ALL CHANGE, NO CHANGE?

Community Care six months on

A second report of developments on the health and social care divide

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- and -

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COMMUNITY CARE:

PRACTICAL PROBLEMS AND SOLUTIONS ON THE HEALTH AND SOCIAL CARE DIVIDE

Report of Seminar II, held at the King's Fund Centre on 1 October 1993

This seminar was organised by the King's Fund Centre and Nuffield Institute for Health as part of their monitoring of developments in community care. The purpose was to identify progress and problems arising six months after the new community care arrangements came into force. The seminar followed an earlier one, in November 1992, in which a Focus Group was formed to discuss their hopes and fears for the 'new' community care.

The same Focus Group, with one or two changes, was reconvened in October 1993 to enable a comparison to be made of key worries and priorities for action. This provided two snapshots of problems and opportunities in community care as seen by a mixed group of people active in the community care arena, ie: senior and middle managers in Social Services and the NHS, general practitioners and physicians, private sector service providers and voluntary organisations in close touch with users and carers.

These snapshots provided indications of change taking place as the reforms are being implemented.

Both snapshots focused on the health and social care boundary in community care, highlighting problem flashpoints as well as innovative breakthroughs.

1. THE VERDICT IN 1993

a) Where things are going well

* **Early signs of service improvements** were reported, although it was recognised that these developments were patchy. These included:

  - good examples of assessment of people's needs, time taken to enable people to explore options and exercise some measure of choice.

  - an increase in alternatives to residential care in some parts of the country, where day care and respite care are being offered by former care homes.

  - greater flexibility in local authority home care services in some places, where night sitting and weekend services are now being offered.

  - care managers are learning fast and beginning to make a difference by buying services for individuals from the independent sector.

- a developing interest in poly-clinics and other primary health care developments, offering people a wide range of services, including better access to social services and to provision which lies in the grey area between health and social care.

- **Improved collaboration between health and social care agencies**

  - local authorities, district health and family health service authorities are talking to each other more and agreeing ways to avoid problems on the health and social care boundary.

  - growing knowledge and commitment to joint community care commissioning is evident in many parts of the country.

  - general practitioners are becoming more aware and involved in community care.

  - health and social care staff are working together to ensure high standards of provision, eg: qualified nurses supervising care staff who are providing services for people with complex care needs.

- **Hospital discharge systems and practices** which are preventing unnecessary delays in assessment. From the point of view of hospital and social services personnel, agreements reached on this potential flashpoint appear at this stage to be robust in the majority of cases.

b) **Where there is cause for concern**

- **No real improvements for users and carers**

  - Uncertainty and confusion for users and carers. This is evident in the increased demand on advice services, where people are no longer sure where to go for help and what can be provided.

  - Increased costs for users and carers, especially where services previously provided free under the NHS are now means-tested by local authorities.

  - Doubts about the choices open to users and carers. In some places, the local authority's own residential care accommodation, and that of former local authority homes which are now in independent trusts, are reported to be full and to have waiting lists. Block contracts with these residential homes may be restricting choice of users who might prefer other options in the private sector.

* **Services changing little in practice**

  - a slow rate of growth and usage of day and domiciliary services. This seems to be due to resistance among some care home proprietors to entering this part of the care market; to resistance among some local politicians to working with the private sector; and to protracted delays on the part of local authority commissioners in drawing up contracts for new day and domiciliary services with private and voluntary agencies.

  - no appreciable improvements in carers' support services.

  - innovative service developments are hard to spot. Commissioners are very cautious, purchasing services which happen to be in place rather than developing, in co-operation with providers, new types of service.

  - deteriorations in services offering help with medication, catheter flushes, bathing, dressings, etc. This help in the home was previously provided by community nurses but, as they are being withdrawn from this basic level of care, home care staff are not being trained or managed in ways to ensure good quality care.

  - insufficient resources for aids and equipment. There are still excessively long waits for OT assessments and for the delivery of equipment agreed.

  - patchy distribution of good practice needs assessments. There are still many examples of assessing people for particular services, rather than looking at their needs as a whole; of a checklist mentality focusing on what people cannot do; of complicated forms and lengthy waits for assessment of up to three months or more in the community. The threat of legal challenges on service decisions is causing cautious and defensive approaches to assessment in some places.

* **Blurred rights and responsibilities,** including:

  - users and carers are not clear about their entitlements.

    As rights to free health care are being redefined, users and carers are not always told honestly what their position is now. This may be because doctors, nurses and social workers are not clear themselves.

  - arguments between the NHS and local authorities about funding liabilities and delays in agreeing who will pay for what.

* **Expenditure being less than expected** at this point in the financial year. While expenditure on residential services appears to have gone down, there is no evidence yet of increased spending on day, domiciliary and respite services. This raises worries that families are having to bear the brunt.

2. COMPARISON WITH 1992 HOPES AND FEARS

Key concerns raised last year were:

* **THE PROSPECT OF CATASTROPHE AS THE NEW COMMUNITY CARE ARRANGEMENTS COME INTO FORCE.**

  No evidence of catastrophe has been apparent this year. The last six months have been quiet, with no major scandals or disasters, associated with the community care reforms.

  However, there has been some concern - notably in the press -about the effectiveness of community services for people who are mentally ill.

* **RIGHTS REDEFINED**

  A continuing theme in 1993, although one that seems to be of less concern to managers and practitioners in the system as opposed to users and carers or their advocates.

* **SERVICE DETERIORATIONS**

  There are still worries that services are not yet working in the way the reforms intended, although a clearer view of what is actually happening in home and day care services is needed. One new worry has to be that services are being spread more thinly or that families are being left to cope. There is also concern that the failure to regulate home care services will allow unscrupulous private firms to enter this market.

* **ASSESSMENTS AND HOSPITAL DISCHARGE**

  The worst fears of 1992 have not been realised. The system is not grinding to a halt. The worries continue, however, as good practice assessment is by no means universal; the assessment process can seem very slow, cumbersome and bureaucratic, and multi-disciplinary assessment can mean rubber-stamping by health care staff. Arrangements at discharge from hospital can be less than satisfactory, with anecdotal evidence of hospitals by-passing the assessment process and sending people home without support arrangements in place, or alternatively people at times remaining in hospital longer than necessary whilst suitable placements are found. There was concern about increased demand in the coming winter which would put increased pressure on discharge arrangements.

* **FINANCE SHORTFALL**

Last year, the fear was that insufficient resources would be allocated to community care and that the money would run out before the end of the year. The worries in 1993 are that some local authorities may be underspent at the end of the year and that this might be wrongly perceived as community care being over-funded. Are conditions attached to the transitional grant or to the distribution formulae causing the problem, eg: unavailability of suitable independent sector services to be commissioned? Is the level of demand the same as expected? Are people being diverted into other parts of the welfare system? There does appear to be some evidence that community health services are receiving increased numbers of referrals from GPs, who anticipate little or no positive response for their patients from their local social services department. Certainly, some community health units and trusts are finding themselves facing the prospect of being overspent, but are unable to access monies made available for the transfer of responsibilities in community care.

3. ALL CHANGE BUT NO CHANGE?

Large-scale organisational and procedural changes have taken place in the NHS and in Local Authorities over the last three years. There was a great deal of 'talking up' surrounding April 1st, 1993, with many people expecting a new kind of community care up and running from that date.

The good news is that the chaos that was predicted by some has not happened. A steady hold on the system has been maintained, with special efforts made to prevent major problems at flashpoints on the health and social care boundary.

For people working at strategic and operational levels in the system, there is a sense of relief that the worst has not happened, and some optimism about possible future service developments despite frustration with the apparent limitations of market systems. They see the potential for greater change as more care managers use devolved budgets and 'play the system' to the advantage of their clients.

Users, carers and their advocates as yet see little or no improvement in the system and in services. Indeed, from their point of view things have become worse in some ways. Access to residential care is reduced and their prospects of receiving more and better day, domiciliary and respite services have not measurably increased. Their rights to (free) services have been eroded and many, who previously might have expected help, are now being screened out of the service system.

4. ADDRESSING OUTSTANDING PROBLEMS IN COMMUNITY CARE -an action agenda for 1994 and beyond.

Ideas for action included:

* **Collect more detailed information about what is actually happening** in community care services before drawing any conclusions or taking precipitate action. This applies particularly to the analysis and interpretation of expenditure trends through the whole year. But it also applies most crucially to the experience of users and carers, whose difficulties can all too easily be hidden from public view. More information is needed about the outcomes of assessment, ie: to what extent are people's needs being met?

* **Share learning about innovative approaches and good practice developments,** so that the good practice developments noted earlier become more widespread and change breakthroughs are given a boost. This is equally important among commissioners and service providers if we are to move on from cautious conventional approaches and make advances in, for instance, tailoring services to meet the needs of black communities.

* **Develop commissioning at care management AND** strategic levels. There is an over-reliance on block purchasing at the moment. We ought to be looking at ways of purchasing to meet individuals' needs.

* **Develop and promote joint commissioning of community care services,** where resources are pooled to tackle long-standing problems on the health and social care boundary.

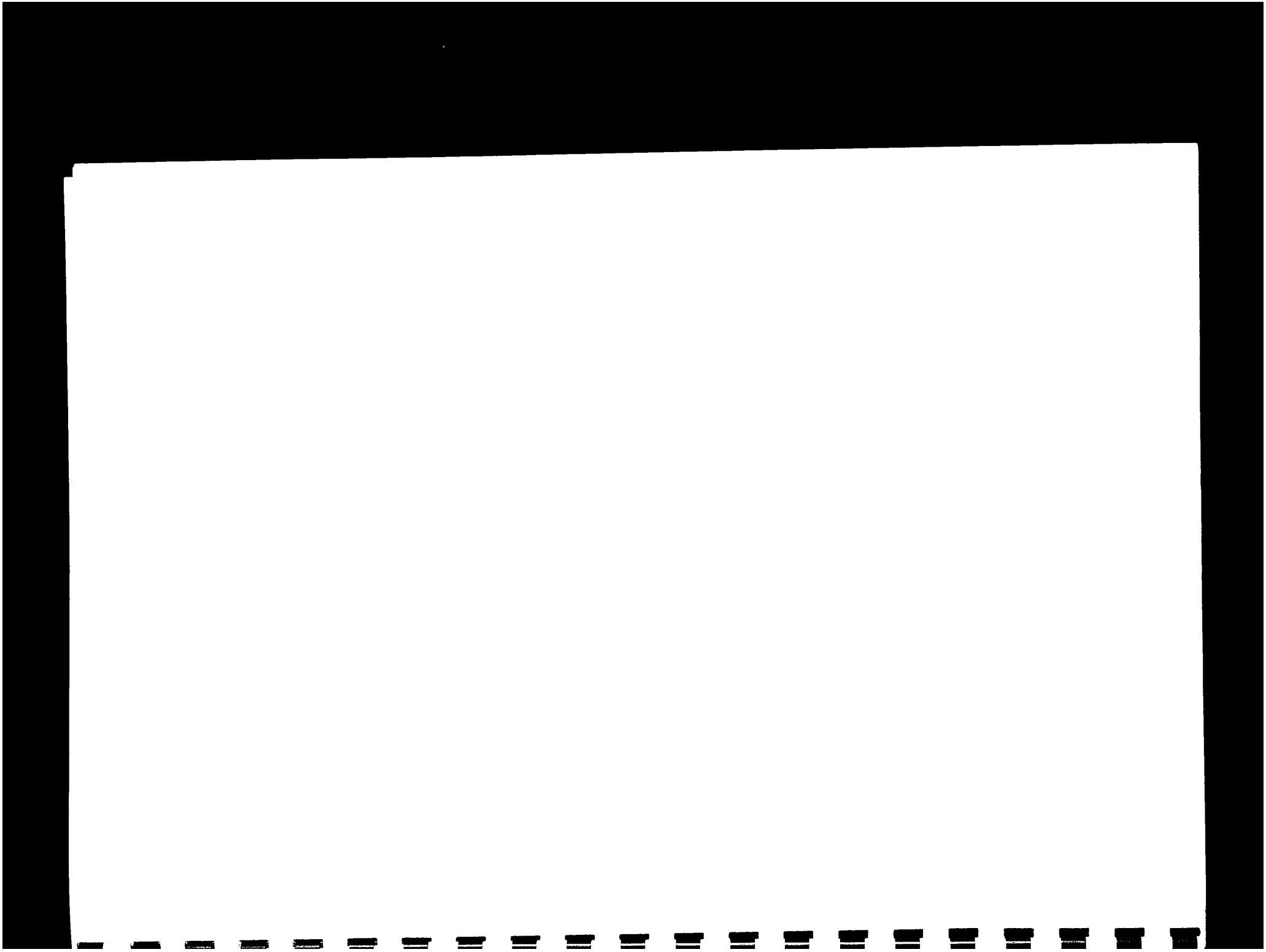
* **Inform people about their rights.** An honest debate and public education campaign would help to clarify the current position regarding health and social care services. Practitioners can also be encouraged to be open and honest about this as they work with individuals needing help.

* **Establish an arbitration system** for individuals who wish to contest decisions made about them or to protest at action taken (or not taken) to meet their assessed needs.

* **Manage the press 'noise' about community care.** Some of the coverage of community care is misinformed and possibly mischievous. More proactive contacts with the press, sharing the good news and the dilemmas and difficulties, might help to achieve a more fair and balanced view of developments.

A message to central government

Do not let community care fall off your agenda after all the work that you and others have undertaken to reform the service system. Put your efforts now into supporting service developments, encouraging creativity and innovation alongside high standards of service. At the same time, ensure that community care is a central component in the developing NHS and local authority policy agenda.



5. CLOSING REMARKS

The Focus Group will meet again next year to track the issues which have been raised in 1992 and 1993.

In the meantime, the results of this dip into community care six months on will be sent to the Parliamentary Under-Secretary of State for Health for his information. Efforts will also be made to share our findings with colleagues in health and social care services and with user and carer organisations. A report will be made available on request and media coverage will be sought as a means of getting the main messages across.

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