NHS." What is clear is that the standards were drafted by one agency (the Department of Health), the criteria and assessment process will be developed by another (the Healthcare Commission), and the products will be approved by a third (the Secretary of State). This does not bode well for coherent development or independent assessment.

The standards include a catch all requirement that "healthcare organizations meet the existing performance requirements set out in the annex." These very specific targets pre-empt the development of criteria by the Healthcare Commission. Moreover, whether even these will be achieved is not clear. For example, the NHS Plan stated that by December 2004 people would have guaranteed access to a primary care doctor within 48 hours. Official figures show that performance had improved from 75% of cases in March 2002 to 97% in February 2004,⁷ but independent surveys by the Picker Institute put the figure at 54% in 2004.⁸

No allowance is made for standards to be tested by providers and assessors to ensure they are understandable, relevant, and achievable. Nor is there provision for training of assessors or for preparatory self-evaluation by providers. The criteria and assessment process must be finalised by March 2005 and put into effect from April 2005. There is no process or timetable for evaluation and revision.

The Healthcare Commission is faced with the impossible task of developing from these standards a robust and fair assessment process inside eight months. Experience in other countries suggests that the first cycle of a standards based assessment programme needs well defined procedures, simultaneous development of standards and criteria, and at least three years of preparation.⁹

The interests of all concerned, including the public, could be better served. For a start the Department of Health should publish where the standards came from and how they were selected. Reviews in the first year should be regarded primarily as tests of the system

rather than true assessments of individual organisations. Radical redesign of the standards should begin after six months' use (in September 2005), rather than waiting for 2006-7.

International guidance¹⁰ should be followed in the design, development, and application of standards. The same guidance should be used by the Healthcare Commission to develop realistic, understandable, and measurable criteria for assessment and to adopt an assessment process that is proved to be reliable.

The Department of Health has misjudged the research, technical expertise, and time needed to develop and test a fair and reliable process of external assessment. The burden will fall on the fledgling Healthcare Commission as assessor and on the early guinea pigs who are assessed.

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Competing interests: CDS consults on quality standards for the World Bank, WHO, and health ministries—except in the UK.

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Case management and community matrons for long term conditions

A tough job that will need highly trained professionals

Improving the care of people with long term conditions is a key priority for the NHS, and a central part of UK Department of Health's Improvement Plan.¹ Just 2% of patients with chronic conditions account for 30% of unplanned hospital admissions and 80% of general practitioners' consultations. Chronic disease now accounts for 78% of all spending on health care in the United Kingdom, and this percentage will rise with an increasingly ageing population. The process of case management (or care management) lies at the heart of the government's plans for the care of people with long term complex conditions. An NHS case manager—a new type of specialist clinician, usually a nurse comfortingly designated a community matron—will identify suitable patients, assess their

needs, and then work with local general practitioners and primary care teams to develop tailored personal plans to prevent worsening of the condition and, where possible, to prevent unplanned admission to hospital.²

By 2008 all primary care trusts will have developed their own case management approaches, and more than 3000 community matrons should be working to reduce unplanned admissions by 10-20%. Case management is intended to work alongside initiatives such as the expert patient programme,³ enabling patients to make better informed choices and improve their self care. Most recipients of case management will be older people with multiple or complex disorders, although the programme is intended to cover all age groups.

Can case management deliver better outcomes for patients and substantially lessen unplanned admissions? A recent King's Fund review urged caution for the NHS, finding only 19 studies in the past decade where case management was linked to healthcare services, intervention lasted more than three months, and outcome measures included change in use of health services.⁴ In many studies the case management concept was unclear: some referred to a team process rather than to one person's role, and in one project the term meant simply that a nurse coordinated care over the phone.

There is, however, encouraging evidence from established schemes in the United States, largely aimed at frail older people with multiple disorders and disabilities, operating within the framework of managed care organisations. United Healthcare Group's Evercare model has already spawned nine pilot sites in the United Kingdom. The Kaiser Permanente and Pfizer Health Solutions models of vertically integrated health care depend on similar principles, and some primary care trusts in the United Kingdom are copying some elements of these schemes.⁵ An interim report on the UK pilot sites points out that, although the "data rich, information poor" NHS is not yet equipped to identify the population at risk or to monitor the financial consequences in shifts of care, the better coordination of services by "advanced primary care nurses," that is case managers, is beginning to show benefits in terms of reducing unplanned admissions to hospital.⁶

Curiously, much of the healthcare research ignores the wealth of directly relevant social care literature published over the past 20 years. The lessons learnt from research into case management for frail older people with multiple disabilities were adopted in part in the 1990 Community Care Act, although they were rarely implemented in full. These case managers were usually trained social workers, but their target clients were essentially the same patients that are now thought to be suitable for the new community matrons. Successful case management depended on a method of identifying the target population; a trained professional assuming a sense of responsibility, authority, and accountability for assessing and ensuring the ongoing delivery of appropriate care; and control over a devolved budget with financial incentives to substitute less costly care where possible and the knowledge to mobilise and use resources appropriately across a group of clients.⁷

The most effective schemes of case management have close links with secondary care allowing ready access to clinical assessment by specialists.⁸ One such example is the Australian Aged programme, where case managers are allied to specialist medical teams for hospital based care of elderly people and where financial incentives drive the cooperation of health and social care services.⁹ Effective schemes involve comprehensive assessment and reassessment by specialist doctors, have access to a multidisciplinary clinical team, a means of linking medical and social services, and crucially, financial levers encouraging the substitution of hospital care by home care or residential care.¹⁰ Successful programmes in the United States all assume full risk sharing based on a capitation funding allocation for their clientele.

Community matrons in the United Kingdom will not make much impact on hospital admissions,

however committed and involved they and the general practitioners are, without the active involvement of hospital specialists, local social services, and the right financial levers. While primary care trusts are exhorted to establish a vertically integrated care system across the divide between primary and secondary care, acute hospital trusts have a financial incentive, under the new NHS financial regime of "payment by results,"¹¹ to admit the maximum number of cases possible.¹¹ Primary care trusts will need to create alternative levers to drive primary care and hospital teams to collaborate.

Furthermore, where will the 3000 community matrons come from? Many US case managers have training to degree level, and effective case managers in successful UK schemes have been postgraduate social workers with further specific training. The role of nurses has been limited in case management to date in the United Kingdom,¹² and there may be few community nurses who are ready to project the necessary personal gravitas and exercise the clout necessary for skilful negotiation with general practitioners, hospital consultants, and social care providers. The need for training is huge.

Case management is a tough, difficult job to do well, whose complexity and difficulty is often underestimated. There is a profound dearth of information on whether the long term health problems of younger, ethnically diverse populations can be managed in similar ways to ethnically homogeneous older populations, or whether intermediary advocacy might be needed to facilitate the work in disadvantaged communities. The same is likely to be true for expert patient programmes. Improving the lives of people with long term conditions requires the whole NHS to behave differently on a nationwide scale, and community matrons may make a constructive contribution if thoroughly retrained. Real change in patients' experience, however, may take longer than the government hopes.

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