FIT FOR CHANGE?

SNAPSHOTS OF THE COMMUNITY CARE REFORMS

ONE YEAR ON

by

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EXECUTIVE SUMMARY

This paper reports on the first phase of a joint King's Fund Centre and Nuffield Institute initiative on monitoring community care implementation. It provides the first independent account of progress in implementing the community care changes which is based on sampling a vertical cross-section of stakeholders in a range of localities.

The monitoring involves working with five focus groups established in a range of localities across the country (including an inner and an outer London borough, two shire counties, and a metropolitan authority).

The findings are broadly supportive of the conclusions of central monitoring, but also point to some important differences. Monitoring by the Department of Health, and by the Audit Commission has produced a picture of smooth transition and steady progress.

The current study does not contradict these findings, but it does indicate some of the costs of achieving this transition, and the contrasting perceptions of strategic and operational staff. The central monitoring has, to date, reported on the first six months of the community care changes. This account of local developments provides a more recent snapshot. The focus groups were convened at the end of the first year of the community care changes (March/April 1994), and it is intended that the same groups will meet again in a year's time.

It was recognised in all five focus groups that it was still too soon to judge the success of the community care reforms. However, it was clear that the hopes which people had held prior to April 1993 were showing some signs of realisation, while many of the fears which had existed had proved to be over-pessimistic.

USERS AND CARERS

The difficulties of involving users and carers in community care planning and evaluation were reflected in the five local focus groups. The involvement of users and carers was difficult to secure. Even when it was possible to include such individuals it was rarely possible to reflect a diversity of user and carer interests. Where users and carers raised concerns which were not consistent with those of purchasers or providers, those views tended to be side-lined. Clearly, the involvement of users and carers in a meeting was no guarantee that their interests would not be marginalised.

Where service users and carers did participate in the focus groups, they had low expectations of the community care reforms, and they were less inclined than service purchasers and providers to judge there to have been substantive improvements over the first year. There were particular concerns over increased charging for services and the impact of changing boundaries between health and social care. Some carers were especially concerned that they will face increasing demands, and that their own needs will not be addressed. The perceived reduction in access to residential services was seen as an early indicator that this was proving correct. This also underlined the very real conflicts which exist between developments which carers may wish to see, and the service objectives being pursued in the *Caring for People* reforms.

PROGRESS AND PROBLEMS

In evaluating the impact of the community care reforms during the first year of implementation, we were especially interested in issues arising on the interface of health and social care. The boundary between the two services has long been recognised as problematic. Moreover, the boundary is a shifting one which has been thrown into particular relief by the community care changes.

It is interesting, therefore, to observe that while issues along this interface were apparent in all five focus groups, other issues emerged as being equally important.

- Service Improvements?

  Improvements were judged by all five groups to have taken place both in actual service provision, and in improved working relations. However, with the exception of a few individual examples, evidence of service improvement was thin, and the belief in improvement was often not grounded on firm data. Indeed, the relative dearth of monitoring and management information was apparent in all five localities. In some instances, the belief that services were becoming more flexible, and better suited to individuals' needs, was contradicted by the objective evidence that the range of options remained limited (other than in specific initiatives) because of the absence of any substantial diversification of the independent sector into domiciliary and day services.

- Better Joint Working

  Improved working relations were reported both between statutory agencies, and between these agencies and the independent sector. While in some instances these good relations were building on a long established tradition of co-operation, in others it was clear that the community care changes had provided a significant catalyst.

- **Change Fatigue Among Staff**

Staff had generally risen to the challenge and worked hard to make the necessary changes, but it was clear that this had imposed significant costs on staff, especially on those in operational roles. The stresses on some staff (particularly hospital social workers) were such that recruitment was becoming an issue. While much effort went into preparation for the community care changes at both local and central levels, it is clear that the change process is by no means complete. If the changes are to continue without major problems, questions arise about how best to ensure the 'fitness' of the organisations to make the changes. If support to individuals and services is not addressed at this stage, there may well be problems ahead. The change agenda has been a long and demanding one, and some members of the focus groups reported their feeling of tiredness and even demoralisation. This also reflected the impact of other changes taking place, such as mergers between DHAs and FHSAs, and impending reorganisation of local government.

- **The Changing Health and Social Care Divide**

Some of the problems which were encountered during the first year were a continuation (and extension) of established difficulties, whereas others were arising for the first time. Health and social care boundary issues were apparent in three main areas: the uncertain and changing divide between community nursing and home care; hospital discharge; and long term continuing care responsibilities. Service providers all reported pressure from relatives to keep patients in NHS care, and believed there to be a growing awareness among the public about their 'rights' to free NHS care.

- **Managing the Market**

Problems in managing the market were evident in Year 1, but these were largely in respect of the failure to develop a market for alternatives to residential care. However, this failure was not attributed to insufficient resources. All five focus groups were concerned about resources for local authorities after the ending of the Special Transitional Grant (STG) arrangements in 1996/7, but resource pressures were not identified as a major issue at this stage.

Independent proprietors of residential and nursing homes were critical of the manner in which local authorities were seeking to contain prices, and they remained pessimistic about their continued viability. The widespread bankruptcies which were predicted had not emerged, although some home closures were said to have taken place. The slow diversification of the independent sector was attributed to various factors, but the lack of national registration or accreditation was perceived by social services purchasers as a major impediment to local development.

- **GPs Not On Board**

  A final area of difficulty in all five localities was identified as the poor engagement of GPs (especially fundholders) in community care. Not only were GPs thought to be poorly involved and ill informed about the community care changes, but in some instances GPs were seen to be actively undermining new approaches (for example, by using hospital referrals to by-pass liaison with social services). These difficulties may be seen as a particular reflection of a more general set of problems in which policy contradictions were identified. The NHS reforms were seen by some to be poorly integrated with the community care changes. Similarly, policy in particular issues such as mental health, and on drug and alcohol services, was seen to run counter to the ethos of the community care reforms.

CONCLUSIONS

The focus groups reinforced the general findings of central monitoring. The first year of the community care changes has progressed relatively smoothly. However, the experience of staff working at the front line has been different from that of many managers. Smooth transition has been accompanied by high costs for some in terms of work load and the consequences of 'learning by doing'.

Problems at the health and social care interface have been in evidence, but have not been as overwhelming as some predicted. Nonetheless, it is the consequences of the problems which are being more or less successfully managed, rather than their underlying causes which have been resolved. In particular, further clarification is required in policy for continuing care and charges for services in order to resolve local uncertainty and confusion.

The situation remains volatile. Underlying problems remain, and many of the real achievements are built on the uncertain foundation of goodwill. Without adequate investment in support to individual staff; in organizational development; and attention to policy clarification, the capacity to maintain momentum and to address the continuing change agenda must be in doubt.

INTRODUCTION

Since 1992 the King's Fund Centre for Health Services Development, and the Nuffield Institute for Health have been working together to identify progress and problems in implementing the community care changes. In particular, this monitoring has focused on issues arising on the boundary between health and social care. It was believed that this would highlight problems arising and requiring remedial action either by central government, or by health and local authorities. It was also believed that it would be valuable to identify where and how service changes along this boundary were having a positive impact on the lives of users and carers.

A national focus group comprising 30 individuals from different parts of the country was established. This included managers and practitioners from the NHS and local authorities, together with representatives of the voluntary sector, users and carers. Two reports reflecting the perceptions of the group have been published(1)(2), and the group is continuing to meet on an annual basis.

The King's Fund and the Nuffield Institute decided to complement this national level of information gathering by establishing five local focus groups across the country. Groups were convened in an inner and an outer London borough, in two Shire counties, and in one Metropolitan authority. Meetings took place at the end of the first year of the community care changes (March/April 1994), and it is intended that the five focus groups will reconvene at the same time in 1995.

The focus group meetings were facilitated in order to track hopes and fears which had been identified prior to April 1993; to understand whether and how difficulties are being resolved, and to identify successes; and to highlight new issues emerging.

This report on the discussions of the five local focus groups provides the first independent review of progress with implementation of the community care reforms. The methodology entailed bringing together purchasers of health and of social care, with managers and front line providers, and users and carers, thus providing a vertical cross-section of community care stakeholders.

Despite the best efforts of all involved, it was difficult for the focus groups to reflect equally the interests of all stakeholders. Some groups were clearly under-represented. This was especially true of general practitioners and representatives of the FHSA, but it was also true of service users and of carers. This has important implications.

The community care reforms place particular emphasis upon the involvement and consultation of users and carers. In establishing the focus groups we asked local contacts to invite individuals whom they would usually involve in planning or consultative meetings. The poor response rate on the part of users and carers suggests that their involvement in other consultative meetings may be similarly problematic. Moreover, the difficulties of engaging some of those users and carers who did attend the focus groups also point to wider concerns over genuine - as opposed to tokenistic - involvement of these groups.

FINDINGS: CENTRAL MONITORING

National monitoring of the community care reforms has comprised a programme of regular joint monitoring by the Social Services Inspectorate (SSI) and Regional Health Authorities, and a series of 'special studies'(3). The monitoring has presented "an encouraging picture", albeit one based only on the first six months of implementation. The Department of Health has observed that while "it is obviously too early to make a final judgement", nonetheless, "almost everywhere basic structures are in place and beginning to work well in both social services departments and the NHS"(4). Monitoring by the Audit Commission has produced a similar picture of "cautious but steady progress"(5).

Central monitoring mechanisms have been principally concerned with assessing localities' progress with implementing the structural and administrative changes required by the community care legislation. These changes were summarised in the list of 'eight key tasks' issued jointly by the NHS Management Executive and the Social Services Inspectorate in March 1992(6), as follows:

* Agreeing the basis for required assessment systems for individuals.

* Clarifying and agreeing arrangements for continuing care for new clients in residential and nursing homes including arrangements for respite care.

* Ensuring the robustness and mutual acceptability of discharge arrangements.

* Clarifying roles of GPs and primary health care teams.

* Ensuring that adequate purchasing and charging arrangements are in place in respect of individuals who will be needing residential or nursing home care.

* Ensuring that financial and other management systems can meet the new demands likely after 1 April 1993.

* Informing the public of the arrangements made by the authority for assessment and the provision of care.

In 1993 the Department of Health reiterated that the first priority for 1993/94 would be "to ensure that the arrangements being put in place for assessment and securing care and for the management of budgets work effectively"(7). The monitoring to date has therefore been less concerned with examining whether and how the systems being put in place actually lead to real changes in approach, or to improvements in outcomes for service users and for carers. The Audit Commission described the new procedures and financial systems being put in place in terms of the essential 'infrastructure' needed to under-pin a needs-led approach. It is vital, however, to remember that the establishment of the infrastructure is a means to an end, and not an end in itself. Central monitoring mechanisms need to move beyond checking that the infrastructure is in place, to examining its impact on service users.

FINDINGS: THE FOCUS GROUPS

In all localities visited there was a sense of caution, and a view that it was still too soon to judge the success - or otherwise - of the community care reforms. Nonetheless, it was also apparent that the hopes which people had held for developments after April 1993 were being realised (at least to some extent); while their fears had generally proved to be over-pessimistic. However, perceptions also differed markedly both between different groups of stakeholders (such as statutory and private), and between different levels of personnel (for example between social services managers, and front line operational staff).

The verdict on progress over the first year was generally a positive one, but many concerns remained. There was particular anxiety about the longer term future, especially about the resourcing of community care beyond the ending of the Special Transitional Grant (STG) period.

The difficulties of co-ordinating services, and of distinguishing policy and practice responsibilities, along the grey interface of the health and social care divide are well known. While the community care reforms have not created these issues, in many instances the changes have thrown them into sharp relief. This is especially evident around respective responsibilities for hospital discharge, and for continuing care, as well as for support in the community. Uncertainties and concern about these issues were apparent in all five groups. The distinction between health and social care responsibilities is also one which has substantial implications for service users and their carers. While services provided by the NHS are free of charge, increasingly those arranged by the social services authority are subject to means testing and charges.

A number of clear themes emerged from the five focus groups. These are presented below.

1. HOPES AND FEARS

In all five focus groups it was apparent that progress with implementing community care had generally been more successful than expected. However, it is important to understand the criteria for judging such success. As was the case with central monitoring, the major template for the focus groups judging their own success or failure was still the one provided by the Foster/Laming list of eight key tasks.

The tracking of hopes and fears which people had held for community care prior to April 1993 provided a useful mechanism for assessing progress. The major themes which emerged in addressing hopes and fears are summarised below.

HOPES

- Increased support for carers.
- Informed choice for users, and more services available from which to choose.
- User empowerment.
- Better focus for social worker time, and chance for care managers to develop really good packages of care.
- Better standard of service to users.
- Rise in standards of private sector, and disappearance of poor quality providers.
- Hope for more attention to client groups other than elderly people.
- Better resourcing.
- New opportunities.
- Better continuity and multi-disciplinary teamwork.
- Closer liaison between statutory and voluntary sectors.
- Services developed to fit needs, rather than needs shaped to fit services.
- Improved respite support.

The hopes which individuals held for the community care reforms were remarkably consistent across the five groups, and generally mirrored the aspirations which were stated in the *Caring for People* policy documents. Thus the white paper(8) advanced six key objectives for service delivery:

- Promotion of the development of domiciliary, day and respite services to enable people to live in their owns homes wherever feasible and possible.
- Making practical support for carers a high priority.
- Making proper assessment of need and good case management the cornerstone of high quality care, with packages of care being designed in line with individuals' needs and preferences.
- Promotion of a flourishing independent sector, making maximum use of private and voluntary providers, and so increasing the range of options and widening choice.
- Clarification of agency responsibilities.
- Securing better value for money by means of a new funding structure which would not provide any incentive in favour of residential and nursing home care.

Several of these aspirations are of direct relevance to any consideration of issues arising on the interface of health and social care policy and provision. Satisfying the objectives would require the development of working relations between various health and social care agencies, while the establishment of flexible care packages presents a clear challenge to service boundaries.

The nature of fears which members of the five focus groups held for community care beyond April 1993 reflected a number of themes which had also been in general currency around the time of the implementation of the *Caring for People* reforms. Thus although nationally the proposals had generally been welcomed, there had been considerable concern that the changes would be inadequately resourced and would represent a 'poisoned chalice' to local authorities. Similarly, there had been widespread worry about the preparedness of local authorities to cope with the change agenda (fears which led to the establishment in October 1992 of the Community Care Support Force to assist with local preparation). These same concerns were also reflected in the national focus group meetings during 1992 and 1993.

FEARS

- Massive bed blocking.
- Intense shortage of resources.
- Bankruptcy in the private sector.
- Worries over competence of local authorities.
- More demands and complaints from users.
- Increased bureaucracy and paperwork.
- Bombardment of change - too much happening.
- Loss of social worker skills such as counselling.
- More about money than values.
- Voluntary sector fears about being squeezed out.
- Uneconomic - private and voluntary sectors squeezed on price.
- Neglect of lower category needs and preventive support.
- Entry of large private care providers.
- Limited choice (reduced options to enter residential care).
- Overwhelming demands - unable to meet individuals' expectations.

As the above list indicates, within the five local focus groups, fears were similar to those which had been held more widely. While the worst case scenarios which had been predicted had generally not materialised, nonetheless many of the fears remained, and the future was still uncertain. It was notable also that service users and carers admitted that they had been far more sceptical about the likely achievements in prospect, and that their expectations for change differed sharply from the expectations of purchasers and providers. In one group, for example, a service user with physical disabilities confessed to having held "no great hopes for real change", but had believed "things could not get any worse." Elsewhere, a carer looking after an adult son with severe learning disabilities had hoped that improved support for carers would lead to residential provision for her son.

2. GOOD NEWS AND BAD NEWS: PROGRESS AND PROBLEMS

Work with the five focus groups sought to identify both progress and problems which had emerged during the first year of the community care changes. We were concerned with implementation matters in general, but paid particular attention to issues on the interface of health and social care. Perhaps the most striking finding was that the health and social care boundary was not emerging as such a dominant concern, and other issues were therefore also in evidence.

Individual comments on progress during the first year reflected a range of perspectives. At one extreme was the cautious praise that "things didn't get any worse!", and that the experience had been one of "evolution", rather than the feared "revolution." In general, however, comments indicated genuine and substantive progress. The expectation that things might deteriorate during the first year was clearly apparent in the fears which were identified in Section 1 above. This general expectation of catastrophe had also been evident in the King's Fund/Nuffield Institute work with the National focus group during 1992 and 1993.

It is important to note that the distinction drawn between good news and bad news, or between progress and problems, was by no means black and white. Many issues on which progress was evident were nonetheless still seen as problematic. Similarly, some of those areas identified as problematic - such as hospital discharge - were also ones in which substantial improvements were said to have taken place. Moreover, perceptions differed markedly between different 'stakeholders' - both within and between different professional groups.

PROGRESS DURING YEAR 1

A considerable number and range of issues were identified as evidence of progress across the five focus groups. Despite the apparent diversity, it was clear that these items in fact addressed issues in two major areas.

i) IMPROVEMENTS IN SERVICES

Improvements in services were claimed by all five focus groups, and the main dimensions of such improvements identified by participants are listed below.

- *Good care management systems developed to cope with complex needs.*

- *Complex packages of care being assembled to enable some individuals to remain in the community.*

- *New forms of service developing which facilitate greater choice for individuals (for example, the flexibility to pay neighbours who are acting as carers to people in the community).*

- *Some success in diverting people from residential care to community based alternatives.*

- *Some improvement in support for carers.*

Although group members pointed to improvements in services over the first year, it was clear that in many instances this belief was an article of faith rather than the result of objective evidence. The lack of evidence pointed to the widespread under-development of monitoring or management information systems. This finding also reinforces the conclusion to the Department of Health monitoring of the first six months of the community care changes, in which it was observed that "information, monitoring and review systems are not yet sufficiently refined to enable managers fully to assess the effectiveness of the strategies they are implementing."(9) While it was believed by some group members that more people were being maintained in the community, hard evidence for this was often lacking. Similarly, there was a lack of evidence that people's choices had increased, and in some instances evidence was contradictory.

The fact that nowhere was there an established strategy for developing the home care market, and that the independent sector was extremely slow to diversify into such provision, seemed inconsistent with a belief that packages of flexible care were being developed to meet the needs of people in the community. Certainly some instances of such care could be identified, but these were by no means the general pattern. In one shire county, for example, it was observed that terminally ill patients were "for the first time getting the packages of care they might have chosen". Whereas in this locality in the past it had been rare for people to be discharged to die at home because appropriate support was not available, a "significant change" had taken place in developing such services. While particular instances of flexible alternative community based services were evident, this was a long way from describing a general trend towards responsive community based alternatives to residential care.

ii) IMPROVED WORKING RELATIONS

The second major area in which focus group members identified progress was in improved working relations between different groups of stakeholders. These improvements had a number of dimensions, as indicated below.

* *Health and social services have generally found ways of working together.*

* *Improved and more positive relations developing between social services and the private sector.*

* *Improved liaison between voluntary and statutory authorities.*

* *Better consultation with users and carers.*

* *Better information provided to users and carers.*

* *Hospital discharge arrangements more systematic, with little evidence of bed blocking emerging.*

The factors which had facilitated such progress varied between localities. However, the commitment of staff everywhere had been a major influence. In addition to the commitment and motivation of individual staff, the impetus for progress with community care implementation came from a number of sources.

A history of good collaborative relations was important in some localities, and established informal arrangements became crystalised through sharper role and responsibility definition. Elsewhere, it was the very urgency of the change agenda which had obliged people to get together, clarify roles and establish systems. In some localities this led to a striking - "almost revolutionary" - transformation in relations, particularly between the statutory and private sectors. Where successes were identified, there was also evidence of good preparation and piloting of new approaches in advance of the changes in April 1993. In addition to ensuring that localities were well prepared, advance piloting was especially valuable in securing widespread ownership of new approaches on the ground.

PROBLEMS DURING YEAR 1

In the same way that fears rather than hopes had tended to dominate the climate prior to the implementation of the community care changes, it was clear that despite the undoubted achievements of year 1, there were nonetheless substantial problems. Many such issues were identified, but most of these could be classified into one of the categories below.

There was striking consistency between the five focus groups, although there was evidence too of some locality specific issues. For example, the inner London locality faced particular difficulties which reflected both the distinctive pressures within London as well as the impact of the Tomlinson report(10) and subsequent change and protracted uncertainty. Similarly, one of the Shire counties was already experiencing the depressing impact of planning blight created by the prospect of local government reorganisation.

i) PROBLEMS ON THE HEALTH AND SOCIAL CARE BOUNDARY

In evaluating the impact of the community care reforms during the first year of implementation, we were especially interested in issues arising on the interface of health and social care. The boundary between the two services has long been recognised as problematic, particularly where respective responsibilities are unclear and joint working is necessitated. Moreover, the boundary is a shifting one which has been thrown into particular relief by the community care changes.

However, as we have already noted, while issues along this interface were apparent in all five focus groups, they were not so dominant that other issues were not also being addressed or seen as equally important.

Some of the problems which were encountered during the first year were a continuation (and extension) of established difficulties, whereas others were arising for the first time. Health and social care boundary issues were apparent in three main areas: the uncertain and changing divide between community nursing and home care; long term continuing care responsibilities, and hospital discharge.

Both continuing care and the provision of support at home were seen as problematic for service users when a shift in the boundary between health and social care also meant a shift from a free (NHS) service to a charged for (social care) service. The uncertainty of responsibility for long term care was an issue in all localities, and although most frequently encountered in respect of care for elderly people, it also arose in other areas including: provision for people with head injuries; for those with severe learning disabilities, and for those requiring convalescent or terminal care. Service providers all reported pressure from relatives to keep patients in NHS care, and believed there to be a growing awareness among the public about their 'rights' to free NHS care.

The boundaries between residential care homes, nursing homes and hospital care were also seen as a barrier to providing the best care for individuals. In one locality, in particular, there was frustration that artificial distinctions between services prevented the necessary input of convalescent support to individuals in residential care homes. The wish to provide more responsive and flexible care was impeded by the restrictions on local authorities providing health care.

The particular concerns identified in the boundary issues of continuing care, and support in the community are listed below.

Community Nursing/Home Care Interface

* *Issue in all five localities over changing responsibilities between the two services, and the impact on clients both in terms of charges for services, and appropriateness of care.*

* *Unacceptability for clients of home care staff providing intimate personal care (e.g. bathing).*

* *Perceived inequity between clients receiving free (NHS provided) community nursing support, and those paying for social services home care.*

* *Concern that home care staff will not always pick up early signals of deterioration which a nurse would be alert to.*

* *Problems in joint working - lack of coordination and continuity.*

Uncertain Long Term care Responsibilities

* *An issue in all localities, but focused on different points of the system. Most common concern in relation to continuing care of elderly people, but issue also in respect of responsibilities for the care of: people with head injuries; people with severe learning disabilities; people requiring convalescent or terminal care.*

* *Widespread experience of pressure from relatives to keep patients in care of NHS in order to avoid means testing for social services.*

* *Boundaries between residential, nursing and care for the elderly mentally infirm (EMI) militate against "efficient, flexible provision" which could prevent people having to be moved from one stage to another.*

Hospital discharge was another 'boundary issue' in the localities. It was also an issue in which central monitoring had generally indicated that arrangements were operating smoothly, despite heavy workloads on staff undertaking assessments. Nationally, there has been little evidence of serious bed blocking, or changes in the incidence of this. However, in the first year authorities have had little data with which to plan. In many authorities it would be impossible to produce hard evidence on either improvement or deterioration. A Nuffield Institute study on hospital discharge arrangements in the early days of the community care reforms observed that information bases had been rudimentary, "and certainly inadequate to enable the development of reliable forecasting and practice models in advance of implementation".(11)

While all authorities in the country produced evidence of strategic agreements on hospital discharge, it was apparent within the focus groups that this did not necessarily guarantee the smooth operation of discharges in practice. Hospital discharge arrangements provided a particular example of an area in which although the anticipated disasters had generally not taken place, working practices were still highly problematic and increasingly bureaucratic. This conclusion needs to be viewed in context. A member of a focus group in an inner London locality reminded the rest of the group of how things had been previously:

> "We are not moving from a situation in which everything was good. Hospital discharge was largely theoretical, and was without proper consideration of needs. There were some examples of good practice prior to April 1993, but the general picture was one we couldn't be proud of."

Among many front line staff there remained confusion and uncertainty over responsibility for deciding discharge. Hospital social workers faced particular stresses in trying to manage discharges in the best interests of patients while under continuing pressure from hospitals anxious to maximise throughput. Some of the other difficulties with managing hospital discharge which emerged in the five focus groups are summarised below.

Hospital Discharge

* *Anecdotal (but not widespread) evidence of increase in bad discharges.*

* *Continued uncertainty over who is in charge of discharge decisions.*

* *Conflicts and disagreements between hospital and social services staff over assessments, and poorly understood eligibility criteria.*

* *Enormous stress on hospital social workers, largely coming from continuing pressure in hospitals to maximise throughput.*

* *Confusion over roles and terminology - e.g. some private nursing homes have their own nursing care plan which is different from the discharge care plan.*

* *Discharge process is taking longer (particular issue for private homes experiencing longer interval between initial visits and people entering a home).*

* *Discharge become more complex, and hence more problematic - "before there was less dialogue and more action."*

* *Time taken in dealing with complex assessments leads to delay in dealing with simple assessments.*

* *Assessment procedures duplicating efforts with little or no coordination.*

* *Highly bureaucratic systems introduced - great increase in form filling and paper work.*

* *Concern that time spent in assessment and paperwork leaves inadequate room for social work support such as counselling and advocacy.*

* *Lack of reliable information for localities to be able to judge how well hospital discharge is really working.*

* *Discharge of people to nursing homes who previously would have remained in hospital beds - concern over number of such discharges who die within a week of discharge.*

ii) MANAGING THE MARKET

In addition to these health and social care boundary issues, a number of other problems were also identified. 'Managing the Market' provides a recognisable shorthand for summarising a set of issues arising between social services purchasers and independent providers. Some of the difficulties which were apparent need to be seen alongside the earlier accounts of improved working relations. In all five focus groups it was clear that relations remained uneasy, at least to some degree.

The arrangements for the transfer of the Special Transitional Grant had been criticised by - among others - the House of Commons Health Committee. The Committee concluded that the nature of the funding formula, and the conditions attached to local expenditure might impede the implementation of good local care plans by reinforcing existing patterns of residential and nursing home provision.(12) The Department of Health's requirement that 85 per cent of the STG transfer should be spent on the independent sector was essentially intended to assist a smooth transition to the new system. In view of this 'safety net' it was, perhaps, surprising to find so many local independent providers in the five focus groups who had anticipated the changes with such alarm. One such provider had summarised his mixed feelings in the remark that he hoped "the light at the end of the tunnel wasn't a train coming."

The distribution of the Special Transitional Grant (STG) had also been significant. While there was universal concern across the five focus groups about the adequacy of resources in the longer term, during the first year there had not been great pressure on expenditure. The conditions attached to the STG were variously perceived as both a barrier and an opportunity. From the perspective of private sector providers, the period of relative stability had been welcome. Within social services, the capacity to use resources more flexibly, and to devolve budgetary responsibility had also provided further opportunities, although the requirement to spend 85% of the transfer on the independent sector was also seen as restrictive.

Local authorities appeared to have been fairly successful in controlling prices for residential and nursing home places, with the result that independent proprietors remained pessimistic about the long term viability of their business. As indicated previously, prior to April 1993 widespread bankruptcy and closures of private homes had been predicted, but had failed to emerge, although some home closures were said to have taken place.

Most of the problems of managing the market were associated with the failure to develop a market for alternatives to residential care. The slow diversification of the independent sector was attributed to various factors, but the lack of national registration or accreditation was perceived by social services purchasers as a major impediment to local development. However, some independent providers seemed eager to develop alternative services, but felt that they were being held back from doing so by the reluctance of social services departments to identify service needs or to establish contractual arrangements for alternative patterns of care.

Managing The Market

* *Continuing mistrust of social services by private providers, particularly where social services have been establishing Trusts for services which were previously directly provided. Suspicion that referrals will not be operating on a level playing field.*

* *Belief in some quarters that social services have too much power vis a vis the independent sector, and function as "judge, jury and hangman."*

* *Widespread belief on part of private sector that social services' pricing policy makes the continued existence of the private residential and nursing home sector uneconomic and volatile.*

* *Independent sector has been slow to diversify into domiciliary and other non-residential services. Partly impeded by lack of national registration/accreditation arrangements. Voluntary sector providers are responding even more slowly than the private sector, and are largely unable to accommodate the flexibility of spot purchasing which is required.*

* *Market harder to manage for some client groups than for others. For example, learning disability services have tended to inherit a different system of remote facilities, rather than one developed locally to meet local needs.*

iii) GPs NOT ON BOARD

A further area of difficulty in all five localities was identified as the poor engagement of GPs (especially fundholders) in community care. Not only were GPs thought to be poorly involved and ill informed about the community care changes, but in some instances GPs were seen to be actively undermining new approaches (for example, by using hospital referrals to by-pass liaison with social services). The difficulties of getting GPs to attend meetings were widely identified. However, there appeared to be relatively little understanding of the practical difficulties which GPs - as frontline service providers - might face in attending meetings. Similarly, while the 'problems with GPs' were readily acknowledged, there were few - if any - signs of practical steps being taken to attempt to remedy the situation. The issues identified by the groups which are summarised below were all concerned with the problem rather than with solutions.

GPs Not on Board

- *Reflected in the composition of focus groups; in only two meetings had it been possible to involve an FHSA representative, and neither was a GP.*
- *Problematic in community care implementation generally, but especially clear around hospital discharge issues.*
- *GP fundholders perceived by social services as particularly "maverick".*
- *Some GPs using hospital admissions to by-pass liaison with social services.*
- *Tensions between objectives of a team approach, and style of working of independent contractors.*
- *Different agenda of GPs for community nursing (GPs using practice nurses for things not of great relevance to community care).*

In part, the difficulties with GPs were a particular reflection of a more general set of problems in which tensions and policy contradictions were identified between the community care changes, other policy reforms, and developments within the NHS. These are summarised below.

Policy Contradictions

- *NHS internal market reforms seen to be poorly integrated with community care changes.*
- *Mental health policy: introduction of supervision register seen as cutting across the ethos of community care.*
- *Drug and alcohol services funding inadequately recognises the additional needs of inner cities.*

iv) CHANGE AND UPHEAVAL

A final set of difficulties was identified in all groups in terms of the general impact of long term change and upheaval. The development of a financial, managerial and administrative infrastructure to support the community care changes had created a substantial change agenda, particularly for social services staff. While staff had generally risen to the challenge, and worked hard to make the necessary changes, it was clear that this had imposed significant costs on some personnel, particularly those in operational roles.

In one London borough, for example, a senior nurse remarked:

> "We are in a very negative morale state. That is relating to the changes, We are going through mega changes - including cultural change."

This was echoed in a Shire County where it was observed that people were all coping with very full agendas, and had been doing so for an extended period, with the result that there was "a significant level of being knackered." However, in some localities there were sharp differences between the perceptions of strategic and operational staff. Thus in another Shire County a senior social services manager observed that implementation had gone "remarkably smoothly", and pointed to the lack of major problems with the systems which had been established. By contrast, a colleague responsible for a group of social services team managers described the process as "a nightmare", and observed that implementation had been "extremely stressful and problematic." Other issues which were identified under the theme of change are indicated below.

Change And Upheaval

* *Constant feeling of change very destructive -"trying to keep things going on shifting sands."*

* *Continual restructuring adds to difficulties - people frequently change their roles and responsibilities.*

* *Need for a period of consolidation to adjust to changes.*

Some of the difficulties which were being experienced in the five localities reflected the fact that many longstanding issues - such as hospital discharge, and responsibility for continuing care - were being confronted for the first time. In consequence, the problems have become more explicit. In one locality it was observed that this had a particular impact on social services:

> "There is a tendency to lay the blame for whatever is happening at social services' door. Before the community care changes, hospitals could do as they liked."

This was putting social workers "under incredible stress; they are going down like nine pins", and meant that it was extremely difficult to recruit social workers to hospital work.

The fact that the community care changes have brought many long standing issues and difficulties into the open was widely recognised. Thus, for example, the difficulties of ensuring that GPs were 'on board' with wider changes were not new, but had become of greater importance since April 1993 in view of the renewed emphasis on coordination and multi-disciplinary working. Similarly, the shift to a needs-led approach to service provision had highlighted concerns over un-met needs and questions of rationing. A member of one focus group suggested that services have always been constrained, and the issue is not therefore about whether or not services are rationed, but about whether the new system is better in its effects than the old one. The inadequacy of many local monitoring and information systems to address such questions was apparent.

Whether the new model of community care was producing better results for service users and carers was a controversial and inconclusive matter. While there were signs of an improved service being provided for a small number of highly dependent individuals, there was a widespread belief that this was generally at the cost of a reduced service to those with lesser needs. Indicators of client satisfaction were crude and poorly developed. For example, individuals pointed to the relative lack of complaints, or the absence of judicial review and challenge to assessments. In several groups there was concern that despite the new emphasis on greater choice for service users, in practice such choices had been reduced, particularly in more restricted access to residential care.

3. WAYS FORWARD: LOCAL AND NATIONAL AGENDAS

In identifying problems and barriers which had impeded progress during the first year of the community care reforms, the focus groups also proposed various issues which needed to be addressed if these were to be overcome. Clearly, some of these raised matters on which central government clarification or guidance is required, while others addressed local agendas for action. The major issues which arose in respect of both of these are presented below.

National Issues

* Clarification required over respective NHS and local authority responsibilities for long term care.
* Clarification required over relationship between mental health care programme approach for people judged as dangerous, and community care responsibilities.
* Conflicts between registration and care requirements (e.g. Nursing homes seen as too traditional and institutional, as exemplified by nurses in uniforms).
* Recognise tensions and lack of co-ordination between changes in NHS and community care reforms.
* Do something to address position of GPs, especially situation of fund holders which is 'out of synch' with everyone else.
* Recognise need for period of calm and consolidation to adjust to major changes.
* Registration and accreditation needed for independent home care services.

It was also recognised that some issues needed to be addressed locally. Some of these were highly specific to local circumstances. However, a number of common themes also emerged, as indicated below.

Local Issues

* Better strategic planning needed.
* Geographical localities for GPs, rather than practice boundaries, might facilitate coordinated local focus.
* Improved efforts needed to strengthen linkages between social services and Primary Health Care Team.
* More joint training needed (especially around assessment), and including independent sector.
* More monitoring and review required.
* Address skill mix issues: what is needed, and who needs to do it?
* Increase devolution of purchasing power to care managers.
* Need to increase diversification of service provision.
* Experiment with new ways of doing things.

The generality of the above list suggests that while members of the five focus groups had all been able to identify problems which they were experiencing in implementing the community care reforms, and to specify further areas in which they believed that central government needed to act, they were less able to identify specific local strategies which might be pursued in tackling their difficulties. This incapacity to address an action planning agenda has substantial implications for the nature of individual and organizational development support which is required if the momentum of the community care reforms is to be sustained.

4. CONCLUSIONS

The five focus groups provided a rich and detailed source of information on the local implementation of community care. Such data is especially valuable when considered alongside other sources of information on monitoring and evaluation. The findings from the focus groups do not contradict those of central monitoring, but they do provide a more detailed picture of some of the challenges in local implementation.

The first year of the community care changes has progressed relatively smoothly. However, the experience of staff working at the front line has been different from that of many managers. Smooth transition has been accompanied by high costs for some in terms of work load, and the consequences of 'learning by doing'.

Progress in implementing the community care reforms has so far been judged largely in terms of the template provided by the 'key tasks' of administrative, managerial and financial systems reform. Such achievements are not to be dismissed or seen as unimportant, but they are only the first steps towards judging the real achievements of the community care legislation. Criteria of success must increasingly be defined not solely in these dimensions of infastructure, but also in terms of improved outcomes for service users and for carers through the development of flexible needs-led services, offering a greater range of choice, and maximising independence.

Problems at the interface of health and social care have not been as overwhelming as some predicted. Nonetheless, it is the consequences of the problems which are being more or less successfully managed, rather than their underlying causes which have been resolved. In particular, further clarification is required in policy for continuing care responsibilities, and around charging for services, in order to resolve local uncertainty and confusion.

Despite undoubted progress in implementing the community care reforms, there remains a substantial change agenda. The situation is still fragile. Underlying problems remain, and many of the real achievements which have occured, have been built on the uncertain foundation of goodwill and individual commitment. There is a clear need for support to localities, particularly in developing strategies to tackle practical implementation problems. Without adequate investment in support to individual staff (especially those at operational and 'front line' levels); in organizational development, and without attention to policy clarification in the areas which have been indicated above, the capacity to maintain momentum and to address the continuing change agenda in implementing Caring for People must be in doubt.

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