Community Care:
Managing the
Cascade of Change
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The Audit Commission oversees the external audit of local authorities and the National Health Service (NHS) in England and Wales. As part of this function the Commission is charged with reviewing the value for money provided, and to this end undertakes studies and audits of selected topics each year.

The Commission's aim is to help those who manage and work in local government and the NHS to deliver the best possible service within the expenditure level determined by the Government. Sometimes this means finding ways of doing things more efficiently and cheaply, thus freeing resources which may be used elsewhere in the service. But cost-cutting is not an end in itself; the ultimate objective must be to ensure that NHS expenditure makes the maximum contribution to enhancing the health status of the population, and that local authority services deliver good value for money.

For the past eighteen months the Commission has been reviewing arrangements for implementing community care. The policy of caring for people in the community in preference to hospital whenever it is feasible and sensible to do so has been supported by successive governments for many years. The Commission has maintained an interest in the implementation of this policy for some time. A report was published in 1986, entitled Making a Reality of Community Care (Ref. 1) which identified a number of serious weaknesses in the way the policy is being pursued. The Government has subsequently introduced major change, with the NHS and Community Care Act 1990 providing the legislative framework.

This Act also gave responsibility for NHS Audit to the Audit Commission, allowing an extension of the Commission's role to include services provided by district health authorities and the newly formed family health services authorities (FHSAs). Three studies have been undertaken looking primarily at the roles of local authority social services, district health authority community health units and community trusts, and FHSAs. The first two have been completed and will each shortly be the subject of a separate report; the FHSA study will be completed during 1992.

The community care policy calls above all else for co-operation and co-ordination between authorities. This overview therefore focuses on interagency issues. Much of the material is supported and developed at greater length in the individual service reports. This is the first time the Commission has commented on interagency arrangements in this way, but with links between health and local authorities becoming ever more important, other such reports are being planned.

The studies have involved visits to local and health authorities throughout England and Wales. The community health study was undertaken by Peter Illsley and Russ Phillips, and the social services study by Claire Blackman and Judy Renshaw, both under the general direction of David Browning and Ross Tristem.
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Summary

1. For many years there has been a gradual shift in the balance of care away from hospitals to care in the community. Spending on community-based care now exceeds spending on hospital care.

2. But the implications of this shift for the way services are managed have not yet been fully acknowledged. The organisational framework inherited from the past places undue emphasis on the role of services, with the needs of users and carers taking second place. It has itself become a major impediment to further development, producing inflexibility and rigidity.

3. To redress the balance, the Government articulated a new vision in its Community Care White Paper Caring for People. That vision attracted widespread support and was legislated in the NHS and Community Care Act 1990. It tackles many of the worst features of the old system and aims to produce a shift in influence away from services in favour of users and their carers. It creates a planning framework in which agencies must start to work much more closely together and places great emphasis on consultation and collaboration at every level. And it addresses inconsistencies between community care policies and social security arrangements for funding residential and nursing home care by transferring the care element of this funding to local authorities.

4. Central to the new approach is the separation of responsibility for commissioning and providing services. In the health service a commissioner/provider separation has already been introduced. In local authorities, clearly confirmed as the lead agencies for community care, the concept of care management is being promoted as the corner-stone of high quality care. The aim is to link users' and carers' needs more directly with the resources available, with providers adjusting their services to meet these needs.

5. While this rebalancing between service providers and the needs of users and carers appears straightforward, in practice it requires adjustments at every level which in turn trigger further complications in an ever increasing cascade of change. This process is only now starting and it is not yet possible to describe the full implications. At present it is easier to outline the problems than the solutions – although it is possible to start identifying the general direction in which solutions must be sought.

6. The planning process must start with a fundamental reassessment of needs. Authorities must review needs together, and develop objects and priorities for meeting these needs, setting out their intentions in plans. They must also manage policies into practice, setting in place service commissioners and assessment procedures, aligning arrangements for co-ordinating care between authorities. When commissioning care services, authorities will need to set in place service agreements, and all must be underpinned by improved systems and information and arrangements for securing quality.
7. Any one of these changes would tax the ingenuity of most managers. All of them together present a daunting challenge, at a time when social services authorities are already implementing the Children Act 1989 and Criminal Justice Act 1991, district health authorities' attention is more focused on setting up the new commissioning/provider framework for hospital care, and family health services authorities are only just establishing themselves in their new roles.

8. The first and most fundamental requirement is a thorough understanding and acceptance of the nature of the changes at every level of each authority. The whole change will need to be managed with sensitivity, with heavy emphasis on working together and sharing information with other agencies, on information to all staff, users and carers, with a considerable investment in training at all levels, and with a gradual approach, managing change at a sustainable but steady pace.

9. The Audit Commission plans to help with the implementation process in conjunction with the Social Services Inspectorate and Regional Health Authorities. To this end arrangements in health and local authorities for both service commissioners and providers will be audited, not with the expectation that comprehensive new systems will be in place, but to help authorities identify the most significant gaps and address the needed changes systematically.

10. But there remain some issues that individual management units cannot address, that make an already difficult task more onerous. Particular difficulties occur where authorities that must relate with each other do not share the same boundaries, or where shifting responsibilities are not matched by any realignment of finance. These wider issues will need further thought if they are not to disrupt an already complex task.

11. The new approach creates an opportunity for services at local level to be restructured and reorientated towards solving the real problems of real people in a way which matches their needs and aspirations. But big changes in policy and practice locally are still needed if the Government's objectives of a user-centred and cost effective system of community-based health and care services are to be realised.
Introduction

1. The care of sick and dependent people is typified in the minds of many by large acute hospitals provided by the National Health Service (NHS) complete with casualty, operating theatres and high drama. But for large numbers of people help is provided not in hospital but in the community where they live. A huge proportion of this care is ‘informal’, provided free by relatives and friends. A major role (and in the future a lead role) is played by local government – principally the social services, but also housing, education, and others. The NHS plays a key role with family doctors and community health services such as district nurses and health visitors. Help is also provided in the form of cash payments from social security to support informal care.

2. Independent agencies are becoming increasingly important sources of help. There has been rapid growth in the private provision of residential and nursing homes encouraged by the availability of social security benefits; and there are increasing roles for all kinds of voluntary agencies whether major charities, housing associations or small self-help groups.

3. All told, publicly funded community-based care costs over fourteen billion pounds – more than the hospital service. This represents a large shift in the last decade. Ten years ago identifiable spending on community care was about the same as the hospital budget; now it is a third higher (Exhibit 1). Ensuring that these huge sums, channelled in an enormous variety of ways, deliver value for people and value for money is therefore one of the most important issues of public policy.

Exhibit 1
PUBLIC EXPENDITURE ON COMMUNITY-BASED CARE IN ENGLAND
Community-based care now costs the public sector more than the hospital service.

Source: See Appendix
4. The community-based care services are now in a state of upheaval every bit as significant as that facing hospitals. New ways of working value each person as an individual and aim to promote as full and as normal a lifestyle as possible. They require services to adjust to meet each person's needs, rather than expect users to fit in with service requirements. Under previous arrangements the services received were often more dependent on the referral route taken even for people with similar problems (Exhibit 2); now services should be tailored to meet needs – whichever route is followed. This change of emphasis leads to a different approach (Exhibit 3).

Exhibit 2
THE FORMER METHOD OF WORKING
Services received by users were often more dependent on the referral route taken.

5. As a result there is increasing pressure as community services are asked to help more people with more complex needs. There has been a gradual shift in the balance of care away from hospitals into the community. The numbers of people in long stay hospitals (whether elderly, mentally ill, or disabled in some way) have been declining with the community expected to take the strain. People are discharged earlier from acute hospitals with average stays in geriatric beds halving over ten years, for example (Exhibit 4). And with the increase in day treatments they may no longer even stay overnight. There are increasing demands for alternative options from childbirth to hospice care at home; and many conditions such as asthma and diabetes are managed in the community where the hospital would once have been the automatic focus.
A change of emphasis leads to a different approach. A NEW METHOD OF WORKING

6. All of these trends have been placing greater demands on the services in the community to provide a response which is both more complex and more flexible. Greater involvement with users and carers is increasing demands for greater flexibility and more choice, exerting a pull away from traditional services and institutional care; changing practice is pushing people with more complex needs into the community, requiring greater inter-agency co-operation to meet these needs (Exhibit 5, overleaf).

7. There have been many comments on the difficulties that result, including reports from the Commission in 1986 (Ref. 1), 1987 (Ref. 2) and 1989 (Ref. 3). The Commission's first report

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**Exhibit 3**

A NEW METHOD OF WORKING

A change of emphasis leads to a different approach.

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**Exhibit 4**

LENGTH OF STAY IN HOSPITAL: GERIATRIC BEDS IN ENGLAND

Average stays in geriatric beds have halved over ten years.


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**Exhibit 5**

Graph showing the length of stay in geriatric beds from 1979 to 1988/89.
Greater choice for users is exerting a pull away from institutional care; changing practice is pushing people with more complex needs into the community.

in 1986 entitled 'Making a Reality of Community Care', identified three main problems, all traceable to faults in the underlying structural arrangements.

— Financial – the policy required a shift of responsibility from hospitals and health to the community and local government, but the parallel shift of finance had been minimal; additional 'bridging' funds to finance the changes had been limited; and social security benefits had been out of step with the main thrust of community care policy, producing a rapid expansion of private residential and nursing home care (Exhibit 6).

— Organisational – the responsibility for implementing the policy was fragmented between agencies.

— Institutional – the arrangements for releasing staff and resources for transfer to new services were inadequate.

8. Following publication of that report the Government commissioned a review from Sir Roy Griffiths who reported in 1988 (Ref. 4). The Government articulated a new vision in its Community Care White Paper Caring for People (Ref. 5) which attracted widespread support and was legislated in the NHS and Community Care Act 1990. Subsequently, it has been further developed and expanded in policy (Ref. 6) and practice guidance (including Refs. 7-13). Parallel changes in the National Health Service have created new family health services authorities (FHSAs) and changed the way funds flow through the system with the introduction of a commissioner/provider separation within the hospital and community health services previously directly managed by district health authorities (DHAs).

9. All of this activity has triggered change in the way care is organised and delivered. The new approach tackles many of the worst features of the old system. It aims to produce a shift in influence away from services in favour of users and their carers, tackling the inertia built into the old system. It creates a planning framework in which agencies must start to work much more closely together, thus tackling the problems of organisational fragmentation. Emphasis is placed on consultation and collaboration at every level of the organisation.
10. Authorities must establish a shared appreciation of how local needs should be determined; they must agree objectives, targets and priorities; and local authorities must publish their intentions in community care plans. Authorities must also establish policies for key operational areas, including the co-ordination of care through commissioning, care management and assessment procedures – essential for managing the new policies into practice. When commissioning care services, they will need to agree on service agreements. And all must be underpinned by improved systems and arrangements for securing quality.

11. In addition, the contradiction raised by social security funding is being addressed by transferring the care element to local authorities over several years starting in April 1993, providing them with additional money – although there are inevitably some who question whether the finance will be sufficient to match the considerable new responsibilities that go with it.

12. The Government has set out a transitional timetable:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 April 1991:</td>
<td>Complaints procedures, inspection units, and specific grants for tackling mental illness and drug and alcohol misuse</td>
</tr>
<tr>
<td>1 April 1992:</td>
<td>First community care plans</td>
</tr>
<tr>
<td>1 April 1993:</td>
<td>The start of the transfer of social security funds to local government, and the introduction of new assessment procedures</td>
</tr>
</tbody>
</table>

But these are only the initial tasks. The magnitude of the changes required at all levels of health and local authorities should not be underestimated. In lengthening the timetable for the introduction of the new community care arrangements and, in particular, in deferring the shift of social security funding to local authorities until April 1993, the Government has recognised that these changes are likely to take time.
13. Over the last eighteen months, the Audit Commission has undertaken a review of the preparations for implementing the NHS and Community Care Act in social services departments, while at the same time looking at the implications for community-based health services of the new legislation. Separate reports addressing the key issues confronting each type of authority are in preparation. This first report provides an overview with primary focus on interagency issues. Two others are to follow, looking at DHA community health services (Ref. 14) and local authority social services (Ref. 15). A further paper on FHSAs is planned for the end of 1992.

14. In this report, the underlying problems inhibiting change are reviewed in chapter 1; the cascade of change facing authorities is outlined in chapter 2; and some initial steps for promoting change are the subject of chapter 3. The Audit Commission aims to work with authorities starting at a sufficiently early stage of development to help prevent difficulties rather than identify them after they have happened.

15. Progress is being made at different speeds in different authorities, and, on the surface at least, the deadlines for the Government's initial timetable should be met in most places. But the fundamental changes to organisational culture required have still to work their way through. Big changes in policy and practice at all levels are still needed if the Government's objectives of a user-driven and cost-effective system of community health and care services are to be realised, and it is likely to take many years for this process to reach completion.
1. The Legacy of the Past

16. Over the years, health and local authorities have developed services of which they may justly feel proud. There are many committed and highly professional workers working very hard to help people with a wide range of different problems. But the organisational framework inherited from the past has not kept pace with recent developments and is limiting the effectiveness of some of this work. It evolved to provide a particular style of care that does not easily fit with current thinking. Many of the problems of community care can be attributed to trying to manage the new way of working within the old organisational framework.

INFLEXIBLE FINANCE

17. Much of the inflexibility in the system can be traced to the way services are financed. It is not so much the amount of money available as the way money is allocated that causes many of the problems.

18. Most of the finance for community-based care flows from central government and is divided between the main authorities providing care (with additional funds raised locally by local government). In the NHS and local government it is then allocated between services (Exhibit 7). This top-down method of funding appears straightforward. But it causes problems at both the inter-agency and at the intra-agency level. The inter-agency level concerns the way money is allocated between individual authorities.

Exhibit 7
THE FLOW OF FINANCE FOR COMMUNITY-BASED CARE
Finance flows from the centre down to services.
INTER-AGENCY DIFFICULTIES

19. In his report, Sir Roy Griffiths called for clarity of responsibility matched by 
corresponding finance sufficient to discharge that responsibility, with managers held to account 
for their performance against the guidelines set. But agreement on responsibility and on the 
provision of finance to match has been difficult to achieve. There has been little agreement on 
the boundary between health and social care (although staff in the West Midlands Region have 
been taking a lead – Ref. 16).

20. Even if clarity of responsibility can be agreed, it must be complemented by agreements 
on ways to adjust finance on a continuing basis between authorities to reflect constantly shifting 
demand – a characteristic of developing policies. There are many examples of a progressive policy 
saving money for one authority (and perhaps overall) only at the expense of an increase in cost 
to another.

21. For example, the policy of community care for people with a learning disability reduces 
the load on DHAs, while increasing the load on local authorities. Compensating transfers of 
funds have been minimal. There is no evidence that health authorities are raiding these budgets 
for other services – yet (Exhibit 8). Rather the money is being retained within hospitals in spite 
of falling numbers of places, and hence, rising cost per place. But once hospitals start to close in 
earnest, large sums of both capital and revenue will be released. Unless arrangements are in place 
to transfer the money, financial provision for this group is likely to reduce, as local authorities are 
unlikely to be able to make up the difference from their own budgets (although they have already 
found significant additional resources – Exhibit 8). DHAs should identify in their plans details 
of hospital closures, setting out how they intend to redeploy the finance released.

Exhibit 8
SPENDING ON SERVICES FOR PEOPLE WITH LEARNING DISABILITIES IN ENGLAND
Health authorities continue to maintain spending levels... 
... in spite of falling numbers of places and hence rising cost per place.

Source: See Appendix

22. Conversely, changes in funding for nursing homes could leave DHAs with difficulties 
over discharge arrangements from acute hospitals if suitable provision is not negotiated soon. At 
present many elderly people are discharged from acute hospital to nursing home places financed
by social security benefits. In this way lengths of stay are kept in check, although some argue that a nursing home many not be in the best interest of all such patients. From 1 April 1993 arrangements will change with the care element of the social security money transferred to local authorities for use as they see fit. Responsibility for making (and paying for) care arrangements on discharge will transfer to social services. If they are slow to make these arrangements, hospital beds will become blocked as lengths of stay rise, with a knock-on effect on hospital waiting lists at a time when there is pressure to keep them in check. The temptation for local authorities to divert funds to make good any shortfall in provision for people with learning disabilities could be considerable. To ensure suitable arrangements, responsibilities should be clarified, and social services authorities held to account for their part in receiving people on discharge from hospital.

23. There are also examples of overlaps between the responsibilities of DHAs and FHSAs who manage family doctors (general practitioners or GPs) and their support services. Many services can be provided by both, although usually in different settings. Examples include the use of clinics with practice nurses (employed in general practices and partly financed by FHSAs) which could in certain circumstances replace domiciliary visits by district nurses (employed by DHAs). Management by GPs of patients with asthma and diabetes can replace hospital care of these patients. The 1990 GPs' contract promotes such initiatives, but at a cost to FHSAs, saving DHA funds. In this situation, the regional health authority (RHA) could in theory be in a position to make adjustments into FHSA budgets although it is not yet possible to say whether any such action is being taken.

24. In the case of the health/local authority divide adjustment is difficult. As the Commission stated in 1986 in its report Making a Reality of Community Care, at the strategic level, the allocation of finance to authorities is based on formulae and principles which pay little account to any local arrangements for dividing responsibilities between authorities. Thus any agreement between agencies for one authority to assume a changed responsibility for a particular area of activity in the community cannot easily be reflected by any change in the finance allocated to that authority from the centre.

25. These difficulties are a direct feature of the way central government determines and distributes finance. It is not ideally suited to fund policies that require constant adjustment at the margin between different authorities. In Wales such an adjustment can be achieved more readily, and is being made as part of the All Wales Strategy for Mental Handicap for example. In addition a specific grant has been introduced in Wales to encourage the development of flexible forms of community care for elderly people and people with physical and/or sensory difficulties. In England, authorities must learn to live with the resulting difficulties and work within the existing approach. Recognising problems inherent in the funding mechanism is a step on the way to overcoming them, and improving on ways of aligning finance across agency boundaries to match shifting responsibilities.

26. At the local level, the 'dowry' mechanism is available for transferring funds as people are discharged from long stay hospital but there is no provision for new people following on who do not enter hospital in the first place.

27. These difficulties can become particularly acute where authorities are managing change with falling budgets. While funds overall have been rising (Exhibit 1) and funds for social services
departments are set to rise very significantly when the transfer of social security funds starts in 1993 (with corresponding increased responsibilities), some authorities with historically high levels of expenditure are currently facing cuts. Local authorities with expenditure above standard spending assessment and health authorities with expenditure above 'capitation' are in this position. Change invariably costs money and requires bridging finance and it is difficult to plan positive innovative changes against a backdrop of cuts. There are some who consider the current level of funding to be insufficient (Ref. 17), but it is difficult to establish whether or not this is the case without a clear statement of both responsibilities and the finance available to meet these responsibilities.

28. Local authorities' budgets for community care will be changed from April 1993 onward when the transfer of finance from Social Security begins. Details of the arrangements have yet to be announced but considerable sums are involved – in excess of £1 billion. There is uncertainty about how this transfer is to be arranged and whether it will include finance for both residential and nursing home care, or whether some part of the finance for nursing homes will be allocated to DHAs. Some corresponding clarification of NHS responsibility for long term care facilities for elderly people could also be needed (Ref. 18). Some are also expressing concern about whether the money transferred will actually find its way to community care. The possibility of hypothecating the funds during the transfer could help reduce the level of uncertainty. The Government has indicated that there will be a single formal transfer of resources from the Department of Social Security to local authorities in the 1992 public expenditure survey covering the years 1993/94, 1994/95, 1995/96, with provisions in subsequent surveys determined in the light of changing demand. In the meantime authorities must do the best they can against a background of considerable financial uncertainty.

29. Problems are further compounded by difficulties with boundaries. Only about a quarter of DHAs out of nearly 200 relate to social services authorities and FHSAs on a one to one basis. In all other situations there is more than one DHA to each social services authority and FSHA and in the case of the larger counties and FHSAs, the ratio can be as high as six or seven to one. In some places, DHA and social services authority boundaries are hopelessly entangled (Exhibit 9). The chances of a single integrated policy framework in such situations must be reduced.

INTRA-AGENCY DIFFICULTIES

30. The pattern of financing also causes problems at the intra-agency level, affecting the way money has been allocated to individual services within authorities. The top down method of funding tends to tie up money in advance, on patterns of service inherited from the past. The interests of services and authorities can tend to take priority and produce inflexibility and resistance to change, preventing a smooth response to the steady shift in the balance of care.

31. In DHAs and social services authorities, services receive their budgets at the beginning of the year, usually adjusted for inflation or to reflect some marginal change, either up or down. Having received their budgets for the year, services within authorities are then secure to shape their own role. There is often excellent work done with great dedication by caring staff. But a top down approach does not guarantee that changing priorities are being met. Central management attempts to change direction are sometimes thwarted – there are many different types of professionals who jealously guard their autonomy to shape the way they work.
32. Top-down funding also creates services that operate in separate compartments. There is little incentive to work with others, and there can be many difficulties. The more complex, integrated packages of care required for effective care in the community are difficult to co-ordinate. The main method available for co-ordinating services at present is cross-referral.
Staff in one service perceiving that another service may be able to help, refer on the person concerned. The receiving service then decides if the applicant meets its criteria and whether there is sufficient capacity available. This approach appears more designed to limit care than to provide the sort of flexible response needed if community care is to work properly and it can be very wasteful and annoying if each service and agency duplicates assessment and reassessment of people’s needs. Often one service may be let down because another is withdrawn or not provided (although in many situations staff are working very hard in spite of these obstacles with users receiving high standards of care). Professionals such as GPs and social workers who play a key role in identifying needs and referring on are often frustrated in their attempts to put together sensible packages of care.

33. Some of these difficulties can be tackled by adjusting the overall pattern of services and introducing new services to fill gaps. But top-down funding leaves little for new initiatives. Existing patterns of service tend to persist from year to year. Closure or major reduction of services and redeployment of the finance released are relatively rare, and are often met by fierce resistance from staff, members of the public, and local politicians. As a result service levels are often haphazard and random, more rooted in the past than addressing the needs of the present.

NEEDS

34. Against this background there has been no real advantage in charting the needs of the population. Any attempt to identify needs simply identifies shortfalls in existing services which have been very difficult to meet without additional resources. There has been no urgency to undertake a comprehensive review of needs because no comprehensive response has been possible. There is a risk that a pattern of services not directly related to needs has persisted.

35. This is not just a theoretical point. Analysis of existing spending profiles confirms the point. Spending on community health services, for example, varies considerably between DHAs with some spending twice as much per head of population as others (Exhibit 10). And yet there is only a poor correlation between spending and indices of need (for example the index developed by Professor Jarman of St Mary’s Hospital) and no correlation with numbers of elderly people – major users of district nursing services. People over 75 in some districts have two or three times as many district nurses available to them as those in others.

36. Furthermore, there is no correlation between community health spending and spending by other related services – hospitals, social services, or FHSA services such as practice nurses. These difficulties are further compounded by difficulties in reviewing needs from first principles. It remains a difficult and underdeveloped subject.

OBJECTIVES AND PRIORITIES

37. As a result of this built-in resistance to change, policy formulation has been difficult. The policy of an authority has tended to be the sum of the operating policies of all the separate and by no means consistent services provided. Central policy statements have tended inevitably to be rather general and unspecified – ‘to provide care to all those people who require it within the resources available’. Occasionally a concept may be promoted from the centre with sufficient attention to influence the individual services. For example, the concept of ‘normalisation’ – that people receiving help should be helped to live as normal a life style as possible, being treated with
Exhibit 10

EXPENDITURE ON COMMUNITY HEALTH SERVICES IN ENGLAND AND WALES

Some DHAs spend twice per head as others... ...with only poor correlation between expenditure and indices of need...

...and no correlation with numbers of elderly people, so that people over 75 may have two or three times the number of district nurses available to them as in others.

Source: See Appendix

dignity and respect – has made much progress and shaped many services for people with learning disabilities improving access to housing, transport and other services. But by and large policy change is reduced to the marginal few percent of the budget not already committed at the start of the year. New creative ideas often have to be promoted outside existing services with marginal funding, hanging on by a thread from year to year.

OPERATIONAL CO-ORDINATION

38. There has also been a legacy of problems at the operational level. Operational co-ordination is patchy – again the result of separate arrangements that do not correspond. If community care is to work as intended, it should be possible to support quite heavily dependent people with multiple needs in their own homes. Such people require 'packages' of care made up
INTERAGENCY CARE COMBINATIONS

8% of elderly people over 65 in one area were receiving services from both health and social services, with less than 1% receiving a combination of four or more services.

Source: University of Wales Department of Geriatric Medicine: Research Team for the care of the elderly

of a number of services from different sources. But such packages are not common. In one area 8% of elderly people over 65 were receiving services from a combination of health and social services with less than 1% receiving a combination of four or more services (Exhibit 11). Three quarters received just one or two services from one or other authority. Given the Government’s priority for targeting more dependent people, this pattern is likely to need to change in the future.

SERVICE DELIVERY

39. The Government also intends that services in the future should be drawn from a mixed economy of care, with increased consumer choice. A funding method which locks most of the finance up at the start of each year has ensured that most services provided by local authority social services are their own (Exhibit 12). DHAs use NHS services almost exclusively. However, staff in both types of authority help find places in independent residential care and nursing homes currently funded by Social Security.

INFORMATION SYSTEMS

40. The previous two paragraphs and exhibits show authorities delivering a relatively limited pattern of care mainly supplied by the public sector. It is difficult to establish whether this analysis does justice to the true variety of support, simply because information is not available that allows the pattern of support to be analysed. Nearly all data are based on services – so that it is possible to identify how many people are seen by this or that service in a year, but impossible to review the situation from the users’ point of view.

41. The figures in Exhibit 11 are based on one authority. But no more extensive information was available to the Commission or – far more importantly – to managers responsible for organising care. No authority visited had any information systems that could tell managers in
The past method of funding has ensured that most services provided by local authority social services are their own.


either authority the range of services deployed to a particular individual from health and social services – let alone from the independent sector or from relatives and friends. There was very little available on unit costs of services; and there was only occasional systematic information available to managers (let alone users and carers) on the range of services available throughout an area. Such information systems as exist are nearly always service orientated. There is a particular need to strengthen the information available to users and carers outlining their entitlement and the services available to them.

42. But even within services, information is usually poor. Services that are provided with their income guaranteed at the beginning of each year have little incentive to review how effective and efficient they are. In the NHS, 'efficiency savings' have been imposed from the outside for some time, trimming budgets by the odd percentage point to force services to review their operational arrangements. But even so, inefficiencies (and probably reduced effectiveness) persist. Wide variations were observed in the use of different grades of staff and how staff spent their time in community health services. Few services had regular caseload reviews, and staff often went unsupported. And in social services, information is rarely used on a regular basis to shape and direct the way services respond to the needs of users. However, some managers are beginning to make real efforts to start to construct appropriate systems. In future, such systems must become the norm rather than the exception.

QUALITY

43. Most local authorities now have inspection units and both health and local authorities should have complaints procedures. But here again, the search for quality is being imposed from the outside. Arrangements for staff to review their own performances in a constructive, supportive manner are rare and need to be encouraged.
THE INHERITANCE

44. The service-centred approach inherited from the past has left authorities with a lot to do. There are difficulties at all levels – more severe in some places than others. Many authorities are beginning to make progress, but the full magnitude of the task is only now becoming apparent.
2. The Cascade of Change

45. The response to the funding and organisational problems outlined in Chapter 1 has been to aim for a shift in influence from those who provide to those who use services. But by shifting the focus to put users’ and carers’ needs first, a process of change has been set in motion which will turn organisations upside-down.

46. The focus in future must be each individual’s needs, and the flexible deployment of services from a range of agencies (where necessary) to tackle them. Thus the process of assessment must become the centre around which all else is built. As yet, there is no single established way of doing this, and each authority must work out its own approach, although the Department of Health has issued practice guidance on assessment (Refs. 7 and 8). Many are making good progress; Islington Borough Council, for example, is piloting a radical new approach as part of its drive to bring services closer to the community through a decentralised network of neighbourhood offices (see case study over). This approach takes the process beyond assessment for services to assessment for community living – looking at the needs of each individual and his or her carers in a comprehensive way.

47. This type of approach provides the required basis for the greater flexibility and the focus for closer interagency working. But it must in turn be underpinned by changed financial, structural and procedural arrangements. A key requirement is somebody in each authority responsible for co-ordinating the approach, and commissioning appropriate services, but who is not directly responsible for the need to make full use of existing services whether appropriate or not. This requirement in turn points to the separation of responsibility for commissioning and providing services. In DHAs the separation has already been introduced. In local authorities, the concept of care management is being promoted as the corner-stone of high quality care, with the care manager ‘acting as broker for services across the statutory and independent sector’ (Ref. 6). The aim is to link users’ and carers’ needs more directly with the resources available, with providers then adjusting their services around these needs (Exhibit 13, on page 22). Each authority must decide how best to make this work in practice in view of its local circumstances.

48. Under these proposals the commissioner or care manager arranges through service agreements for providers to provide services; and because there is no involvement with existing services there should in theory be no commitment to the status quo, so that users’ and carers’ needs should not be compromised by any requirement to make full use of existing provision. Commissioners and care managers should co-ordinate service packages to make best use of the limited funds available, addressing the difficulties caused by services operating in separate compartments.

49. This apparently straightforward redirection of finances through a commissioner and care manager thus appears (on paper at least) to overcome many of the difficulties encountered in the past. But the process of implementation inevitably generates new difficulties and requires other adjustments which in turn trigger further requirements in an ever-increasing cascade of change.
Case Study:

LONDON BOROUGH OF ISLINGTON – COMMUNITY LIVING ASSESSMENT

Islington is piloting an innovative approach based on an assessment for community living. The aim of the assessment is to understand the needs of the individual, not to decide the suitability for particular services. The assessment process starts with referral to the neighbourhood office:

![Diagram of assessment process]

- A lead assessor is identified who will be a member of the assessment group. The group will inevitably wish to call on a wider group of contributors.
- Recommendations will be made as to how the assessment is to be implemented and which needs can form a public service agreement. Needs which cannot be met by public services will be documented for the community care plan.
- The public service agreement provides a guarantee of what users and carers can expect (e.g. number and use of home care hours). In particularly complex cases a care manager will be appointed to oversee delivery and review of services. For others a key worker will be allocated.
- Statement of needs and services summarises in writing in a brief report (sent to the co-ordinator and person assessed which sets out a statement of need, resources currently provided and resources recommended. The co-ordinator negotiates for and makes a decision on service provision. The assessor does not personally provide services to the people they assess.
Key to the process is the production of the statement of assessment. A pro forma is used but the purpose is to reach decisions first and foremost about the needs of the person seeking help – which should then provide all the relevant information for application to specific services if necessary.
TOWARDS A MORE FLEXIBLE SERVICE

50. There are many who feel uneasy about these changes. They are concerned about the introduction of apparently alien commercial concepts into services whose prime function is to care for people; and they are especially concerned at any prospect of the needs of users and their carers being resolved in the market place. Such concerns are understandable, if misplaced, and if the new approach is to succeed, they must be allayed. The essence of the new approach is not the procedural changes introducing contracts, competition, etc, but the establishment at the heart of the service of a direct relationship between users and their carers and commissioners who can direct resources in a flexible way to meet their needs. If the approach is always viewed from this perspective, it is easier to understand the procedural changes that must follow. Equally, it is not possible to adapt the new approach without procedural change. Starting from the user/commissioner relationship and building out from there is likely to produce a radically different pattern of provision.

51. Authorities must therefore go through significant readjustments to reorientate their approach to implement the new policies. They must identify needs more systematically; policy formulation must become more clearly defined and overt, and must be shared between authorities; operational arrangements for commissioning care must be aligned with delegation of authority where appropriate, with budgets to match; and a host of other adjustments must be made to assessment procedures, service agreements, information systems, quality control and to the management of individual services.

52. Will it all work? Much of the new approach is theory – as yet untried and untested on any large scale. Much of it is based on research projects usually run by people with high abilities and high motivation often with extra funding. The results of these projects are often very encouraging with real improvements to the quality of life of users and their carers. But it must become possible to replicate these results on a large scale if the Government's initiative is to bear
fruit. The potential pay-off is huge. The new approach creates an opportunity for services at local level to be restructured and reorientated towards solving the real problems of real people in a way which matches their needs and aspirations.

ALIGNING INTERAGENCY ARRANGEMENTS

53. An essential first step is to strengthen the framework within which agencies can work together. The Government’s stated objective is to provide a service in which ‘the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective of the service user’ (Ref. 6). These same objectives have led others to provide a single commissioning authority. For example, in Northern Ireland, acute services, community health, social services and the transferred social security funds will all be channelled through a single appointed authority. Real progress is being made – especially in the last eighteen months with increasing integration of local health and social services management. Services and payments plus other local services are also brought together in Norway, but in this case the authority is a locally elected one. In Arizona, a US federal demonstration project has brought health and social services together under a single management to great effect.

54. Merged arrangements like this are not now possible in England and Wales. But the essential features can, with goodwill and co-operation, be duplicated. This could involve authorities pooling their budgets for particular policy areas by mutual agreement to form commissioning consortia. In its 1986 report the Commission proposed either that one authority should be given lead responsibility for some policy area of mutual concern to act as agent for others with local authorities being made responsible for people with learning disabilities for example; or that some sort of joint framework should be set up for services for elderly people, for example. Such options could still provide practical solutions, without the need for complete integration. However, any consortium arrangements should be by mutual agreement locally, rather than by central direction. Such local agreements have been formed by DHAs setting up commissioning consortia (Ref. 19).

55. To make them work properly legal restrictions on local authority finance for health care and health finance for social care would need to be addressed. Mechanisms for exercising both political and financial control of pooled budgets would need to be carefully worked out.

56. But whatever models are adopted, the current changes increase the necessity for effective joint working. At the very least, authorities must recognise that they must sink their differences and work together setting out their intentions with financial contributions clearly identified in mutually compatible plans with each authority’s responsibilities clearly identified. Hence, compatible plans are not a rather desirable optional extra, but provide the framework that will hold authorities together. Staff in the different authorities come from different backgrounds, and sometimes have different perceptions of each other, but both are equally able to address these difficult challenges if given the right framework. Any continuing failure of health and local authorities to work together will make more radical solutions increasingly unavoidable in the future. If authorities wish to avoid further upheavals (as most do), the onus is on them to make the present arrangements work through active co-operation.
57. There is also an opportunity to address the boundary problem. Some DHAs are already merging their commissioning arrangements to provide larger commissioning consortia. There are moves to develop much greater collaboration between DHAs and FHSAs (and some are proposing an eventual DHA commissioner/FHSA merger as one option – Ref. 20). At the same time local government re-organisation is under consideration, with unitary authorities likely to be created in what are now two-tier areas.

58. There can be little doubt that coterminous DHAs/FHSAs and social services departments would facilitate the development of community care plans. And the smaller the number of authorities who must relate to each other, the higher that chance of successful joint working. But without a further legislated structural change – which few would advocate at this stage – that happy outcome is highly unlikely to emerge. It is critical, therefore, that as the twin process of commissioner consolidation in the NHS and local government reorganisation proceed, the need of the community care services for coherent decision-making and rationally constructed funding is kept to the fore. The Government's draft guidance to the Local Government Commission rightly emphasises the need for strong professional management and close co-operation between agencies.

59. Previously, as services were provided separately, it was possible for the different authorities to operate separately, meeting for the occasional joint consultative committee. In future, as authorities go back to basics it will be necessary for them to do so together. Quite apart from the statutory requirements imposed on social services to consult with other authorities and the voluntary sector when preparing the community care plan, it will simply not be possible for authorities to work out what they are going to do unilaterally without regard for the actions of others. There are too many potential gaps and overlaps.

60. Furthermore, in future, policies will need to extend beyond the narrow confines of social services and community health units, requiring a corporate approach from local government including housing, education and others, and a review of the balance between primary, secondary and tertiary care from health authorities. FHSAs and GPs – particularly fund holders – have a key role to play; and policies for special needs housing should be aligned with the community care plan. Each authority must identify what it is going to do in relation to the others.

61. Inevitably, these pressures for greater co-ordination will change the focus for senior management and members in most authorities away from a preoccupation with services towards greater attention to policy formulation and joint working with other agencies. Thus authorities whose respective services have been vertically integrated with only occasional cross border-contact, will in future have to start integrating horizontally (Exhibit 14). There are a number of positive developments showing how this can be done; some authorities (especially DHAs and FHSAs) are making joint appointments of directors of planning, for example.

ASSESSING NEEDS

62. The planning process starts with a fundamental reassessment of needs. With funds no longer committed to services, policy can no longer be equated with the sum of services' operating policies and some new form of direction is required. The focus must shift to users' and carers' needs, but immediately this shift raises major problems of assessment and choice. Assessments
THE CHANGING FOCUS FOR AUTHORITIES
Under the new proposals, authorities with vertically integrated structures must start to integrate horizontally.

at present rightly take account of a wide spectrum of needs but which combinations should trigger an intervention? As long as authorities’ responses were anchored to the services provided, these wider (and very difficult) questions could be circumvented. Now they must be confronted.

63. But authorities do not start with a blank sheet. They are already providing services to large numbers of people. A ‘stock take’ of their current users should give authorities a starting point. Demographic information (and the new census is timely – see Ref. 21) will help them to expand from this start and – most importantly – front line staff will be able to comment on the needs they encounter on a day-to-day basis.

64. Local authorities have been given the lead role for assessing need – both for the population as a whole, and for individuals. But directors of public health also have a key role to play and FHSAs have considerable amounts of information from GP lists (and increasingly, from their annual reports). It will be important that all authorities pool their information and work out a common approach. At the national level, there are many who are working out alternative ways of defining and measuring need, and this initiative is likely to make a significant contribution
as research findings are sifted and experience is gained. At the local level, individual practitioners sometimes work together to provide a local profile of needs which can inform both their own work and contribute to the overall planning process. The early involvement of providers in identifying needs in this way should increase their commitment to turning plans into reality, with practical operational issues addressed at an early stage.

DETERMINING OBJECTIVES AND PRIORITIES

65. Authorities must then set a policy framework within which to operate. They must revise their policies in a systematic way at regular intervals (Exhibit 15). Objectives and priorities are likely to be relatively unspecific initially, but it should be possible to start to work out the resource implications of the objectives, and match them against existing resources. Inevitably resources will not match aspirations. Initial objectives applied to needs are likely to exceed capacity requiring some hard decisions on priorities in order to reduce the scope to manageable proportions. The likely mix of services required to implement the objectives may not match existing resources, requiring adjustments to the service base.

Exhibit 15
FORMULATING THE POLICY FRAMEWORK
Authorities must formulate policy together in a systematic way, reviewing it at regular intervals.

66. Setting such a framework is going to be enormously difficult, and will have to encompass some very tough decisions on priorities and eligibility criteria. Authority members and senior managers who previously determined service levels and allowed staff locally to ration services, will in future need to take the decisions about rationing, leaving service decisions to commissioners. This turnabout places rationing decisions firmly where they should be – with politicians and senior management.

ALIGNING OPERATIONAL CO-ORDINATION

67. But it is not only at the level of strategic policy formulation that practice must be aligned. The operational arrangements for commissioning and co-ordinating care for users and carers must be compatible. Here some careful thought will be necessary.
68. Authorities have different structures in place, and are developing different models. Social services authorities have teams of field workers and are developing a combination of central commissioning and care management. DHAs have community units (either directly managed or trusts), and are tending to commission services from these units en bloc. FHSAs have networks of general practices which vary from single-handed to partnership group practices, and many are developing as fund-holding practices. GPs' patients are scattered throughout the community within a radius of the practice, and often different practices overlap. Community health services may be linked to practices' primary health care teams, or they may be neighbourhood- or area-based. Social services tend to be patch or area-based.

69. It will be difficult to ensure that operational arrangements are co-ordinated. Furthermore, as authorities come from such different positions, and need to make such fundamental changes they will inevitably have to do so gradually so that they and their staff can adjust to new ways of working. The transition arrangements will need to be carefully planned together, if they are to be compatible.

70. In social services departments care managers are intended to relate closely to individual users and carers – particularly those with more complex needs – and provide integrated packages of care through service agreements with service providers. While this model has attractions there are many issues that authorities will need to address if it is to work. Authorities are experimenting with various care management models which can vary considerably in scope, budgetary control and many other factors. Here again there is practice guidance (Refs. 7 and 8) and a growing body of knowledge at the national level informed by research which will help authorities (for example, Refs. 22-24). The Commission's forthcoming report on Social Services (Ref. 15) considers these matters further. The selection and training of effective care managers will be central to the success of the new approach, and management skills will be of paramount importance.

71. The way in which commissioning of services is to be organised is also evolving in different ways. Price Waterhouse in conjunction with the Department of Health have identified three main approaches (Ref.25):

- social services headquarters as commissioner with areas as providers (approach 1, which is similar to the approach for community health services in most DHAs and is put forward mainly as an interim model)
- a separation at headquarters between commissioners and providers, with separate reporting lines to local commissioners (care management teams) and provider units (approach 2)
- separation between commissioner at the local level (care manager) and providers (homes, home helps etc.) within each area coming together at the local level under area managers.

Each of these different models has strengths and weaknesses and the choice will depend as much on which fits best with existing patterns of organisation as on any theoretical merit for any one model.

72. It may be most appropriate for authorities to adopt the model which most suits them in the short term, possibly adapting it over time as experience is gained. Thus approach 3 may fit many authorities initially where it reflects the way they are organised now. The balance between central commissioning through block contracts and local commissioning through care management can be adjusted with limited funds devolved to local care managers initially. But
as confidence grows and care managers demand more autonomy, supported by improving systems and closer links with other agencies, approach 2 may look more attractive. It removes the potential commissioner/provider conflict of interest from area managers to senior managers and members.

73. In contrast, under current arrangements most DHA community services are purchased centrally, through block contracts with providers. There is a risk that such arrangements may be out of step with those of the other authorities. Most services are purchased from community health units which provide district nurses, health visitors, professions allied to medicine (that is, occupational therapists, speech therapists, physiotherapists, etc). But some are provided from other hospital-based units as outreach teams into the community – a common way of organising mental health services, for example. And GP fundholders could provide services to an increasing extent in the future.

74. A number of options are being considered for organising community nursing services. A working group reporting (Ref. 26) to the NHS Management Executive proposed five main approaches for community nursing services (Box A). Each has advantages and disadvantages, with each promoting some organisational links at the expense of others, changing the relative importance of some key player. Thus options C and E give greater priority to the needs of GPs while option D favours hospitals. The approaches are not intended to be mutually exclusive: for example, A and B could be linked, as could C with either B or E.

**Box A**  
**NHS MANAGEMENT EXECUTIVE WORKING GROUP PROPOSALS**

The Working Group proposed five main options.

<table>
<thead>
<tr>
<th>Option A:</th>
<th>The 'stand-alone' community trust or directly managed unit (DMU). The community unit manages all community health services offering them to other agencies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option B:</td>
<td>Locality management neighbourhood nursing model. Mixed teams of community staff are managed in localities under the overall control of the community unit.</td>
</tr>
<tr>
<td>Option C:</td>
<td>Expanded FHSA model The FHSA assumes responsibility for the provision of community services under an agency arrangement.</td>
</tr>
<tr>
<td>Option D:</td>
<td>Vertical integration or outreach model. This model combines secondary (hospital) care and community services.</td>
</tr>
<tr>
<td>Option E:</td>
<td>Primary health care team – GP managed. Community services are under the control and management of general practice.</td>
</tr>
</tbody>
</table>

75. These models provide a range of options for local choice, although change in funding arrangements, with the introduction of the commissioner/provider split, is changing the focus of the debate. Henceforth the future form of community health services will need to take account
of the commissioning arrangements, when selecting the organisational model. Block contracts and a single organisational model for all services are unlikely to provide sufficient flexibility.

76. Several commissioning arrangements are possible, reflecting policies and priorities agreed between authorities at the strategic level (Exhibit 16).

Exhibit 16
POSSIBLE COMMISSIONING ARRANGEMENTS
Several commissioning arrangements are possible, including central, local, and agency commissioning.

77. Block commissioning of services from the centre could be highly appropriate where services are relatively self-contained and clearly defined – a screening service for example (health visitors monitoring young children) or for ongoing care of a relatively straightforward, stable group of elderly people. Alternatively funds could be delegated on an agency basis to hospitals, GPs, social services, or even the voluntary sector – to purchase after-care for a programme of hip replacements for example, or to provide physiotherapy for GP patients, or for social services to set up services for people with learning disabilities.

78. And local commissioning could be the best way of arranging complex packages of care for people with multiple needs, in association with social services care managers. Block allocations of resources could be made by health and social services authorities to local teams, who then sub-contract with a range of providers to secure flexible packages of care for individuals. Commissioners would need a firm view of the return expected in health or social gain, with local teams held to account for delivering them. One possibility would be for health authorities also to introduce care management, closely linked with social services and with GP practices –
particularly fund holders – for people with complex needs, while still funding most routine services through block contracts (Exhibit 17).

Exhibit 17
INTEGRATED COMMISSIONING THROUGH CARE MANAGEMENT
DHAs should consider setting up a care management function, preferably in conjunction with social services. Care managers should then link with GPs – especially fundholders.

79. Against this background, the organisation of community health services, appropriately enough, becomes secondary to needs and priorities. Providers would need to organise themselves to respond to the commissioning arrangements, possibly with community teams based in hospital (outreach teams), general practices, and specialist teams (for people with disabilities for example). All of these could be under one umbrella organisation, such as a community health unit or FHSA, or they could be organised separately depending on local circumstances. Either way, organisation should follow needs as formulated by service commissioners – not the other way around.
80. Care managers and local commissioners would need to link closely with general practices – especially for the organisation of primary care teams. In many ways general practices form a natural focus locally for care services, and many fund holders in particular will be looking to offer as full a range of services as possible. Such locally integrated community care (LINCC) schemes could provide the basis for delivering the 'seamless service' that the Government is aiming to provide.

SETTING ASSESSMENT ARRANGEMENTS IN PLACE

81. Policies and eligibility criteria at the strategic level must be mirrored by local assessment arrangements. The Government has given social services authorities the lead role in co-ordinating such assessment and issued practice guidance (Refs. 7 and 8). Where people are assessed as requiring services, authorities may be obliged to provide them. Hence it will be important that individual care managers operate in agreement with central policies adopting overall objectives and priorities. Such policies should, in return, form a framework guiding and protecting care managers from overload and 'burnout'.

82. Assessment arrangements must also reflect the relative roles of the different agencies and care management arrangements. Many people requiring help will have relatively straightforward needs and will not need either complex assessments, or individual care management. Some may not be eligible for services at all but could benefit from advice about ways of tackling their problem for themselves (advice on welfare benefits, private domestic agencies, interests that promote health by promoting exercise and friendships, etc). Such people may not need the specialised attentions of care managers, and could benefit from help from workers with a more generic – though no less rigorous – training. Others may require a complex web of interacting services providing round-the-clock intervention. A hierarchy of assessment arrangements may be required from preliminary screening by GPs, nurses or social services generic workers through more specialised assessment to multi-disciplinary assessment possibly involving small case conferences (Exhibit 18). Clear definitions are required setting out when cases should be passed to others so that GPs, health workers and social workers all know how to work the system without wasting each others' time.

CO-ORDINATING SERVICE AGREEMENTS

83. With the introduction of commissioning arrangements, with funds channelled through service commissioners, the relationship with service providers changes radically. It is this change that is causing considerable disquiet, on the grounds that the basic security of providers may be undermined. There is also concern about the introduction of competition and privatisation, and how services will cope with such concepts.

84. Here in particular it is important to view the changes from the perspective of the commissioner/user relationship. The aim of the shift in influence from providers to users and commissioners is to provide a more flexible, more appropriate response to the needs of users and their carers, and all service agreements should be judged against this key objective. The intention should be to free finance for creative and imaginative responses to needs – not to establish contracts which squeeze providers unnecessarily.
85. Given this objective, finance must be devolved at least in part, albeit within the clear policy framework set at the centre. Commissioning arrangements described in the previous section will provide the operational framework. A variety of forms of service agreement is possible.

86. Here again the Government has issued extensive practice guidance (Ref.12). Different arrangements are possible depending on whether money is paid as a block or individually through spot purchases. The degree of specification can vary from highly detailed to virtually nothing. Various intermediate arrangements are possible - for example the block contract with 'call-off' arrangements. Under this form of contract, a negotiator, possibly based at the centre, sets the contract, and negotiates the rates. Local commissioners then make use of the service, with each unit used charged against their budgets, usually at standard cost. Providers may negotiate a 'floor' - a guaranteed minimum volume of business paid for irrespective of actual use in order to cover overheads. No doubt many other combinations and possibilities will emerge over time.

87. Different arrangements will be useful in different situations. Used effectively, money can be released for more creative service patterns (Exhibit 19). At present health authorities are starting with block contracts with limited specifications. Local authorities give grants to voluntary organisations, which again are block contracts with limited specifications. But many services
A variety of forms of service agreement is possible. Used effectively, money can be released for more creative and imaginative service patterns. Such as chiropody for example are available privately for spot purchase, and could be used to give greater flexibility; and many services are available which could boost social care – such as the occasional use of taxis for transport or local restaurants/pubs for meals, where local authority alternatives such as mini buses or meals-on-wheels provide a less ‘normal’ service. Clearly such arrangements will need good financial controls to secure proper accounting of public funds.

88. A careful balance will have to be struck between the needs of users and the capacity of providers to respond. The form of the service agreement with providers will determine the balance between security and self-determination for services (the traditional approach) and flexibility and adaptability for commissioners (the new approach). This balance is likely to favour the traditional approach initially, but gradually change over time as people get used to other ways of working. In any case commissioners will be reliant on providers for information about users’ needs and changes occurring on both an individual and a collective basis – requiring a close working relationship and understanding rather than a ‘split’, reflected in contracts backed by suitable monitoring arrangements.

89. The new approach, if it is working properly, will need some adjustment to service levels – otherwise nothing will have changed. Given the current balance, there will need to be a shift of funding away from traditional services, if finance is to be released to fund new initiatives. Such a shift must be managed very carefully. Authorities have several years experience of running down long-stay hospitals - but this experience is not always encouraging. And it is not always possible
to anticipate which services will be preferred and which will be redundant. A pattern will only emerge when the collective decisions of care managers start to build.

90. Equally it will be necessary to stimulate new alternative services. Here authorities may need to work as development agencies, listening to the requirements of care managers, spotting gaps in the pattern of provision, and providing, or encouraging the independent sector to provide, services to fill the gaps supported by appropriate pump-priming funds and advice. Given the Government's key objectives (Ref. 6), particular attention should be given to stimulating domiciliary, day and respite services. All of this depends on there being sufficient independent providers willing and able to supply high quality services, and authorities will need to develop strategies for stimulating and encouraging as many new quality services as possible.

91. One possible vehicle for managing this change in an acceptable way is 'locality planning' with commissioners and care managers from all authorities meeting with local service providers to discuss the general shape and direction of services for the locality taking account of inter-authority objectives and priorities and the overall plans of the agencies concerned. However, care would be needed to keep the workload under control, as those who have piloted locality planning have found it time consuming. Block contracts could be renegotiated through this forum, with support from staff from the centre, with planned, phased reductions for services no longer required, releasing funds for spot purchasing or new block contracts for the development of new services. Initially care managers are likely to have small budgets for spot purchasing – perhaps only a few percent of the total budget – with most of the funding going through block contracts.

92. Such an arrangement would ensure stability in the early years while everyone adjusts to the new way of working. But locality planning could also provide a framework for moving away from this initial phase in a controlled way. It would provide a forum in which providers would be able to gain an appreciation of care managers' thinking, allowing them to respond to emerging needs – developing more flexible outreach or out-of-hours services for example. The balance between spot purchase and block contracts could adjust from year to year in a manageable way, to meet changing needs. And the forum itself, by promoting closer links between different commissioners as well as providers, could go a long way to establishing locally integrated community care schemes.

STRENGTHENING SYSTEMS

93. It will be very important to strengthen and develop systems to support the new ways of working - particularly where commissioning is devolved. Various types of system will be essential, including financial controls and client information systems, and information and training for staff. More details are included in the Commission's forthcoming reports on community health and social services (Refs. 14 and 15).

94. If greater flexibility and wider choice are to be introduced, good financial controls will be needed to protect the interests of tax and charge payers, users, commissioners of services, and service providers alike. The Commission has set out the principles for good controls in its management paper Better Financial Management (Ref. 27). Four requirements were identified, summarised in Box B. Considerable work has been done, and much useful material prepared by
the Financial Management Partnership (Refs. 28 and 29). Authorities who are making use of
this material should be in a sound position to produce good systems.

95. *Client information systems* will also be required, feeding through to needs assessment
which forms part of the policy framework, so that those responsible for setting policies and
eligibility criteria have good information about the needs of people presenting for help and
assessment. Such systems must be compatible between agencies, and in an ideal situation, could
even be merged – provided that issues of confidentiality can be overcome. A scheme in East
Dyfed in Wales operates on these principles under the title 'community operational support
systems (COSS)' and the Welsh Office has introduced key data sets relating to social/community
care. Many GP practices are developing good systems, although confidentiality could limit the
extent to which they could be shared. At a more immediate level, each person in receipt of a
complex package of care could have a single set of notes, to which all practitioners could refer.

96. All of these changes are significant, and staff will need to be kept informed at all stages,
with considerable *training* in the many new skills that will be required. Training could be doubly
effective, helping to forge new links, if it could be undertaken jointly between agencies, and once
again the Government has issued practice guidance (Ref. 13). Further material is soon to be
published by Nalgo Education in partnership with the Joint Initiative for Community Care (Ref.
30). Only by convincing staff and taking them along with the developments will senior
management be able to deliver the potential improvements.

**IMPROVING MONITORING AND QUALITY**

97. The separation of the commissioner from the provider role will also mean that
commissioners will need to monitor the services that their users and their carers receive especially
with the growth of a multiplicity of new independent agencies. Just as with needs, quality
measurement is at a very rudimentary stage but it is developing fast, with a growing literature (for
example Refs 31 to 33). What is needed is an approach that will build the search for quality into
the services themselves. And there must be the promotion of a 'learning culture' in all authorities,
with staff enabled to learn and improve as a result of monitoring. Commissioners will also need
to ensure that they have direct access to the views of users themselves.

98. A particular focus for the future will be to improve measures of *outcomes* so that the
impact of all the changes on the well being of users and carers can be assessed. Quality measures
should be mirror images of authorities' objectives – so that they show whether these objectives
have been realised. The Government set out in its policy guidance (Ref. 6) six key objectives:
— to promote the development of domiciliary, day and respite services to enable people to live
in their own homes wherever feasible and sensible;
— to ensure that service providers make practical support for carers a high priority;
— to make proper assessment of need and good care management the cornerstone of high
quality care;
— to promote the development of a flourishing independent sector alongside good quality
public services;
— to clarify the responsibilities of agencies and so make it easier to hold them to account for
their performance;
— to secure better value for taxpayers' money by introducing a new funding structure for social care.

99. Authorities should measure their performance against these as well as against their own key objectives. Other work on setting quality standards as well as on the preparation of charters is likely to provide additional measures in addition to key indicators and performance indicators available nationally. The newly formed inspection teams and complaints procedures in social services can be expected to provide a focus for many new initiatives. And on professional issues, clinical audit and accreditation are making progress.

**Box B**

**PRINCIPLES OF SOUND FINANCIAL CONTROL**

There are four key principles for promoting effective financial control.

**The first principle**

is that financial responsibility must be aligned with management responsibility. Here, the overall policy framework, and the design of the arrangements for operational co-ordination, commissioning and care management will provide the framework for financial delegation. Four rules must then be observed:

— every budget should have a budget holder – and only one;
— front line managers should, as far as possible, be budget holders for items under their control but not for items that they cannot influence in practice;
— items excluded from frontline managers' control should be managed elsewhere;
— senior managers should supervise the financial management of those reporting to them.

The amount of money delegated and the pattern of delegation will depend on identified needs, policies and priorities – and on management capability. Budgets are likely to be recast for groups of users, rather than for services, and then allocated to commissioners. Transition arrangements for phasing in the changes will be needed as it will not be possible to change overnight and certainly not before the installation of good information systems.

**The second principle**

is that responsibilities should be clarified. Managers should operate within clear rules that should meet three objectives:

— managers should have incentives to control budgets and improve efficiency;
— systems should be as clear as possible to operate, and as free as possible from manipulation and 'gamesmanship';
— budgets should follow authorities' political priorities – although budget holders should be involved in drawing them up if they are to become committed to sticking to them.
Budget holders must be in charge of making sure that the budget – and no more than the budget – is well spent to further agreed objectives and priorities.

The third principle

is that management should be supported by good financial information systems. Each budget holder should receive a regular budget report. Supervisory managers should receive summary reports for the budgets of everybody reporting to them, with the chief officer/general manager and director of finance receiving a regular report on the financial position of the authority.

Reports should be well presented and brief. Budget holders who need to use the information must be comfortable with the format – so that both they, and the accountants who advise and support them, should be involved in its design. Commissioners and providers will need different information with commissioners given reports on how much of their budget has been used, and providers (who should be set up as cost centres with trading accounts) given reports on income and expenditure. Where possible, non-financial data should be included to give additional management information (as unit costs, service utilisation etc).

Reports should also be up to date. Commissioners should have statements of the amount of money already committed at any particular point in time. They should also have budget profiles setting out the pattern of spending over the coming year, and ideally their commitment accounting systems should project forward to tell them how much of their total budget is committed for the year if nothing changes. To help speed up reporting and reduce paper flow, direct data entry should be used wherever possible, and managers should ideally be able to produce their own reports on screen and paper.

The fourth principle

is that managers should be well supported by a streamlined administration. Those who assume greater delegated responsibility should be able to rely on good financial support and advice. Delegation will increase the demand for advice – but it should also free staff at the centre of some of their more detailed responsibilities. In future they will need to work more closely with individual managers, meeting the needs of their clients while still maintaining strong links with the central finance function. An important feature of greater delegated responsibility is the need to support it with a limited number of ‘early warning’ indicators that will alert managers to problems before they get out of hand.
THE MANAGEMENT CHALLENGE

In conclusion, the relatively simple adjustment of putting users' and carers' needs first, which then leads to the commissioning of services triggers an ever-widening series of changes, presenting a daunting challenge (Exhibit 20). If community care is to have any chance of success, the change process itself will need to be managed with considerable skill.

Exhibit 20
THE CASCADE OF CHANGE
Putting users' and carers' needs first triggers an ever-widening series of changes.
3. Promoting the Changes

101. Faced with such an agenda, authorities have every right to feel intimidated. It is difficult to know where to start. And these demands come at a time when social services departments are already implementing the Children Act 1989 and the Criminal Justice Act 1991, when DHAs’ attention is more focused on setting up the new commissioner/provider framework for hospital care, and when FHSAs are only now establishing themselves in their new roles.

102. It is important that authorities organise themselves systematically to tackle the changes confronting them. The Government has set a time-table for the initial steps in the change process, mainly affecting local government social services – although the social security transfer also has profound implications for hospital discharge. But these changes are just the start. And health authorities – both DHAs and FHSAs – have their own agendas for change. Continuous adjustments will be needed at all levels from the Government on down if the new ways of organising care in the community are to fulfil their promise. Authorities will need to schedule the changes carefully if they are not to be overwhelmed, and their plans will need to be carefully monitored. Networks setting out the critical paths to be followed will be required. An evolutionary approach is likely to be the most appropriate – provided that sufficient momentum is maintained. And in addition to Government guidance, other agencies are also providing help and support (for example, Ref. 34). By such steps, the potential chaos of the cascade of change can be turned into a more ordered agenda.

103. The agenda for both commissioners and providers will be similar although the emphasis will be different. Those commissioning services will be more concerned with policy, although they will have an interest in operational arrangements; while service providers will be mainly concerned with operational arrangements but will have an interest in policy. Each will need to forge close working relationships with the other.

104. The first and most fundamental requirement is a thorough understanding and acceptance of the nature of the changes at every level. There are still many people, from authority members to front line staff who do not understand the fundamental nature of the changes and the reasons for them; and many who think that the changes are only superficial and that in reality businesses will continue much as before. Some people feel threatened – particularly service providers who suspect commissioners may not wish to purchase their services. The change will need to be managed with sensitivity, with heavy emphasis on working together with other agencies; good information must be continuously provided to all staff, users and carers; and a gradual approach must be adopted, managing change at a sustainable but steady pace. Above all, there will need to be a considerable investment in training at all levels for the many new skills that will be required – including assessment, care management, management of budgets, use of new information systems and a host of other skills.
THE ROLE OF THE AUDIT COMMISSION

105. The Audit Commission plans to contribute to the process of promoting change by identifying best practice, and drawing attention to gaps and inadequacies as they arise.

106. To this end, arrangements in health (both DHAs and FHSAs) and local authorities for both commissioners and providers will be audited to ensure that authorities are addressing the changes systematically. An overview summarising the degree of co-ordination between local, district health and family health services authorities will be produced during 1992 together with more detailed reviews of arrangements within local authorities and district health authorities. Detailed reviews of progress in FHSAs will follow in 1993.

107. The audits in each type of authority address the issues outlined in Chapter 2. They focus on three key areas:
— policy
— operational arrangements
— interagency co-ordination

Each of these areas is subdivided into a number of 'modules' within the overall audit framework (Exhibit 21). The respective roles of commissioners and providers are to be addressed – especially in DHAs where the divide is becoming well established. Each health audit module contains issues for commissioners and providers separately.

POLICY

108. Each authority will need to establish its own policy framework. Auditors will not question policy, but they will be reviewing authorities’ approach to needs assessment, combining demographic data with data collected locally. The process of setting objectives, calculating resource implications and adjusting priorities will be examined. Auditors will also review arrangements for producing forward plans and consulting with others.

OPERATIONAL ARRANGEMENTS

109. Plans must also set out how authorities intend to manage their policies into being. The key to this will be the commissioning arrangements. Local authorities will be experimenting with care management; health authorities will need to consider how they are going to link with the new structures. And assessment arrangements will be crucial if co-ordinated care packages are to result. Auditors will be reviewing authorities’ plans and intentions.

110. The form of the relationship between commissioners and providers will also be crucial. Auditors will be checking that arrangements are positive, that the full potential for effective use of funds is being seized (and properly controlled), and that funds are not locked up in contracts that constrain rather than enable.

111. Considerable attention will be given to systems – particularly financial information systems where funds are being devolved to local commissioners. Sound financial controls and commitment accounting for both commissioners and providers are essential if the new arrangements are not to disintegrate. And with social services expecting injections of new cash transferred from social security in 1993, good systems will be essential. Auditors are particularly
well placed to advise on these matters. Arrangements for training for these changes must also be in place.

112. Finally auditors will be commenting on the introduction of arrangements for ensuring that users and carers receive a quality service. Commissioners will need new methods of approach to ensure that what is being provided is of a high quality. The development of such methods is in its infancy, although authorities should be able to demonstrate that they are giving this difficult topic due consideration.

CO-ORDINATING CARE

113. All of the policy and operational issues must be co-ordinated between authorities. There are real potential benefits for authorities to pool their individual knowledge about needs; and it will be essential for them to co-ordinate their policies, objectives and priorities. Simply
going through the motions of consulting on each other’s plans after decisions have been taken will not be good enough.

114. At the operational level it will be necessary to set in place linked arrangements for co-ordinating care and assessment, and for ensuring that packages of care involving components from different agencies are properly co-ordinated.

115. As auditors check through both policy and operational arrangements in each authority they will be asking questions about how the authority is linking at every level with others. Reviews will also be undertaken of the machinery in place for promoting joint working – whether it is limited to a rather infrequent formal contact through joint consultative committees or whether alternative mechanisms have been introduced with everyday contact between officers at every level. In this way auditors will gradually build a picture of the degree of co-operation between authorities.

PROBES

116. The picture that will emerge from this work will inevitably be rather general. To test co-operation more thoroughly, two specific exercises are to be undertaken which will focus on areas where co-operation is essential – the boundary between hospitals (both acute and long stay) and the community. People crossing these boundaries who require ongoing support leave one supportive environment and must move to another. If this support is not forthcoming, then either the discharge will be inhibited, blocking beds, increasing lengths of stay and, in acute hospitals, affecting waiting lists; or else it will take place anyway requiring people to manage (or perhaps fail to manage) alone.

117. The first probe focuses on reception arrangements in the community for people discharged from acute hospitals, with particular emphasis on the preparation for 1 April 1993, when local authorities will assume responsibilities for people currently going direct to nursing homes. Arrangements within the hospitals are covered by separate Audit Commission studies of bed management and nursing. It will be essential to develop a policy framework and operational arrangements if the difficulties outlined in paragraph 22 are to be avoided.

118. The second probe focuses on arrangements for resettling people with learning disabilities from old long stay hospitals. Here the policy of transfer has been in place for many years and should be well established. If authorities have not sorted out this area, then it is unlikely that they are making any serious attempt to work together.

REPORTING

119. The outcome of each audit will be an individual report to each authority setting out the key issues to be addressed within the authority. But in addition, the intention is to produce an overview summarising the degree of co-operation between authorities, setting out where authorities need to work together to improve co-operation. To this end issues raised in each authority which have implications for other authorities will be drawn together to ensure that collaborative arrangements are appropriate as illustrated in Exhibit 21. The Social Services Inspectorate and regional health authorities are monitoring progress with the changes, (Ref. 35) and auditors are linking with them to ensure a consistent approach.
OUTSTANDING ISSUES

120. But there remain some issues that the Commission cannot address. Further thought will need to be given to the boundary problems between authorities, and to ways of aligning finance across agency boundaries to match shifting responsibilities.

CONCLUSION

121. The process now under way will, over time, change local and health authorities out of all recognition. It will be difficult to manage these changes and there will be constant frustrations on the way. But the goal is well worth the effort – better, more flexible services for users and carers alike, more suited to their individual needs. The audit process will be structured to support and promote that objective.
Probe 1

ACUTE HOSPITAL DISCHARGE

The first probe focuses on reception arrangements in the community for people discharged from acute hospitals, with particular emphasis on the preparation for 1 April 1993 when local authorities will assume additional responsibilities for people currently going directly to residential and nursing homes.

Objectives:
1. Are authorities jointly assessing the present and future need for nursing and residential home places? Have they agreed on the size and nature of the problem and the opportunities presented by community care?
2. Are there plans setting out how the numbers of people going into homes can be reduced? Are both authorities putting in place arrangements (staff, administration, procedures) for implementing the changes on 1 April 1993?
3. Are the resource implications for both sides set out and agreed? Is the local authority satisfied that the health authority will make available any extra resources needed for community health services? Is the health authority satisfied that its beds will not become blocked?

Needs:
Are health and social services authorities mapping the current pattern of people discharged from hospital who need support - particularly those who go to residential and nursing homes direct from hospital?

Objectives:
Are authorities reviewing the potential for reducing flows to residential and nursing homes by substituting domiciliary care?

Plans:
Have the roles and responsibilities of health and social services been agreed?

Co-ordinating care:
Who co-ordinates care for people ready for discharge? What is the role of hospital social workers?

Services delivery:
How are services co-ordinated? Are there dedicated staff or some other arrangement? How does liaison and cross-referral work between community health and social services?

Information:
Are systems in place to record hospitals'wards' referral patterns; numbers placed in nursing homes or who required help on discharge; current patterns of deployment of staff in support of discharge?

Quality Assurance:
Are patients given sufficient useful information? How are observations from community staff fed back to the hospital? How do authorities evaluate whether discharge arrangements have gone smoothly?
Probe 2
REPLACING LONG STAY HOSPITALS FOR PEOPLE WITH LEARNING DISABILITIES
The second probe focuses on arrangements for resettling people with learning disabilities from old long stay hospitals into facilities in the community.

- **Objectives:**
  1. Are authorities jointly planning arrangements for people with learning disabilities?
  2. Have they a common approach to the estimation of needs and operational arrangements?
  3. Are financial provisions appropriate with capital and revenue cash flows set out in the plans, showing how the gradual transfer of responsibility from health to social services is to be matched financially?
  4. Are authorities introducing common monitoring systems and arrangements?

- **Needs:**
  How are local needs being measured? Jointly? What information is held about the current hospital population?

- **Objectives, priorities:**
  What are the principles which shape the policy? How have priorities and target groups been defined?

- **Plans:**
  Has a plan been introduced for learning disabled services? Is the plan joint or separate in each authority?

- **Co-ordinating care:**
  How do the staff of the different agencies plan and work together? How are individual needs to be assessed? Who will hold budgets, at what levels?

- **Service delivery:**
  How are services to be financed in future? Is there devolution of responsibility, authority and budgets?

- **Information:**
  Management information should be shared between authorities. What information systems are in operation/planned?

- **Quality Assurance:**
  What are the arrangements for monitoring the achievements of the policy against its aims? How are standards to be maintained (and improved) in the hospital as it runs down?
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EXHIBIT 1

The figures in Exhibit 1 all refer to England and are at 1989/90 prices. Figures for 1979/80 have been reflated using the GDP index, rather than any of the indices specific for the NHS because the exhibit contains a mix of NHS, local authority and social security spending. The key comparison in the exhibit is between hospital and community rather than between 1979/80 and 1989/90 since different deflators will produce different comparisons for these two years.

Hospital and community health spending figures have been taken from the Department of Health programme budget for these services. The figures for hospitals include all out- and in-patient services. Those for community health including district nursing, health visiting, chiropody, community midwifery, prevent school health and family planning. Central administration, ambulance expenditures and joint finance have been excluded.

The programme budget shows a rapid increase in expenditure on community health services, and this is reflected in the figures used here. Some part of this increase may be accounted for by the change to Körner style returns in 1987/88, as a result of which it appears that some expenditure previously allocated to hospital spending was re-classified. There is no way of saying exactly how large this effect is, but it may account for more than £100 million of the apparent switch of resources.

Expenditure on primary care and personal social services has been taken from the Department of Health's 1991 annual report, Cm 1513, and the public expenditure white paper, Cm 8175.

Figures for expenditure on social security support for care in the community comprise the attendance, invalid care, severe disablement and mobility allowance. These have been derived from the Department of Social Security's Departmental Report for 1991, Cm 1514, and the public expenditure white paper, Cm 8175.

Figures for income support payments to people in residential care and nursing homes have been derived from those published in the second report of the House of Commons Social Services Committee, Session 1990/91, HC 395 and supplemented by additional information from the Department of Social Security.

Data for social security spending is available for Great Britain only. The England figures have been calculated according to England's share of Great Britain population.

EXHIBIT 8

Source of both NHS and personal social services spending is the House of Commons Health Committee, Session 1990/91, Report on Public Expenditure on Health Matters HC 408, tables 4.1 and 4.2 respectively.

EXHIBIT 10

Community health service expenditure has been taken from financial return FR13 for 1989/90. The Jarman underprivileged area, which combines eight factors into a single measure was supplied by Professor Brian Jarman of St Mary's Hospital, Paddington. Health Services indicators provided the number of district nurses per 10,000 population aged 75+.
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