Regular Review

Community care II: possible solutions

ELAINE MURPHY

There are many examples of good practice that have solved at least some of the problems of community care. The King's Fund memorandum *Facilitating Innovation in Community Care* identified four components that characterised good community care services.¹

Four components of good community care

Clear values and principles about what community care services are trying to achieve—Staff with a real sense of purpose and vision lie at the root of all successful services. Such a common vision has been achieved in certain services for the physically handicapped, elderly people, and people with mental handicap, but it has been extremely difficult to achieve in services for mentally ill people, where there is often a diversity of opinion on what the service objectives should be.

The views of the recipients of services must be considered—The views and wishes of recipients of community services are important when decisions are being made on the type of care received. Consumer choice by individuals and their families is recognised as important, even when in practice the choice available is quite limited.

Professional knowledge and techniques of treatment and care play a valuable role—The best community care schemes make maximum use of medical and other professional skills. Some projects in frustrated haste have developed without the full cooperation of local consultants. A conservative profession does not like to see change for change's sake, but it is worth planning at a slower pace to ensure medical commitment.

Access to all the usual community services—All those community services enjoyed by everyone should be available to the disabled in the community; for example, they should be able to obtain education, housing, leisure services, employment opportunities, and NHS facilities as other members of society do.

Six features of successful schemes

The Audit Commission in its report on community care identified six features that it believed fostered innovation.²

The existence of strong and committed local champions of change—Entrepreneurial drive was the single most important factor identified by the commission. There are of course dangers in fostering a breed of single minded individuals—the hospital service has enough strong consultants who have built empires without much evidence on the cost benefits of what they are offering. Successful

Summary of changes needed to improve community care

National

- (1) Greater collaboration and integrated policy development between the Department of Health and Social Security and Department of the Environment, and between health and social security within the Department of Health and Social Security.
- (2) Effective financial incentives to foster joint planning between statutory agencies and develop voluntary agency participation.
- (3) Incentives for developing primary health care commitment to community care policies.
- (4) An independent inspectorate to monitor quality of care.

Local

- (1) Organisational structures that foster effective case management.
- (2) A neighbourhood focus for delivering the service.
- (3) An emphasis on training and development of care staff.

innovation must therefore be measured against a set of explicit objectives, but how do we ensure that this entrepreneurial activity occurs widely and is not confined to a few unusual individuals? The present government has been successful in promoting the expansion of small businesses in the past six to eight years; can the public sector learn from this success? Some of the key factors that have fostered the growth of small businesses have been: (a) more flexible employment laws encouraging the selection and recruitment of good quality staff and permitting the removal of unsuitable staff; (b) training and retraining; (c) financial incentives that reward successful performance; and (d) the greater availability of risk finance for pump priming. Could such incentives not be introduced into the public sector?

Focus on action and achievement—There should be a focus on action and achievement rather than on merely maintaining the status quo. Joint planning works best where small local teams focus on a particular objective under strong chairmanship.

Locally integrated services—Innovative community care schemes are often the result of service providers from statutory and voluntary agencies banding together and bypassing the official joint planning machinery.

Focus on the local neighbourhood—An integrated service is more easily fostered in a defined geographical area that is sufficiently small and self-contained for it to have a recognisable identity and for professionals from different agencies to know each other personally. The Cumberlege report on community nursing services and the Barclay report on community social work advocated this policy.^{3,4} The current drive to decentralise the managing and planning of community care services to localities or geographical patches flows from a need to recognise the differences between one area and another so as to be more locally accessible and responsive to an individual's needs.

Decentralisation often means, however, different things to the different statutory authorities—for example, authorities often plan in parallel to decentralise but in quite different ways, and specialist teams such as those in mental handicap providing a service across several neighbourhoods often find themselves squeezed out of the planning process.

Multidisciplinary team approach—Successful projects necessitate teamwork by many professionals, but what makes teams work together effectively is not clear. The problems generated by interprofessional tensions at a time of uncertainty and change points to a pressing need to establish clear lines of responsibility and a system of accountability that reflects the team's joint responsibilities.

Partnership between statutory and voluntary agencies—Some of the most original schemes have been initiated by the voluntary sector. They tend to be local and small but can be cost effective and flexible.

The need for structural changes

The Audit Commission decided that only fundamental structural changes to the organisation and management of services would bring about the environment necessary for locally integrated community care to flourish. It proposed three major structural changes.

Firstly, local authorities should be made responsible for the long term care of mentally and physically handicapped people, except for those in need of medical supervision, who would remain the responsibility of the health service.

Secondly, a single budget should be established for the care of the elderly in the community with contributions from the NHS and from local authorities. The amount paid would be determined according to a centrally agreed formula, and the budget would be controlled by a manager who would purchase services from whichever public or private agency gave the best value for money. The manager of the budget would be supervised by a joint board of representatives from both local statutory services.

Thirdly, for mentally ill people the NHS should remain the main authority responsible for care, but the possibility should remain for developing a central budget similar to that proposed for elderly people; alternatively, the NHS should have the ability to purchase local authority services on a contractual basis.

These major structural changes have considerable appeal. The notion of a lead agency with overall responsibility for developing services or for buying in the necessary services from local statutory, private, or voluntary agencies makes clear where responsibility should lie; it thus gives a framework for developing a system of accountability and for monitoring and reviewing the service provided to individual clients. These top down changes, which effectively redraw the service boundaries, may achieve little, however, unless

the real operational problem of delivering the service to the clients is tackled first. Let us return to Mr Brown, whose case I described in the first article and who has several medical and social problems.

Case management

Mr Brown needs one identified individual, the case manager, with the responsibility for ensuring that the following happen.

Firstly, he needs medical assessment of his physical and psychiatric problems and a treatment plan to be implemented. This will be the job of the general practitioner, the local specialist services, and the community nursing service. Like most seriously disabled people, Mr Brown does not need a one off assessment but regular reviews of his condition.

Secondly, there must be an assessment of his current living circumstances and social support networks. He needs a plan for daily support and personal care tasks so as to sustain him satisfactorily at home throughout the 24 hours. This plan needs to draw together home care, day care, and respite services.

Thirdly, his financial position and entitlements should be reviewed. Someone should be appointed to act as advocate and financial adviser.

Fourthly, someone is needed to muster help in an emergency.

Fifthly, someone is required to monitor that services are delivered effectively.

Several projects have shown the effectiveness of the case manager approach. One pilot scheme in Camden and Islington funded by the King's Fund provides a service to physically handicapped people. The managers coordinate services for individual clients. They have no budget of their own but depend like social workers on the goodwill of professional colleagues in other agencies.

Case managers cannot, however, be held accountable for the quality of service if they have to depend on the voluntary cooperation of other agencies. Similarly if managers have no control over the demand on their service they cannot be held responsible for meeting this demand unless they have an open ended budget. One influential project, the Kent Community Care Scheme initiated by Thanet social services, tested the hypothesis that intensive case management by budget holding specially trained social workers could delay or eliminate the need for residential care for disabled elderly people.⁵ Case managers had authority to purchase statutory services and also to employ local support workers. There was a clear line of accountability, and a system of monitoring the budget and the quality of care. The Kent scheme has proved cost effective, and the method has been adopted in some other social services departments.

The Guy's Age Concern project was based on a similar model.⁶ It used a voluntary agency employee as case manager but was targeted at severely disabled dementia sufferers. The case manager had a fixed budget to buy in services from statutory services and employ local paid helpers and local voluntary agencies. This scheme proved less successful than the Kent scheme in keeping people out of institutional care.

Case managers must be accountable to one senior manager. Devising suitable structures to foster this aim is a major problem. A central budget held by a local consortium or joint board of statutory agencies could in theory blend together the best of existing traditions. A system of local neighbourhood

managers accountable to the board and with budgets to spend at their discretion for individual clients provides a framework for developing a responsive system. There are, however, two drawbacks.

Drawbacks to joint boards

Firstly, joint boards would be vulnerable to local political priorities. It seems reasonable that elected councillors should have an important voice in providing services in their own locality, but in practice councils whose political objectives are hostile to the more innovative developments in the NHS could block initiatives that did not further their priorities. Furthermore, to work effectively joint boards should be subject to a review of performance as are NHS districts. This would inevitably curtail local autonomy, though it is difficult to see how such a review system could be effectively implemented given the current system of local politics.

Secondly, the massive reorganisation necessary to implement such joint boards would be costly. The Public Expenditure Policy Unit has briefly reviewed the financial and organisational implications of the Audit Commission's proposal and has pointed out that, though organisational boundaries may be redrawn, problems of coordinating community care with the acute hospital services, day hospitals, day centres, and long stay hospital beds would remain. Redrawing the boundaries would still exclude leisure facilities, housing departments, environmental health departments, and a host of minor agencies that constitute a total service. The concept of one comprehensive health service for one client group, which many psychiatrists and geriatricians feel is essential, might well be lost—the acute hospital arm would be cut off managerially from the community arm of the service. The financial arrangements would also be complex and would need to be sufficiently flexible to take account of local variations in social demography but also remove any haggling between authorities on their respective contributions. Major restructuring of the funding of health and social services would thus be necessary.

Existing structures would remain intact, but clear responsibility for service development would be given to one statutory agency. The Welsh Office's All Wales Strategy for services for mentally handicapped people is an excellent example of lead agency management.⁷ The project, now half way through a ten year programme, has been remarkably successful and has helped to foster the idea of giving a lead responsibility for initiating service innovations to local authority social services departments.

But other key features were almost certainly of greater importance than simply designating a lead agency. Firstly, there was the commitment of the former Secretary of State for Wales and of senior civil servants in the Welsh Office. The strategy was driven from the centre. Secondly, a clearly articulated set of principles was established, with flexibility on their implementation. Thirdly, service users and their families helped shape the service. Fourthly, additional resources were made available in advance of hospital closure. Fifthly, service providers were trained as a central initiative and with adequate funding.

These features do not depend on designating a lead agency but could be encouraged within the existing framework. If these features were to be combined with major changes in financial incentives so as to foster joint planning and project development using case management principles, community care could be made to work effectively within existing budgets. Such changes, however, imply a need for a degree of collaboration between the DHSS and the Department of the Environment which at present does not exist and which can be initiated only by the Cabinet.

Maintaining standards

Finally, we need a strong, independent inspectorate to develop audit systems and monitor the quality of the service. This could raise standards. The model of the Health Advisory Service would be suitable, but more emphasis needs to be given to consumers' views and a new inspectorate should be given greater influence over implementing its recommendations.

I thank Peter Griffiths, David Hunter, and Celia Pyke-Lees for their constructive comments.

ELAINE MURPHY

Professor of Psychogeriatrics,
United Medical and Dental Schools of
Guy's and St Thomas's Hospitals,
Guy's Hospital,
London SE1 9RT

- 1 King's Fund. *Facilitating innovation in community care*. London: King's Fund, 1987.
- 2 The Audit Commission. *Making a reality of community care*. London: HMSO, 1986.
- 3 Department of Health and Social Security. *Community nursing review. Neighbourhood nursing—a focus for care*. London: HMSO, 1986.
- 4 National Institute of Social Work. *Social workers, their roles and tasks*. London: NCVO, NISW, 1982.
- 5 Challis D, Davies B. *Case management in community care*. Aldershot: Gower Publishing, 1986.
- 6 Murphy E, ed. *Home or away: home support schemes for elderly people with mental and physical disabilities*. London: National Unit for Psychiatric Research and Development (in press).
- 7 Welsh Office. *All Wales strategy for the development of services for mentally handicapped people. Review of progress since March 1983*. London: Welsh Office, 1987.