988. A working model for care management practice was developed over the next year. By April 1990, nineteen clients had agreed to use the care management service, ten care packages had been formulated and five had been implemented.

Significant features of the Andover project's approach include:

- A major investment in information sharing and public relations work.

- An assessment process which places a good deal of emphasis on getting to know clients well, exploring their ambitions for themselves, and making contact with their support networks.

- Working with 'brokers' to develop service packages appropriate to individual need, including developing and accessing services not traditionally provided by health or social services.

- Working across agencies: one care manager was a nurse from Winchester health authority while the other was a social worker from Hampshire social services. Similarly, one of the service 'brokers' was from day services while the other was from a Housing Association.

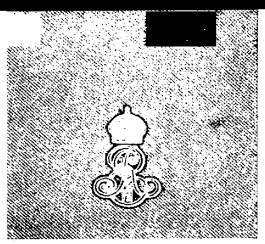
A budget of £9,500 was devolved to the project in its first year, followed by £15,000 in the second. This was spent on items of

service packages which care managers were unable to secure within current service provision. Overall, devolution of budgets and securing appropriate financial structures for care management has proved to be slow.

As a result of the success of the Andover work, Hampshire social services department is now in the process of establishing three more 'fast track' care management projects in the three other geographical divisions of the County. The aim of this new programme, which will include the original Andover scheme as one of its four projects, is to allow each district in the County to have contact with care management and for each project to cover a different adult client group, so that the department can gain experience across the range of adult priority groups. Experiments with the concept and practice of clients acting as their own care managers and having direct access to money and resources will be tried. The programme is fully supported by senior management within the social services department.

Significantly, each project within the programme will be run by local area offices. This is because the programme is intended to be an intermediate stage between experimental projects like the original Andover scheme and the full-scale implementation of assessment and care-management processes across the entire social services department. The new extended programme of care management will attempt to explore further and — where possible — to resolve lessons and issues raised in Andover. These have been well expressed in the project's first annual report, and are reproduced in Box 3, because of their implications for the implementation of care management elsewhere.

As part of the implementation process, the four care management projects are:



- **Holding a series of workshops**

  The aim of the workshop series is to facilitate joint learning, share progress and problem-solve. Each workshop will be on a specific topic: assessment, quality, business planning and the costing and management of care management. Findings from the workshops will be publicised to the rest of the social services department, as part of the process of 'spreading the word' about care management. In addition, each project will hold an 'awareness day' to tell other workers, colleagues, and voluntary organisations about their work.

- **Developing a major training strategy**

  Training and development officers will be working with each project.

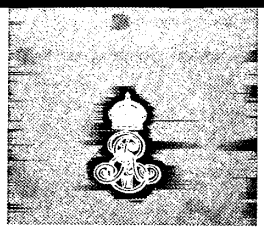
- **Testing out draft referral/request pro formas and community care assessment documents**

  Each project has been supplied with a 'floppy disk' version of these documents which they are free to edit and amend as experience dictates. Results and progress will be regularly pooled at meetings between the projects and headquarters planning teams, held with the intention of encouraging 'bottom up' learning.

- **Developing service agreements with the voluntary sector**

  Service level agreements are gradually being developed with voluntary sector providers, although a full-scale contracting and costing policy has not yet emerged for either statutory or for voluntary sector services.

As part of wider efforts to support these developments, a high-level panel of elected members and SSD officers has been established to look at community care issues over the next two



years. New strategies, such as 'Changing for Choice', a policy for services for people with learning difficulties, have been developed which emphasise the importance of disaggregating large scale services. A carers assessment document has been developed in conjunction with carers groups, and a Quality Service Unit has been established for a year now, with a complaints officer in post.

Financial devolution to support local operations is also underway. Each area office now has its own finance, personnel and systems support officers. A computerised financial management system is in the final stages of development, and will soon be available to all area officers. Greater flexibility on virement and small budgets is becoming possible. A computerised 'resource directory' for Hampshire has also been developed and is available on computer at some 2,500 locations across the county to give details of local and national resources, with a contact name for each.

BOX 3

Lessons from the Andover Case Management Project

In the first year of the Andover Case Management Project a great many ideas were tried and tested. At the end of the project's first year key 'lessons' from those important first experiences were distilled into a list by the project's staff, along with some important unresolved issues around care management practice:

1. Case Management builds on the best of current practice with clients.
2. Case Management changes the relationship between the client and the agency. The agency must be prepared to be explicit about the choices available, to be decisive about resource allocations and to clarify constraints. The client must share responsibility for choices made.
3. Client, carers and staff expectations and attitudes about services and how they are provided will need a fundamental change. Case Management bases the service on needs that can be met within available resources. In the past, people have typically received an "all or nothing service" and often on a long term basis e.g admission to a day service, 5 days a week. Changes in this will mean people may perceive or experience a loss in service. The benefit will be they receive targetted services at the appropriate time.
4. Linked to '3'. above, a significant factor in creating the right conditions for Case Management to operate is ensuring a wide range of people in the locality are informed and understand it. This must include service users, families, staff, voluntary organisations and other stakeholders. Investment in this type of public relations is a high priority and will incur costs.

5. Staff will require new skills in:
   - Costing
   - Budgeting
   - Assessment of need
   - Design of packages
   - Information technology
   - Drawing up contracts.
6. Key organisational changes needed are in financial mechanisms and information systems. Flexibility and accessibility are essential in both.
7. Costing/pricing policies for our own services are vital.
8. Case Management with individuals does not necessarily have a direct impact on overall patterns of service delivery. Strategic planning for service delivery must be used to create the right framework for services to be negotiated at the level of the individual.
9. Time for networking and development may be necessary depending upon the fitness of the services and the community to support individual packages of care. Case Managers can do the work but this seriously limits the number of people they can develop packages for.
10. Partnership with other significant resource providers in the locality has strengthened the project and helped sustain it.
11. It is emerging that implementation of packages the project has been working with will rely heavily on the availability of support workers. This signals a possible impact on patterns of employment within the "direct care" side of the service.
12. Case Management is new, exciting and has many possible interpretations. There is no definitive version but progress cannot be made unless a model is agreed, adopted and supported despite its limitations. This stops endless unprofitable debate and enables operationalisation.

13. Implementation of Case Management exposes territorialism. Some of this concerns protecting current roles/responsibilities but some also foreshadows aspects of the competitive market reflecting future roles/responsibilities.
14. It is much easier to unlock revenue from some aspects of the service than others. For example, day and field resources are easier to unlock than residential.
15. It takes more time to plan and arrange individual services, so is costly to organise, but the financial outlay for the care package may well be cheaper.
16. There is a need to make a distinction between services for clients and for carers when designing and contracting the care package.

Questions unresolved

A lot has been learnt from the project but some questions remain unresolved or have not yet been addressed through thework we have done so far. These questions are:

1. Who manages a Case Manager?

2. Which clients are allocated a Case Manager?

3. What is a package?

4. On what basis are resources allocated to individuals?

5. What are the parameters of financial flexibility and to which levels should financial responsibilities be devolved?

5. How much information sharing and PR work is needed?

Management of Case Managers

Early rhetoric about Case Managers stressed the value of their independence from 'providing agencies'. This enabled,strong advocacy on behalf of the client, objectivity and creativity, and avoided conflict of interests when decisions about resource allocation had to be made. This suggested a high level of accountability to the client and management outside of current main agency structures.

To balance this, experience of care management in practice exposes the fact that conflicts between client needs and resource constraints are undeniable and not resolved through changes in management arrangements. It is useful, however,to have access to resources and the power to allocate them, as close to the client as possible. But this in turn exposes the issue of who agrees or vetos the plan devised by a client and Case Manager if it is in conflict with other needs or management decisions.

The project has not tested any particular managementarrangements and has therefore only explored the issues. Itis possible that the answer lies in separation ofassessor/purchaser and provider within

the power to allocate them, as close to the client as possible. But this in turn exposes the issue of who agrees or vetos the plan devised by a client and Case Manager if it is in conflict with other needs or management decisions.

The project has not tested any particular management arrangements and has therefore only explored the issues. It is possible that the answer lies in separation of assessor/purchaser and provider within agencies as proposed in the White Paper 'Caring for People'.

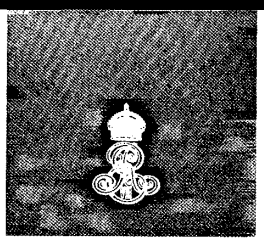
Source: Archer, R and Robertson, G (1990): *Andover Case Management Project: Services for people with a mental handicap*, **1st Year Report**, Hampshire Social Services Department and Hampshire Health Authority, unpublished report.

5. Postscript on MAIN: Lessons from networking

In reflecting on the experience of working together on the implementation of assessment and care management, participants concluded that one of the striking things to emerge from the MAIN network was that there was no 'Holy Grail' or perfect solution on offer. In the end, there was no substitute for authorities' devising solutions in the light of their own particular circumstances and experiences. Recognising the need to develop local approaches and the fact that there was no one 'right answer' was very important.

At the same time, the experience of sharing information, learning and insights with senior colleagues from other places had been extremely valuable in providing participants with ideas to build on when returning to their home authorities. Supporting staff at all levels is an essential part of bringing about change, and MAIN members had found that working together lessened the isolation associated with operating in senior management positions. One of the most useful aspects of the network had been the learning opportunities presented by short presentations on progress from MAIN members.

Participants agreed that small working groups of the MAIN type appeared to generate more useful ideas and approaches than large conferences did. Members' commitment to the network over eighteen months had also been helpful in forging mutual trust and encouraging meaningful sharing. With this in mind, members wondered whether it might be possible in future for networks of the MAIN type to be organised on a regional basis, around particular issues concerning the management of change.



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APPENDIX 1:

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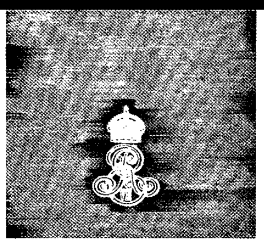

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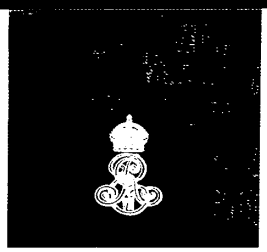

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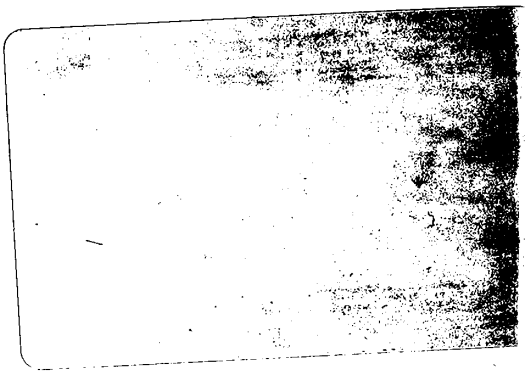
The MAIN network was facilitated by Roger Blunden, David Towell and Virginia Beardshaw of the King's Fund and Lynda Hoare from the Social Services Inspectorate of the Department of Health.



Assessment and care management are about tailoring services around individual needs and about resource rationing. Local authorities' ability to reconcile these competing demands in a way that benefits service users will be critical to the success of the community care reforms outlined in *Caring for People.*

From the spring of 1990, the King's Fund College worked with senior managers from eleven local authority social services departments in MAIN — a network for the implementation of assessment and care management. MAIN was supported by the Social Services Inspectorate of the Department of Health as part of its programme on the reform of community care.

Implementing Assessment and Care Management discusses the issues which confronted the network as its members began to implement *Caring for People* in different local authorities across England. The report records the strategies used to manage the major changes in service orientation and delivery implied by the reforms, and gives a detailed account of local approaches to implementation.

Senior social services managers from Birmingham, Camden, Devon, Hammersmith and Fulham, Hampshire, Humberside, Lewisham, Suffolk, Walsall, Waltham Forest and Wandsworth all participated in MAIN. The network included local authorities with the full range of urban and rural environments across England, as well as contrasting political orientations. In recording the MAIN's work, **Implementing Assessment and Care Management** offers practical approaches towards making *Caring for People* a reality at local level.

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