This is the third of four articles looking at the progress of the community care reforms

Community care in Northern Ireland: a promising start

Alison Tonks

Integrated health and social services, generous funding, and a special sense of community have got Northern Ireland off to a promising start after the government's community care reforms. Public ignorance about the new arrangements remains a problem, but there is little evidence of serious hardship in any client group. The biggest threat is to nursing and residential homes, which face closure as increasing numbers of elderly and disabled people opt to stay at home. After only a year and without the benefit of formal evaluation, however, the real problems for disabled people and their carers may not yet have emerged.

Health professionals, planners, and policy makers in Northern Ireland have been busy. Since the introduction of general management in 1985, they have been faced with general practice fundholding, National Health Service trusts, changes to the allocation of funds between the four health boards, and finally the Community Care Act 1990.

The policy for community care in Northern Ireland is set out in the policy document *People First*.¹ One of the key policy changes, ending unlimited central funding for elderly and disabled people who need placement in residential or nursing homes, came into force in April last year. The four health and social services boards and their units of management, many of them planning to be NHS trusts, were charged with organising and paying for care according to people's assessed needs. The new discretionary and cash limited system led to widespread fears that elderly and disabled people would be kept at home "on the cheap," increasing the burden on carers; that formal assessments of elderly patients in hospital would delay discharge and block beds needed for acute admissions; that elderly and disabled people would have little choice about where they were cared for; that nursing and residential homes would be forced to close, increasing unemployment in an already depressed province; that quality of services would fall with increased reliance on the voluntary and private sector; and that users and carers would be kept in the dark, unable to ask for services in a new and complicated

system. I have tried to assess how far these fears have been realised.

Objective evaluation is difficult. Firstly, the flaws in a health planning experiment of this scale are unlikely to be obvious less than a year after implementation, except for real disasters or teething troubles. Secondly, data on how the changes have affected users of community services and their carers are patchy and incomplete. Finally, it is difficult to gauge the impact of the community care reforms separately from the effects of other changes in the NHS.

Northern Ireland is a year behind the mainland and is still in the first stages of setting up an internal market. For example, six trusts providing community services are to be established in April this year; 20 general practices became fundholders last April, and 20 more will join them this year.

Keeping elderly people at home

People over 75 years, particularly those with dementia, have the most to gain or to lose from the change to health and social services set out in *People First*. The Department of Health and Social Services estimates that 80 000 people in Northern Ireland—one in 20—are over 75. Between 17% and 18% live in some sort of institution (fig 1). Those who live at home rely heavily on services like home helps and meals on wheels. In 1990, 18 000 people needed home helps, 2000 needed meals on wheels, and 3000 attended a day centre.²

Between 1987 and April 1993, however, fewer and fewer people remained at home and the number of admissions to nursing and residential homes climbed exponentially, doubling every two years, fuelled partly by unlimited central funding for this sort of care. By 1990 Northern Ireland had 40% more nursing and residential home beds than the rest of Britain, most of them privately owned.

More choice but homes will close

In its latest five year strategy (1992-7), which predates but encompasses *People First*, Northern Ireland's Department of Health and Social Services asked the four boards to reduce the proportion of elderly people in institutional care from 17% to 12% by 1997. I asked Margaret Bamford, assistant director of social services for Eastern Health and Social Services Board, how the strategy was going and what its impact had been on elderly people in the province and on the nursing and residential homes that cared for so many of them. She was confident that the Eastern board would reach the government's 12% target. A rush of admissions to nursing and residential homes just before the April deadline last year meant, she said, that the need for placements was low at first, but figures for the first six months after April show that two fifths of placements were to care at home.³ Figures for the whole of Northern Ireland are similar. In the first six months of the reforms half of all elderly and disabled people with complex needs were referred for care at home, a fifth for residential care, and a third for places in nursing homes.⁴

FIG 1—Numbers of elderly people in institutional care by year and type of institution (source: DHSS)

Placements do seem to reflect a genuinely better choice for elderly people about where they live. Brian Dornan, director of community services in the Eastern board's Down and Lisburn unit, told me that three quarters of elderly people in Down and Lisburn who would have been admitted to a residential or nursing home before last April now opted to stay at home. None, he said, had been denied a domiciliary care package.

Predictably, the view for private nursing and residential homes is less rosy. Margaret Bamford warned that to meet the 12% target, the Eastern board alone would have to lose 2400 beds, leading to the inevitable closure of some homes. The impact of closure on a home's residents and staff is obvious, and, although none have yet had to go, it seems that only rapid diversification into day care and respite care will save them. Fears that residents of a home facing closure would have nowhere to go were dismissed in parliament last month by Michael Ancram, Secretary of State for Northern Ireland. "The level of accommodation throughout Northern Ireland is such that residents who might need to be relocated on closure of a home will have a reasonable choice of alternative accommodation," he said. He did not define reasonable choice.

Quality and variety

Whether or not services have actually improved for individuals is difficult to assess. Some, the two cases below, for example, undoubtedly have a better deal under the new system of assessment and care management, and so far the Eastern board has had few complaints. It is possible, however, that people don't know how to complain or are ignorant of their entitlements. In the Eastern board's evaluation of the first six months,³ Margaret Bamford conceded that some units of management had been forced to cut home help services, and Bill Love, the Northern Ireland development worker for the Carers National Association, added that some elderly people now had to use their attendance allowance to pay for home helps. "This is an entirely inappropriate use of the attendance allowance and tantamount to bringing in charges through the back door," he said.

One of the main problems for the planners and care managers is developing a "mixed economy" of care for elderly people. Despite some innovations, services are still provided mainly by statutory and voluntary agencies—which, according to Sarah Browne, a community services manager in Down and Lisburn, are struggling to keep pace with demand. A more robust private sector would, she said, allow them to be more flexible when putting together care packages for elderly people at home. "We do spot purchase from private nursing homes, but it's not well developed because most of them haven't yet diversified into

Case history

Mrs B is an 85 year old widow. She suffers from severe dementia, urinary incontinence, and repeated infections of the urinary tract. She is unable to bathe, dress, or feed herself. Until recently she was cared for exclusively by her daughter, who lived with her in a ground floor flat. After a multidisciplinary assessment Mrs B was offered a place on an intensive domiciliary care scheme. The scheme sends someone six mornings a week to help Mrs B out of bed and to wash and dress her. They return two nights a week to help her into bed. She attends a day centre three times a week, taken there by a voluntary organisation. Finally, her daughter uses her attendance allowance to pay for extra help with supervision.

domiciliary care. We need to encourage them to provide services like day care, lunches, weekend respite, or simply sitting for someone for a few hours at the weekend. It's difficult for the smaller homes because they don't have the staff, but it would help if we offered them guaranteed work in the form of a contract."

Other forays into the private sector are rare and still at the pilot stage. One area is piloting a private meals on wheels service, but the project has been dogged by complaints from union officials and from the users.

Assessments

Worries about delayed assessments and bed blocking have so far been unfounded. Over 950 elderly people were referred for assessment in the Eastern board between April and September, and 900 had to wait less than a week for the assessment to start. Only nine had to wait more than three weeks and only one more than five weeks.⁴ Joe Dunne, the community care contracts manager at Down and Lisburn community unit, confirmed that problems with assessment had been few and far between. Their biggest problem, he said, was a lack of non-medical professionals based outside hospital to do assessments.

Delays in organising packages of care also seem to be uncommon. Over 800 care packages were offered to elderly people in the Eastern board between April and September last year. Three quarters were started within a week of referral. According to Michael Ancram, four fifths of care packages throughout the province were started within a week.

A general practitioner's view

Before the reforms, many general practitioners were unclear what their role would be in assessing patients. I asked Dr Denis White, a general practitioner in the village of Dunmurry, how much he and his partners had to contribute to assessments. "We hardly contribute anything," he said. "All we have to deal with is occasional telephone calls from our social worker asking if we're happy with the care option chosen for a particular patient. I've not been involved in a single assessment; we don't even have the forms here. They are all arranged by our patch manager, Sarah Browne, and we're all more than happy with this arrangement. We are in almost daily communication with Sarah so we can offer advice if we think it's needed. So far, though, there have been no problems. I've seen no evidence of wrong placements or poor services."

Health and social services in the Down and Lisburn unit, including Dunmurry, are arranged in patches based loosely around a general practice. Each patch has a team of primary care professionals, social workers, and managers. Denis White said that this model was particularly efficient at dealing with

Case history

Mrs F is a 90 year old widow. She has severe arthritis and walks with difficulty, using a walking frame. She has poor vision and poor hearing and despite being mentally alert needs supervision for most of the day and night. Her four children (two sons and two daughters) were sharing her care, which included lifting, bathing, and changing. An auxiliary nurse visited once a week. After a multidisciplinary assessment Mrs F chose to remain at home. Her care manager buys help from two voluntary organisations. Crossroads Care provides someone five mornings a week to help Mrs F out of bed and to wash and dress her. Extracare provides night cover for 10 hours two nights a week.

assessments and care management and warned that other general practitioners in the province may not share his enthusiasm for the reforms.

Carers need more and better information

The Carers National Association estimates that 210 000 (about one in seven) people in Northern Ireland care for a disabled relative or friend. *People First*, emphasises the importance of their (unpaid) contribution and that assessments and services should be "carer aware."¹ Bill Love of the Carers National Association said that the reforms held great promise for carers but he'd seen little evidence of benefit in the months since April. Their biggest problem, he said, was ignorance of the new system. He criticised the units of management for being too preoccupied with becoming trusts to put time and energy into effective public awareness campaigns, leaving carers in the dark about the reforms. "They need to know how to get an assessment, what it means, and how it will affect their services. Some carers are still worried that if they ask for an assessment they will inevitably end up losing a home help or a visit from a district nurse." The Eastern Health Board's evaluation of the first six months echoes his concern: "Public awareness of services and benefits is still woefully limited . . . contact with user groups revealed that the fate of [publicity] leaflets was probably the shortest route from the front door to the waste paper basket." Bill Love hopes that a forthcoming "uptake" campaign organised by voluntary groups including the Carers National Association, will speed up the process of public education.

The association is also worried that carers and users have no legal rights to assessment and no redress in law if they don't get the services they need. Bill Love explained, "*People First* is not a legal document, it's simply a set of government guidelines that are not enforceable." Many carers rely on respite care, for example, to relieve what may otherwise be an intolerable burden. Now that respite in hospital is increasingly unavailable because of the expense, carers may face inadequate or infrequent respite.

Discharging long stay patients into the community

Northern Ireland has six psychiatric hospitals and since 1975 has pursued a policy of relocating long stay patients into the community. Since 1980 the number of inpatients has fallen by over a third, from 3500 to 2300 in 1991 (fig 2). Research done by Dr Michael Donnelly

at the health and health care research unit at Queen's University, Belfast, shows that remaining inpatients are predominantly old and highly dependent, but he is optimistic that a further third or even a half can be discharged by 1997 if enough suitable community facilities are developed. For those patients already discharged the indicators are good. Since 1979 the number of community psychiatric nurses has increased fivefold and over 200 approved social workers have been trained.²

Preliminary findings from a follow up study of all patients discharged from long term care in psychiatric hospitals in Northern Ireland between 1987 and 1992 indicate that most are pleased to be living in the community and are satisfied with their care.³ Michael Donnelly concluded, "The oft cited failures of community care such as homelessness, suicide, and crime have not been features of the policy in Northern Ireland."

Dr Maureen Watson, a consultant psychiatrist in Holywell Hospital, the Northern board's general psychiatric hospital, agreed that long stay patients rarely, if ever, slipped through the net when discharged. Last year's reforms had, she said, made little difference to the discharge programme or to the already established assessment and case management procedures. She added that the quality of accommodation for mentally ill people in the community was usually high, but there was a need for more staff skilled in coping with difficult behaviour.

Community care is not new for people with learning disabilities either. The number of people living in Northern Ireland's three hospitals has almost halved since 1980, but Dr Caroline Marriot, a consultant psychiatrist at Muckamore Abbey Hospital, is critical of the impact that assessment and care management has had on the discharge programme. "Resettlement just about stopped in April," she said. "With care management has come bureaucracy. Our assessment procedures, which worked well and were led by clinicians, nursing, and social work staff who knew the patients, have been replaced by a series of different procedures for each health board, and they relate to the whole province. Some units [of management] seem to be just reinventing the wheel. We know what level of care our patients need because we've kept detailed data for the past three years on all long term patients, but the information is frequently not being used in the assessment process." She is also sceptical about the quality of facilities being developed in the community. "Over the past two years we have been resettling patients with more and more complex needs. Some community units have been built without considering the sort of support that's required. There's an assumption that these people only need a roof over their heads and some sort of unspecified supervision. We are obviously reluctant to discharge patients to places where, although the surroundings are nice, they get a lesser quality of service or fewer support services than they require or are receiving while in hospital."

Conclusions

The main problems I encountered were poor public awareness, the slow development of a suitable variety of community services, and discharges at Muckamore Abbey Hospital falling foul of red tape. There was, however, little evidence of the disasters that sceptics were predicting last year. Few providers complained of rationing and none of running out of funds. One explanation is the relatively generous funding that health and social services benefit from in Northern Ireland. In 1992 the department's budget was £1160m, an increase of 40% since 1979.³ The availability of bridging finance—over £40m among the four boards—

FIG 2—Numbers of inpatients in psychiatric hospitals in Northern Ireland's Eastern board by year. Figures for 1991 and 1992 are projections (source: Eastern Health and Social Services Board, Review of strategy for health and social care for Eastern board residents (1990))

Queen's University, Belfast. Home of the health and health care research unit

has allowed community services to be set up well before the anticipated savings from the hospital sector are available. Northern Ireland has also benefited from integrated health and social services, avoiding arguments over who funds what and lessening the likelihood of vulnerable people being caught in the crossfire. Finally, the closeness of the community and the strength of the church and of family ties may have saved at least some from ending up on the streets.

- 1 Secretary of State for Northern Ireland. *People first: community care in Northern Ireland in the 1990s*. London: HMSO, 1990.
- 2 Department of Health and Social Services. *A regional strategy for Northern Ireland health and personal social services 1992-97*. Belfast: DHSS, 1992.
- 3 *People first monitoring evaluation, April 1st 1993-September 1993*. Belfast: Eastern Health and Social Services Board, 1994.
- 4 Ancram M. Care in the community. *House of Commons Official Report (Hansard)* 1994 February 22;238:col 176. (No 53.)
- 5 Donnelly M, Mays N, Scott M, McCrystal P, Kerr P, McGilloway S. *Leaving hospital in Northern Ireland: a study of the effects of care in the community for former long stay patients discharged from psychiatric and mental handicap hospitals in Northern Ireland*. Belfast: Health and Health Care Research Unit, 1991.

Managing the new NHS: breathing new life into the NHS reforms

Gordon Best, David Knowles, David Mathew

The essence of the NHS reforms is that they bring market forces to bear on organisations providing public services, while allowing those organisations more freedom to respond in ways that will improve the efficiency, effectiveness, and appropriateness of their services. The new structural changes to the NHS—a leaner management executive and fewer, slimmer regions—could be used either to strengthen these features of the reforms or to frustrate them by allowing ministers and top management to intervene even more at local level and “overmanage” the market. To ensure that the aims of the reforms are not frustrated ministers and the management executive must restrict themselves to laying down clear strategies and then allow purchasers and providers to meet those strategies in their own ways. They also need to ensure that the whole NHS can learn and benefit from local experimentation and devise ways of managing the crises that will inevitably arise; otherwise they might be tempted to become involved in managing the market at too local a level, and the NHS will suffer the worst of both worlds: stifling bureaucracy at the top and parochial self interest locally.

The latest round of reorganisation in the NHS is a watershed in the evolution of the NHS reforms. It entails removal of regional health authorities and their replacement by fewer, slimmer bodies that are also executive arms of the NHS Management Executive.¹ This could either revitalise the original commitment to decentralisation or create the ideal circumstances for

ministers, the management executive, and the Department of Health to “repossess” the NHS and impose even higher degrees of central control.

The temptation for ministers to exert even greater control is high. Not only is there little prospect of any extra funding for the NHS; the very workings of the reforms also pose innumerable possibilities for political embarrassment. Yet centralisation would undermine the potential benefits of the reforms, and in working out the details of this latest restructuring of the NHS the management executive needs to consider the processes that determine how the NHS is managed day to day. Here we consider some of the forces at play in the health service that might tempt the centre to lose its nerve over change and interfere defensively, and also suggest ways of managing the service that will help secure the benefits of the reforms.

Temptations to interfere

The King's Fund traditionally provides a “safe haven” where NHS managers, clinicians, policy-makers, and others can meet to explore and develop ideas and to reflect on management within the NHS. Our impression from taking part in many such discussions is of a momentum for change generated by the 1991 reforms—which has yet to realise the full potential generated by the separation of purchasers and providers. This momentum is, however, accompanied by concern about a widening gulf between the centre, including the management executive, the Department of Health, and the political leadership of the NHS, and those who actually provide or purchase local services. There are several interlinked components to this gulf. All provide reasons why it would be tempting for the centre to intervene and reasons why it should not—and reasons why it is important to clarify the relation between the centre and the rest of the internal market.

The internal market, separating purchasers and providers, has created a new dynamic in the system, which makes choices of health care priorities more explicit. The amount of public interest in this rationing process at a local level is constantly increasing. This has raised awareness of the inherent complexity of maximising value for money in health care and also highlighted the potential for controversy. These are welcome outcomes of the reforms, but they do pose serious difficulties and potential political embarrassment for the secretary of state and the management executive.

Public expenditure—The process of introducing the reforms while sustaining a reasonable level of services has been helped by relatively good outcomes for the NHS from the annual negotiations on public spending. This is unlikely to continue, with little growth money expected at least until 1996-7.

NHS priorities—Within the NHS there is now a

King's Fund College,
London W2 4HS
Gordon Best, fellow in NHS
management
David Mathew, fellow in
organisational dynamics
David Knowles, fellow in
health service management

Correspondence to:
Mr Mathew.

BMJ 1994;308:842-5

Is the NHS best thought of as a market...