Homeward Bound: A New Course for Community Health
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Preface

The Audit Commission became responsible for the external audit of the National Health Service (NHS) in England and Wales in October 1990. As well as reviewing the financial accounts of all Health Service bodies, the Commission's auditors are required to examine the economy, efficiency and effectiveness of health authorities’ use of resources. Each year several health topics or service areas are selected for special study.

The Commission's aim is to help those who manage and work in 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.

The topics selected for the audit year November 1991 to October 1992 are ward nursing, the use of medical beds in acute hospitals and the subject of this report, community health services. This report addresses the problems, challenges and opportunities that confront the wide range of community health services (CHS) under contract to district health authorities (DHAs). As well as examining internal management arrangements, it looks at strategic and operational relationships with other agencies providing related services: local authorities (LAs) – especially social service departments (SSDs), family health services authorities (FHSAs) and hospital units.

To complement this paper the Audit Commission is producing a report on the implementation of the NHS and Community Care Act (1990) by local authorities. And a further report on FHSAs is to be published in 1992.

The team which conducted this study was directed by David Browning and comprised Peter Illsley (project manager), Russ Phillips and Barbara Stilwell with support from Sinead Ferguson, Jim Burden and Mark Davenport.
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Summary

1. District health authorities provide a range of community health services which, in conjunction with services provided by family health services authorities (FHSAs), meet the health care needs of people living at home. The main users are children, elderly people and people with physical or learning disabilities or mental health problems. Increasing attention is being given to supporting carers as well as the users themselves.

2. The community health services consist of a range of different professionals, including doctors and nurses with a variety of skills, and professions allied to medicine such as speech therapists, chiropodists, and occupational therapists. In common with the rest of the National Health Service, there has been a tradition of individual professionalism, with each practitioner taking referrals and operating independently. But there is increasing pressure for change, requiring a more co-ordinated approach in the future if the full potential of the services is to be realised.

3. In the past community services have not received priority attention at the district health authority level. Spending patterns have developed incrementally rather than been planned, and do not relate in any clear way to needs or services provided by others. Many argue, with some justification, that community services have always been the poor relations of the acute sector, suffering budget cutbacks when times are hard.

4. Community services have not been seen as part of an integrated range of services. Joint planning is hampered by institutional and geographical boundary problems. Too often joint consultative committees have focused on marginal issues, neglecting major strategic questions.

5. This lack of overall management control has resulted in a patchwork service. There are significant variations between areas in grade and skill mix and how staff use their time. A lack of case-load and other management information systems too often leaves frontline staff unsupervised and unsupported. And techniques of quality assessment are under-developed. These difficulties often undermine the contribution that community health services make to the health of the nation.

6. Many authorities recognise these difficulties and are now introducing new ways of working. Such initiatives require clear leadership, with authorities clarifying their goals and working with other agencies to identify needs. Joint working cannot be left to chance; authorities need strategies for collaborating with others. In particular, attention should be paid to how the new commissioning arrangements are to be co-ordinated, so that district arrangements fit with both local authority care management arrangements, and with FHSA resources. In the longer term it may be more logical for district and FHSA commissioning arrangements to merge (as they have already done in a number of authorities) provided sufficient safeguards can be put in place to prevent the acute hospital sector from dominating provision. Joint planning would then be simplified with fewer agencies involved.
7. At the operational level, greater clarity in roles and procedures is required between professionals – especially in hospital discharge arrangements – and there are gains to be made from business planning at a team level and from the introduction of protocols. Managers should review grade mix, the use of clinics and equipment, and create a more managerial culture amongst clinicians. Backed by better information systems, they should ensure that staff are properly supervised and supported. Productivity improvements can thereby be secured, to help meet increasing demand.

8. Quality assurance needs better organisation with commissioners and providers each taking a corporate approach involving users more. Community health services must become more confident and responsive to feedback. Weaknesses in performance, highlighted by better information, should be addressed constructively by more supportive managers.

9. The shift in priorities within the NHS in favour of community care is placing greater burdens on community health services, but at the same time it is opening up new opportunities. If a new managerial approach can be combined with the traditional strengths of the professional approach, then community health services will have an increasingly exciting rôle to play in the NHS of the future.
Introduction

1. The community health services meet the health care needs of people living at home that are beyond the scope of ‘self help’, but that do not require the centralised services of hospitals. They prevent, contain or treat physical and mental illness; prevent, treat and limit the effects of injury; enable early and effective hospital discharge; promote positive health; provide practical advice and help in the conception, birth and development of children; support people with mental or physical disabilities; and support and treat those who are dying. The main users of community health services are children, elderly people, people with physical disabilities, learning disabilities or mental health problems, and the families of all such people. Increasingly, services are targeted at releasing the pressure on informal carers to prevent carer breakdown and admission to costly hospital or residential services.

2. A third of NHS revenue expenditure is deployed in the community with three quarters of this third channelled through FHSAs to provide GP, dental, optical and pharmaceutical services. The remaining quarter, representing £1.7 billion in England and Wales in 1990, is allocated by district health authorities to provide district nursing, health visiting, and other specialist nursing, dental, medical and allied professional services (Exhibit 1). Proposals to extend the GP fundholding initiative will transfer the commissioning of some of these services to participating GPs.

Exhibit 1
NHS REVENUE EXPENDITURE
A quarter of expenditure on community services is allocated by district health authorities.

3. District health authorities contract with a wide variety of professionals (Box A, overleaf). Some work almost entirely in the community – for example, health visitors, clinical medical
officers, district nurses and chiropodists. Others, like geriatricians, psychiatrists, and physiotherapists, often have their main work commitments within hospitals.

Box A
COMMUNITY HEALTH PROFESSIONALS

<table>
<thead>
<tr>
<th>Doctors</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatricians</td>
<td>District</td>
</tr>
<tr>
<td>Clinical Medical Officers</td>
<td>Health Visitors</td>
</tr>
<tr>
<td>Geriatricians</td>
<td>School</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>Community Midwife</td>
</tr>
<tr>
<td>Dentists</td>
<td>Community Psychiatric</td>
</tr>
<tr>
<td>Community Dentists</td>
<td>Community Mental Handicap</td>
</tr>
<tr>
<td>Professions allied to medicine</td>
<td>Macmillan</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>Marie Curie</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>Family Planning</td>
</tr>
<tr>
<td>Speech Therapists</td>
<td>Stoma Care</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>Continence Advisor</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Diabetic Liaison</td>
</tr>
<tr>
<td>Dietitians</td>
<td>Paediatric Liaison</td>
</tr>
<tr>
<td>Audiologists</td>
<td>Discharge Liaison</td>
</tr>
<tr>
<td>Orthoptists</td>
<td>Clinic</td>
</tr>
<tr>
<td>Health Promotion Staff</td>
<td>TB</td>
</tr>
<tr>
<td>Community Pharmacists</td>
<td>Nurse Practitioner</td>
</tr>
</tbody>
</table>

4. Over half of community expenditure finances nursing activity with 37 per cent used for general services provided by district nurses and health visitors (Exhibit 2). The remaining nurses play a more specialised rôle, sometimes working with specific groups of people – people with

Exhibit 2
COMMUNITY HEALTH EXPENDITURE BY EACH STAFF GROUP
Over half of community health expenditure funds nursing activity

Note: Total = 99% due to rounding.
Source: Department of Health, Welsh Office – (England & Wales 1989/90)
Several million people use these services each year (Exhibit 3). This is measured in the number of ‘initial face-to-face contacts’ between staff and users. Some initial contacts – the first contact that year – are ‘one-off’ occasions for screening purposes, such as those with community dentists or school nurses. Others may be part of a continuing programme of care running for months or years. The precise number of people who have contact with the service as a whole, however, is not known. This is because information collected is focused on services rather than users, so whilst it is possible to know how many people have used a particular service, it is not possible to know how much an individual is receiving or the combinations of services used. These uncertainties can cause problems at the local level where care must be co-ordinated if it is to be both effective and free from unnecessary overlaps or gaps.

But district community health services are more than the sum of their individual parts. Operating in concert with GPs, local authority social services, voluntary organisations, the private sector and unpaid carers, they are an essential element in the wider network that provides ‘primary care’. The flexibility of the community health workforce at the centre of this network gives it the potential to compensate for shortcomings in existing provision – either within primary
care itself, in low levels of hospital and residential care, or in the ability of particular groups in the community to gain access to services. It therefore provides an essential buffer at the heart of community care. By helping GPs to treat and support their patients, hospitals to make early and effective discharges and local authorities to provide domiciliary and day services, district community health services enable people to spend a greater proportion of their lives at home. At their best, they have pioneered new services for groups that have been left behind by others – such as homeless families, ethnic minorities, and housebound elderly people. As some community units grasp the unique nature of this central rôle and use economies of scale to develop its potential, others face the prospect of being broken up and spread amongst clinical directorates and general practices – reducing flexibility.

STRUCTURAL ARRANGEMENTS

8. The organisational arrangements for managing and co-ordinating these practitioners vary from one district to another. They are often complex – since care must be managed both across agencies and in different settings. Forming and modifying these arrangements have been key tasks for the general managers introduced into the NHS following the NHS management inquiry – the Griffiths report – in 1983.

9. Staff are managed by senior members of their profession or by general managers responsible for a geographical area or particular client group. The level at which professions eventually report to general management varies.

10. The main unit of service organisation is the primary health care team, made up of district nurses and health visitors from the district, and general practitioners (GPs) and practice nurses employed through the FHSA. They are often extended by having social service department personnel attached. DoH policy has encouraged the development of such teams since the 1970s (Ref. 1).

11. Alternatively, nursing services may be organised in ‘neighbourhood’ teams. Following the ‘Cumberlege report’ in 1986, a number of districts set up their nursing services in teams focusing on small communities of 15,000-20,000 people, rather than GP practice lists (although sometimes, as in many rural areas, the two coincide) (Ref. 2). This model can still allow for the attachment of nurses to GPs within ‘active’ primary health care teams which were seen as the most effective units for providing care. Community midwives, other specialist nurses, doctors and the professions allied to medicine are also sometimes organised on a similar ‘locality’ basis.

12. In addition specialist teams exist to support groups of people with specific conditions. Examples include community learning disability teams, special needs teams for children, mental health teams and the occasional disability team for adults. Specialist teams are normally staffed by multi-disciplinary groups of professionals and often have attached social workers. They rarely, if ever, include GPs or other staff contracted through FHSAs, although they aim to work closely with individual GPs. Where community services are closely linked to a hospital department or specialty, specialist liaison staff may be employed, either by that department or by the community unit. The shift of care to the community for conditions like diabetes, or more general areas such as child health and paediatrics, has led to a growth in these posts.
PRESSURES FOR CHANGE

13. These service patterns have evolved steadily over the years. But there has been increasing concern that community health services – in common with other health and social services – are not able to respond with sufficient flexibility to shifting demands, user needs, and the challenges and opportunities presented by changing practice. The traditional 'top-down' financing of health service provision from the centre has led to rigidity and insularity. To counter these difficulties, new financial and organisational structures are being introduced by the NHS and Community Care Act 1990. The Act separates commissioning from the provision of care; it introduces budgets based on the population living in each district, adjusted for age and other factors; it has replaced family practitioner committees (FPCs) with family health services authorities; and it has given local authorities the lead rôle in co-ordinating social care in the community. All of these developments focus considerable attention on community health services.

14. Under the Act, district health authorities have become commissioning agencies. As such they are responsible for assessing the district's health needs, translating them into service requirements and commissioning services from suitable providers. They must then undertake thorough reviews of the services delivered to see that they match the services needed. At the same time, the provider units, whether directly managed units or Trusts, must examine their activities and draw up plans to ensure that they are able to conform to their commissioners' specifications.

15. In future, funds will be allocated to districts according to a formula based on their populations and local needs, thus altering the level of funding available to many, and adding to the pressure for change. Provider units within districts with smaller funding allocations than before will need to attract contracts from elsewhere to maintain existing service levels – a task easier for hospitals since patients travel to them. Community services, however, are much more dependent on funding from their local district health authority. Those which have enjoyed relatively high resources in the past are likely to come under considerable pressure when funds start to reduce. Conversely, districts with increasing budgets and lower levels of internal provision, will need to scrutinise their services in search of development opportunities. How these changes will affect local community resource levels is hard to say – particularly since the introduction of weighted capitation funding has been delayed and districts have contracted on a 'steady state' basis in year one. But as the momentum of reform starts to pick up, so will change become inevitable.

16. FHSAs are expanding their activities rapidly, with new policies and new staff in post. This expansion is increasing areas of potential overlap with district community health services. Authorities will need to sort out their respective tasks if waste and conflict are to be avoided. It will also be vital to clarify the interface with local authorities who will have a new rôle in arranging assessment and co-ordinating social care in the community.

17. These developments are taking place against a backdrop of wider change that is already affecting community services. Firstly, whilst the number of people aged 15 to 64 remains fairly constant, the number of elderly people will increase well into the next century, with a dramatic rise amongst those over 85 years (Exhibit 4, overleaf). If these elderly people use the same
Numbers of elderly people will increase, with a dramatic rise amongst those of 85 years and over.

Source: OPCS

...proportion of NHS resources as their present day counterparts, overall demand will increase. As the population ages, the evidence suggests that the incidence of chronic illness, such as Alzheimer's disease, diabetes and cancer, rises, increasing the demand for long-term community care.

Secondly, patterns of health care continue to shift throughout the NHS. By reducing lengths of stay and increasing day cases, acute hospitals are treating more people and discharging them more quickly. Whilst earlier discharge may generally have increased pressure on community services, properly managed day surgery has had little or no effect to date (Ref. 3). But as the practice expands, day surgery will encompass new and more complex procedures, which may need some aftercare. Chronic illnesses, such as diabetes, and conditions requiring long term care, are increasingly being supported in the community enabling districts to reduce the number of beds in acute hospitals and close mental handicap and mental illness institutions (Exhibit 5). The hospice movement is turning its attention to 'hospice at home'; and 'hospital at home', pioneered by Peterborough in 1978, is being developed in other districts – such as Southern Derbyshire and Pembrokeshire. 'Home health care' is now one of the fastest growing industries in the USA (Ref. 4); and there is an increasing demand for home based health services from childbirth to terminal care. In short, demand for community health care continues to grow.

Finally, in parallel with the shift from hospital to community, there has been a shift in emphasis from cure to prevention. No one would dispute that diseases are best tackled by prevention or with detection and early intervention rather than by belated, intensive treatments in hospitals. Effective health promotion, which offers enormous potential benefits, is predominantly a community-based activity. The government attitude was described in 'The Health of the Nation' which set health targets for the United Kingdom (Ref. 5).
THE SHIFTING PATTERN OF HOSPITAL CARE IN ENGLAND AND WALES
Hospitals treat more people as inpatients and day cases rise...
...lengths of stay continue to reduce...
...and the number of acute beds has reduced and large psychiatric and learning disability hospitals have closed

Source: Health and Personal Social Service Statistics for England (1990); and Department of Health Statistical Bulletin 2/10/90
20. Unquestionably, community health services will become more important in the future. But the trends described above will expose weaknesses in the way services have been managed in the past. They will require more active and systematic management.

21. This report explains how such an approach can be developed. Chapter 1 analyses the impact of the reform process and highlights some of the inadequacies in the present arrangements. Chapter 2 describes how these challenges can be met. Chapter 3 outlines an agenda for action and explains how the Commission will take its own work forward.
1. The Challenge to Management

22. The traditional way of funding community health services has left them ill-equipped to deal with the new challenges and opportunities that are emerging from changing practice and new legislation. Since money in the past has always been fully committed to existing services at the beginning of each year, there has been little scope for any radical review of policy. And as long as services have operated within budget, there has been limited attention to any wider review of their impact or control of their activities. This inactivity has left a legacy of inadequate managerial arrangements in many districts.

A NEED FOR NEW POLICY INITIATIVES

23. An early task for commissioning authorities is to decide the future scope for their community health services. Setting the direction for community health services has never been easy; encapsulating that direction in contractual form will be particularly difficult.

24. One reason for this is the inherent complexity of community health services. They consist of a mix of individual services provided by different agencies and professions serving a variety of functions. Some are relatively specialised, such as chiropody or family planning; others, like district nursing, have broader remits. Although a single, all-encompassing vision can prove helpful in conveying a broad approach and key values, it cannot provide sufficient detail to guide each part of the service. Separate policies are needed for each type of user, covering both hospital and community care, requiring a great deal of management attention.

25. Unfortunately, community health services have tended to remain a low priority for DHA management, faced with the pressures of managing high-profile hospitals, well endowed with powerful interest groups ready to argue their case for funds. Community services are still, in management terms, the poor relations.

26. As a result, the activities of community health services have changed very little in recent years, with the majority of districts 'rolling over' resource levels from one year to the next (Exhibit 6, overleaf). Any alterations to budgets have been to cover higher wage bills and to make the occasional and limited change to one or other of the professional groups. This would not matter if staffing levels were appropriate in the first place. In fact an illogical pattern of services – inherited by health authorities – has persisted.

27. Spending on community health services, for example, varies considerably between districts with some spending twice as much per person as others. And the relationship between local provision and the measures of need available is poor. The 'Jarman Underprivileged Area Score' – a weighted average of eight population factors – can be used to assess demand for community services. But the match between district Jarman scores and expenditure is weak. A
Exhibit 6
COMMUNITY HEALTH STAFFING LEVELS (MEDICAL, DENTAL AND NURSING) IN ENGLAND 1985 ~ 1990
The majority of districts have 'rolled over' community resource levels from one year to the next.

Source: Department of Health

more direct measure of need is the number of elderly people major users of district nursing services. But people over 75 have two or three times as many staff available to them in some districts as those in others (Exhibit 7).

DIFFICULTIES BETWEEN AGENCIES

SUBSTITUTION

28. An alternative cause of the variation could be the impact of levels of service provided by others. Variations in community health expenditure could be compensated by higher or lower spending by hospitals, FHSAs or social services. But here again, no such 'substitution' obtains (Exhibit 8, overleaf).

29. An inverse relationship could perhaps be expected between community and hospital services, with high expenditure in one sector substituting for low expenditure in the other. In fact the reverse happens. The more a district spends on hospitals, the more it is likely to spend on community health services (Exhibit 8a). Where districts have high levels of funding for historical reasons, these have been shared by both hospital and community services.

30. Alternatively, the general medical service, provided through FHSAs, might substitute to some extent for CHS expenditure. However, the mechanism for distributing GPs, the main resource, is geared to produce an even ratio with numbers of people and not to relate resources to need or other levels of provision. The introduction of deprivation payments in April 1991 is compensating GPs for working in areas of high deprivation. But such payments do not guarantee similar levels of access to services, any more than they guarantee a levelling of general practice quality. Moreover, there is no relationship between nursing services employed by GPs, and those deployed by DHAs (Exhibit 8b).
Some districts spend twice as much per person as others... ...with only a weak relationship between expenditure and indices of demand...

... so that people over 75, major users of district nursing services, may have two or three times as many staff available to them in some DHAs as those in others.

Source: See appendix

31. Similarly there seems to be no evidence of substitution of social service and community health service expenditure levels (Exhibit 8c). However, when all health and social service resources are combined, there is a limited relationship between that and the Jarman Underprivileged Area Score in an area (Exhibit 9, overleaf). This is mainly due to the social service element, which is both large and more closely related to demand, as measured by the Jarman index. But on the health side, some communities experience low resource levels in all services provided by both DHAs and FHSAs, whilst others have high levels of provision.

32. Interagency collaboration to improve the overall impact of provision remains the exception rather than the rule. Even within districts, acute and community services are too often seen as distinct entities with plans, finance and management separated into two channels that only come together at the very top of the commissioning authority. Whilst this separation can sometimes promote a clear sense of identity within community services, it can also weaken links with hospitals.
Exhibit 8
HOSPITAL, COMMUNITY HEALTH & SOCIAL SERVICE EXPENDITURE IN ENGLAND AND WALES

(a) The more a district spends on hospitals, the more it is likely to spend on community services.
(b) Numbers of practice nurses, employed by GPs, are not related to numbers of DHA community nurses.
(c) Social service expenditure does not relate to community health service expenditure.

Note: (a) r squared = 0.587
Source: (a) Audit Commission, 1990/91
(b) Department of Health, Oct 1990
(c) Audit Commission, CIPFA, 1990/91

33. Poor collaboration reduces the impact of resources. The resulting inequity brings confusion and frustration to individuals who need care and for whom organisational boundaries are irrelevant.

JOINT PLANNING

34. The formal mechanism for collaborative service development between DHAs, FHSAs and SSDs is the 'Joint Planning' machinery set up in the 1974 reorganisation of the NHS. It is plagued with problems, including different boundaries, differing responsibilities and priorities, and a lack of incentives.

35. Most FHSAs share boundaries with a single local authority. But less than half - 40% - share a common boundary with a single district health authority. The remaining FHSAs cover
When all social service and health resources are combined, there is a limited relationship with demand. From the district perspective, only a fifth share a boundary with a FHSA. That position is subject to change as districts merge across the country.

36. Each agency has different responsibilities and priorities. FHSAs focus on primary health care; districts have also to consider secondary and tertiary facilities. Local authorities have even wider remits with community care competing against other services such as education, housing.

Exhibit 10
DHAs AND FHSAs SHARING COMMON BOUNDARIES IN ENGLAND AND WALES
Less than half of FHSAs share a common boundary with a single DHA.
roads and leisure. Furthermore, districts and SSDs must decide how 'health care' is to be distinguished from 'social care' – a difficult task. And discussions to resolve this problem have been put back by the delay in implementing the reforms set out for local authorities in the NHS and Community Care Act.

37. The agencies are also very different culturally, professionally and sometimes politically. Planning and committee cycles are often out of synchronisation. Their ability to develop, deliver and share a vision of service development depends to a large extent on the position and influence of respective leaders and this differs too. District, and unit general managers, chief executive officers, FHSA general managers and social service directors exercise varying degrees of control constrained by separate legislation and diverse patterns of delegation from their authorities or boards.

38. Finally, the separation of funding and budgets produces insensitivity between agencies in areas of service overlap. Agencies may gain financial advantage by not providing or reducing services; or over-provision may result in expensive and inappropriate services.

39. As a result, discussion at joint consultative committees (JCCs) tends to be dominated by marginal issues such as the development of specific projects or bids for joint finance (Exhibit 11).

Exhibit 11

THE JCC AGENDA
Discussion at JCCs tends to be dominated by marginal issues such as the development of specific projects or joint finance bids.

Note: Taken from JCC minutes in 6 DHAs between 1986 and 1990
Source: Audit Commission survey

40. Whilst meetings provide a forum for endorsing major policy decisions, they are often not used for consulting on them in advance. Important areas of concern between districts and social services, such as policies for people with disabilities and elderly people, children, and the
discharge of people from hospitals, are sometimes not covered sufficiently or not covered at all (Exhibit 12). Topics relating largely to the boundary between FHSAs and DHAs, such as the care of chronic illness, health promotion or family planning, are also sometimes not covered.

Exhibit 12
DISCUSSION OF PRIORITY CARE GROUPS AT JCCs (1987-90)
Important areas of joint concern are sometimes either not covered sufficiently or not covered at all.

41. The supporting system – in which care group planning teams (CGPTs) and locality planning teams (LPTs) feed into joint care planning teams (JCPTs) – is also less effective than it might be. CGPTs and LPTs are often not fully integrated into general management, rendering many irrelevant. JCPTs tend to be large and have to cover a wide and diverse set of services. Hence they are often unwieldy and unfocused making it difficult to develop strategic approaches to care and to foster close working relationships. Finally, and not surprisingly, all joint planning teams are far happier discussing growth, albeit small scale and joint financed, rather than tackling zero growth, contraction or value for money initiatives. These issues tend to be addressed separately within each agency.

OPERATIONAL CO-ORDINATION
42. There is also considerable evidence that operational co-ordination between health and social services or between different branches of the NHS, is not all it should be. For the majority of patients this is not an issue. Those with a relatively straightforward need will have it met efficiently by an appropriate practitioner. Difficulties occur for those who require support from a variety of sources often for a considerable length of time. Many could be supported in the community, instead of in hospital or residential care, if more complex care packages could be assembled and managed more readily. But such packages are not common. An examination of people over 65 years in one area revealed that 8% of people received a combination of health and social services but few – 0.5 percent of the total – had more than two services from each
(Exhibit 13). This will need to change if a credible alternative to 24 hour residential care is to be made available to more dependent people.

Exhibit 13
INTERAGENCY CARE COMBINATIONS
8% of people over 65 years in one area received a combination of health and social services, with only 0.5 per cent of the total receiving four or more services.

Source: University of Wales Department of Geriatric Medicine: Research Team for the Care of the Elderly

43. In a study of elderly people receiving both health and social services, the Personal Social Services Research Unit at Kent University demonstrated a low level of co-ordination between the two agencies with regular liaison in only 7% of cases (Ref. 6) (Exhibit 14). Lack of co-ordination has also been highlighted by previous Audit Commission publications in 1986 for all services (Ref. 7) and 1989 for people with learning disabilities (Ref. 8). The King’s Fund and the Royal College of Physicians reported similar problems for people with physical disabilities (Ref. 9,10).

44. A particular issue for people with physical disabilities is the supply of aids and adaptations. Resources are held by both local authorities and health authorities. Without clear agreements between agencies there can be a confusion of roles and duplication of effort, especially in assessing need. Furthermore, community health staff do not have authority to order equipment, since this is the responsibility of a social service department. Redressing an imbalance between staff and equipment can therefore be very difficult. And supply is often determined by outside agencies or departments with other priorities and pressures. Some of those problems have been overcome by districts and SSDs which have reached firm local agreements about their respective contributions to care, including the resource contribution from each side. Effective examples have included fully integrated joint aids stores, joint appointments of occupational therapists and agreements about accepting assessments of need made by practitioners in other authorities. However, for many practitioners and clients the efficient delivery of aids and adaptations represents a frustrating clash between the immediacy of need and bureaucracy at its worst. A study of district nursing conducted by Birmingham University reported the case of one person who
45. Co-ordination difficulties have been highlighted by inquiries into the circumstances surrounding deaths from child abuse. The publication of 'A Child in Trust', following the death of Jasmine Beckford in 1984, prompted health and local authorities to further review and improve procedural arrangements (Ref. 12). The lack of communication between the social worker and health visitor prevented key information from coming to light which could have prompted changes in the child's care arrangements:

‘If only the two workers on this case had compared notes, they would have quickly discovered that they were being told different and contradictory stories (by the mother).’

A similar report on Kimberley Carlile's death states that ‘information was not shared between the GP, the health visitor and/or social services' (Ref. 13).

46. Confusion over the rôles and responsibilities of different members of the care team has also been uncovered. The report on Doreen Aston (Ref. 14) refers to a misunderstanding of the health visitor rôle as does that on Tyra Henry:

‘The evidence given to us disclosed an unfortunate misunderstanding about a supposed change in the rôle of health visitors in relation to children in care' (Ref. 15).

In such cases, co-ordination problems have borne tragic consequences, leading to a tightening of procedures. The Children Act 1989, implemented in October 1991, requires the setting up of Area Child Protection Committees to address many of these problems. But for people for whom
the results of poor co-ordination are likely to be merely delayed and inappropriate referrals, the motivation to improve is less pressing.

47. One obvious cause of difficulty is the absence of links between the information and record systems used by the various agencies. And within agencies, information is organised by service – making it impossible to build a picture of the pattern of care provided to each user.

48. Multi-disciplinary working, particularly within primary health care teams, is also difficult. Separate lines of control, different payment systems leading to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status, all play a part in limiting the potential of multi-professional, multi-agency teamwork. These undercurrents often lead to a rigidity within teams with members adhering to narrow definitions of their roles preventing the creative and flexible responses required to meet the variety of human need presented. They are also likely to lower morale. For those working under such circumstances, efficient teamwork remains an elusive ideal.

SHIFTING RÔLES

49. This lack of co-ordination will present even greater problems in the future when the projected changes in responsibility start to work through. Other agencies are undertaking much of the traditional work of DHAs – both hospital and community services. If there is no adjustment, unnecessary overlaps in provision could occur and opportunities to provide a more effective and complementary service may be missed.

50. Family health services now have increased responsibilities in health promotion and screening. GPs are more involved in general health checks; they are also encouraged to undertake minor surgery, and practice-based pathology testing has been made increasingly possible by technological advances (although there are problems, outlined in the Commission's report on the pathology services – Ref. 16). While much new work has been generated, some of these responsibilities were undertaken previously by district personnel – for example clinical medical officers, health visitors and school nurses.

51. To assist them, GPs have recruited extra staff – especially practice nurses. The number of practice nurses employed in England and Wales doubled between October 1988 and October 1990 with the number of ‘whole time equivalents’ now estimated to exceed 10,000 (Exhibit 15). The overall distribution of this expanding workforce appears to have come about in an unconsidered way. In under-resourced areas there may be an improvement in service levels; in others, resources may not be used to best effect. But without systematic monitoring of the activities of GPs, practice nurses and district community nurses, it will be difficult to ensure that overall resources are not wasted.

52. Furthermore, FHSAs have an extended executive rôle with responsibilities for planning and developing family practitioner services. This entails assessing the primary health care needs of the local population – an activity also undertaken by community nurses in district-funded provider units, and by public health departments as a key commissioning function. The community nurse contribution centres around the development of health profiles which focus on small localities identifying local health status, together with environmental and social influences. Under the new arrangements this would be seen as a planning and commissioning rôle and, given
Exhibit 15

NUMBERS OF PRACTICE NURSES
The number of practice nurses doubled between 1988 and 1990.

Source: DoH (England & Wales)

The primary health care implications, one that could be located either within FHSAs or the district public health departments.

53. Local Authorities’ responsibilities have been increased with SSDs taking the lead role in community social care. But districts also play a large part in caring for people with disabilities. They provide specialist support such as occupational therapy, speech therapy and clinical psychology; and more general domiciliary care is provided by district nurses and health care assistants.

54. Following discharge from hospital, patients may go into residential care provided by the district, the private and voluntary sectors or SSD residential accommodation. Much of the finance for places in private and voluntary homes comes from social security payments. The care element of these funds for new admissions will be transferred to social services departments from April 1993. Thereafter, funds for residential places will not be available automatically to eligible NHS patients on discharge. This change will affect both direct clinical services and the organisational aspects of care as well. It will be crucial for districts to develop good working relationships with social services if hospital beds are to be released for those who need hospital care.

55. Where community rather than residential nursing is required, there are additional complications. At present there is an enhanced rate of income support to cover the increased costs of nursing and other specialist health care in residential homes. Under current proposals this ‘health-care element’ is included in the funds transferring to local authorities in 1993. But if domiciliary nursing care is chosen for an individual instead, the cost will fall to the health authority, whilst the funds will remain with the local authority. If districts do not provide the extra nursing support required, then community-based care plans may fail. As a result, nursing home admission will be the only option at considerable cost to the local authority.
56. All of these developments demand close interagency co-operation and the Act requires agencies to work together. To further that aim, FHSAs have been brought under the control of regional health authorities; social service departments have to consult their local health authorities on community care plans; and social services authorities have to reach agreement with the appropriate health authority on which community care developments the mental illness specific grant should be spent. At the level of policy, then, there are more mechanisms to promote enhanced inter-agency collaboration. Those involved need to be aware of the scale of the obstacles that remain to be overcome.

MANAGEMENT CONTROL

57. Once policy has been established and agreed, management must be able to ensure that it is implemented effectively. At present there is a lack of suitable controls. As a result, the overall mixture of service patterns observed at district level is mirrored by similar local discrepancies.

GRADE AND SKILL MIX

58. There are significant variations in the grades of staff employed between districts and sometimes between localities within districts (Exhibit 16). Few managers can explain why they employ the grades they do. Given that the demand for community services is set to increase, it is essential that productivity in this and other areas is explored fully. Managers must be aware of what they are getting for their money since the opportunity cost of having a 'rich mix' can be significant (Exhibit 17). The cost of district nurse salaries in England in 1989/90 was approximately £250 million. This would rise to £260 million if all districts used the richest grade mix observed, and fall to £230 million if the most dilute was used – a difference of £30 million. There are also wide variations in how staff at different grades allocate time (Exhibit 18), affecting the cost of services, and possibly the quality of provision.

Exhibit 16
VARIATIONS IN GRADE MIX
There are variations in grades of staff between districts and between localities within the same districts.

Source: Audit Commission survey
Exhibit 17
GRADE MIX COSTS IN DISTRICT NURSING
The opportunity cost of having a 'rich mix' can be considerable.

Source: Audit Commission analysis

Exhibit 18
TIME SPENT ON BASIC CARE BY DIFFERENT GRADES OF DISTRICT NURSE
There are wide variations in how staff at different grades allocate their time.

Source: Oxford RHA, 'Focus on District Nursing', 1986

59. The actual mix of professionals within community services is historically based and has been largely fixed by the professions themselves. Not surprisingly they have tended to propose higher grades and expansion of their services whilst vigorously fighting any proposed reduction.

60. Shifting from that historic position is difficult. Firstly, determining the skills required to meet needs is a complex decision. A high level of high grade staff does not automatically equate to a better service. But equally a blanket allocation of unqualified staff to all basic tasks is likely to result in a loss of quality and may well be less efficient. Secondly, grade mix is a highly sensitive
issue. With little information and evidence, reasoned discussion and analysis is easily replaced by negotiations with management and professionals finding themselves in entrenched and polarised positions. That presents a problem for commissioning authorities who will need to monitor the match between needs and services continually which requires a greater flexibility in service response than is currently possible.

USE OF STAFF TIME

61. A large slice of the community health resource has always been taken up in activities that do not involve 'face to face' contact between client and staff. But some authorities are more effective than others at delivering frontline care.

62. An extensive examination of services in 24 districts (Ref. 17) revealed that travelling, for example, accounted for between a fifth and a quarter of community nursing and a sixth of health visiting time. Travelling aside, significant variations were shown in the average proportion of time that qualified district nurses spent on non-clinical activities, as opposed to time with patients. Districts ranged from 17 to 34 per cent. Differences were neither explained by economies of scale, nor by grade mix. Human resource efficiency seems to be the determining factor. Health Visitors spent between 39 and 55 per cent of time on non-clinical activities, leaving about a third of their time overall for working with patients.

63. Dramatic inconsistencies in the level of non-clinical activity have also been found within districts (Exhibit 19). But managers in many districts are unable to make more efficient use of staff time because they do not have ready access to appropriate management information, and because the relative value of these different activities is not always easy to assess. If all districts were able to reduce non-clinical district nursing time to the level of the top quartile in the sample, 23%, this would generate sufficient resources to increase the workforce in England by

Exhibit 19
LEVELS OF NON-CLINICAL ACTIVITY (AWAY FROM THE PATIENT) IN A SAMPLE DISTRICT
Dramatic inconsistencies also exist within districts.

Source: Audit Commission survey

24
approximately 400 qualified district nurses – an extra 4% – or 800 unqualified staff – an increase of 25%.

CASELOAD MANAGEMENT

64. With no information on either the costs or the outcomes of care, it is not possible to compare the cost effectiveness of different approaches to caseload management. Much depends on the skill and experience of the manager or practitioner. But research – confirmed by this study -- indicates that the efficient management of caseloads is uncommon.

65. Evidence suggests that whilst some teams actively manage their caseloads, many clients remain on the books of other teams without review. The University of Birmingham study (1988), revealed that while a quarter of the clients served by three of the four district nursing teams studied had been on the caseload for over five years, the fourth team had no cases of this duration (Ref. 11). An analysis of three comparable teams within one district showed that the average time on a caseload for the three were: 190, 170 and 100 days respectively. Those differences suggest, at the very least, different policies for caring for individuals between teams. The people who have been on the caseload the longest may be being kept out of residential care; or they may be receiving unnecessary support. Whatever the case, the differences suggest that a proper review of effectiveness is desirable.

66. Moreover, the Birmingham study showed that district nurse resources were allocated unevenly – black clients receiving proportionately less than white clients and elderly female carers less than elderly male carers. Irrational allocation of staff time, and skills, was also reported in a study of community mental health centre teams (Ref. 17). Referrals were ‘self-allocated’, often on the basis of staff interest rather than staff skills, making it difficult for user selection to reflect coherent priorities, or for users to receive services from the most appropriately qualified staff.

67. Client access to services should reflect district priorities targeting those in greatest need. Clients should only receive services which meet set care objectives, and they should be seen by the most appropriate grade of staff. The absence of effective caseload management prevents the realisation of these three objectives.

MANAGEMENT ARRANGEMENTS

68. Many of the difficulties can be traced to poor management arrangements – and in particular to poor information systems. Managers do not know whether they have a rich grade mix, or whether their staff are spending enough time with clients.

69. This lack of information is a particular problem for first line managers in community health who can be directly responsible for between twenty and sixty staff dispersed throughout the community. Not surprisingly, practitioners frequently report that they work not only out of sight but without supervision. They are not held to account, their work is not reviewed, and they are not adequately supported.

70. There are only limited data at the national level on the way that resources within CHS are used; and many districts are unable to provide quite simple information on provision. Few have an information system in place capable of producing the cost of an episode of care, and fewer still can estimate the quality or effectiveness of the services on offer.
71. The Körner reports encouraged the development of information systems in the mid '80s. However, although information is being collected, few managers, and even fewer clinicians, receive regular reports that are usable. When information is received, it is often in an indigestible or inconvenient form. Some receive thick wads of tabular printout. The information demands of districts, regions and the Department of Health or the Welsh Office, have left little time for information departments to examine how they might use data more selectively; and further thought is needed on how data might be presented more effectively to be more informative to local staff and management. As a result, information collection is often resented by staff who see it as a time consuming and worthless exercise. Districts that have been able to provide useful feedback to staff, though, reported that the accuracy of the basic data improved once the staff who collected it found the exercise meaningful.

QUALITY

72. Most of the Körner minimum data set required and collected by 'IT' systems centres on the level of activity – such as the number of face-to-face contacts – rather than the quality and outcome of that activity. 'Quality' and 'outcomes' have been much debated subjects in the NHS in recent years. But although some progress has been made on 'quality assurance', less has been made on the development of outcome measures.

73. As a result it is difficult to compare the efficiency of different units. Those with relatively few face-to-face contacts, and who therefore appear less efficient, may claim to be more effective producing higher quality work – an untestable assertion without measures of outcome and quality.

74. 'Clinical audit', 'management audit', 'user surveys', 'setting and monitoring standards' and 'measuring outcomes' are all now relatively familiar concepts. But they remain rare activities in the day-to-day running of community units. Few districts or provider-units have an explicit strategy that explains how quality is to be gauged or assured. Such initiatives as there are tend to operate in isolation and examples of good practice are often confined to hospitals. Without a clear plan of action, this piecemeal approach is likely to continue.

CONCLUSION

75. None of the above criticisms should be seen as detracting from the contribution which caring professionals make to the welfare of their clients. Community health services are characterised by high levels of dedication among their staff, many of whom work more than their contractual hours. But there are management difficulties at all levels of community health services which reduce the effectiveness of these individual contributions. Policy has been dictated by service patterns, rather than services adjusted to deliver policy. Services operate alongside, but not always in partnership with other community services. Management controls are poor and productivity appears to vary considerably. The development of quality assurance systems is patchy.

76. The rest of this report explores how such difficulties can be, and in some places are being tackled. Practical steps are suggested which can help position community health services to meet the changing health needs of this decade and beyond.
2. Meeting the Challenge

77. The picture which emerges from Chapter 1 is of an under-managed service. The community health services have, for too long, been the ‘Cinderella’ of the NHS, seen as a separate and rather unimportant part. But many authorities are changing the traditional pattern and introducing new ways of working.

ESTABLISHING POLICY FOR COMMUNITY HEALTH SERVICES

78. Under the NHS and Community Care Act 1990, district health authorities and community health providers must first develop and then work to a clear vision founded on the values of the DHA, informed by both local needs and the resources available. Close relationships must be developed with FHSAs and SSDs. The district must strike an appropriate resource balance between hospital and community, and between prevention and treatment. In future, community health services should be seen as part of a continuum for fulfilling health policies rather than a separate, neglected service. The provider must have a clear indication of the services required to meet future needs. The vision should therefore be translated into commissioning strategies for DHAs and business plans for provider units. Most importantly, it must become apparent to those clients who receive services. Health authorities throughout the country are working hard on such strategies and plans.

LEADERSHIP AND COMMITMENT

79. Any vision and strategy for developing community health must be underpinned by strong leadership and long term commitment if it is to succeed. Increasing demands on the NHS – particularly on hospital services – will provide more than enough competing pressures to stall community health development plans unless positive steps are taken.

80. Individuals must be identified at all levels of the NHS with sufficient authority and ability to tackle the development of community health services – not easy at a time when competition for good managers is increasingly fierce. ‘Champions for community health’, a rare resource at the best of times, must now be given greater encouragement. Conditions which stimulate their development and status must be engineered, by, for example, giving preference to managers who have experience of both hospital and community. Existing managers without community experience must be encouraged to develop their knowledge by leading reviews on community health services or by accepting placements in management positions with CHS units. Finally, community general managers should be paid on a par with their hospital counterparts; as long as salaries are based mainly on budget size, community unit posts will remain less attractive.

FOCUSING ON NEED AND SETTING GOALS

81. Changing needs and changing consumer expectations present particular problems for community health services. In common with the rest of the NHS and other service sectors,
assessment of needs and subsequent development of services to meet them have traditionally been led by the professions most involved in service provision.

82. The introduction of the commissioning rôle within district health authorities is partly aimed at strengthening the objectivity of that process. However, it is the providers who are in continuous contact with the actual, if not all the potential, users of health services and as such have considerable knowledge of needs. Commissioners cannot afford to let an 'arm's length' relationship with providers place this valuable source of information out of their reach. Similarly, it will be in the continuing interest of providers to keep in close contact with commissioners so that they can anticipate and prepare for any forthcoming changes.

83. As well as being in close contact with clients, the professionals working in provider units are also likely to be more in touch with advances in care practice. As such they are clearly in a good position to develop new and more cost effective provision. Commissioners should encourage and facilitate such developments. As well as developing a 'purchaser/provider split', commissioners and providers must develop a close working relationship.

84. Commissioners must nonetheless retain an independence strengthened by close links with the public on whose behalf they act. At a district level this remains a difficult task. DHAs have to find ways of constructing a full service specification from a mixture of epidemiological, social, cultural and demographic information as well as the preferences and perceived needs of users and carers in the local population. Informed providers will continue to exert a strong influence. And the actions of local and family health services authorities, GP fundholders and the voluntary sector must be taken into account.

85. DHAs have not yet had time to make all the necessary changes. Nonetheless, many are moving forward in a variety of ways to ensure that they are commissioning the right services. Some, such as Halton, have commissioned surveys to assess the level of un-met need in the district. A similar exercise was undertaken in Chester but commissioned by the main service provider, Chester and Halton Community NHS Trust, in partnership with the DHA. The information is to help both the provider in business planning and the commissioner in its assessment of needs.

86. Stockport DHA is developing a 'localised' approach to service commissioning. Budgets will be allocated to recognisable localities, and decisions on how these are to be spent will be made locally by a group of DHA officers and community representatives, who hopefully are more in touch with local needs.

87. Service development groups can be set up by commissioners and providers working together with the aim of improving the match between need and provision. This is done by bringing together groups of users of particular services and testing with them how well current provision is tailored to their requirements. Services can be altered and then reassessed later to see if they provide an improved fit.

88. South East Thames Regional Health Authority reviewed its 10 year old mental handicap policy in 1988 by inviting people with learning disabilities, carers, front-line staff and service managers to a series of one-day workshops at the regional conference centre. Small groups were formed and participants were assisted and encouraged to comment on their needs, aspirations and perceptions of the services they either received or delivered.
89. RHAs have a key rôle to play in developing community health services. With both DHAs and FHSAs reporting to them, they are in a good position to expect and disseminate good practice through both the review and planning systems, facilitating discussions between authorities and between providers. This approach could be extended to the development of a health intelligence function providing information to commissioning authorities including new developments in care and management, reviews of current practice, and cost and effectiveness comparisons with other districts. Yorkshire RHA has appointed a DGM to lead the development of primary health care. Activities include a series of workshops which bring together key players from all agencies and involving GPs. Local initiatives and experimentation are encouraged and assisted.

WORKING WITH OTHER AGENCIES
TAKING A WIDER PERSPECTIVE

90. When allocating resources for community health services, it is important that they are seen as a part of the whole of health and social care provision (Case Study 1).

<table>
<thead>
<tr>
<th>Case Study 1</th>
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<tbody>
<tr>
<td><strong>VISION AND SERVICE IN SOUTHERN DERBYSHIRE:</strong></td>
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<tr>
<td>Community health resources should be seen as a part of the whole of health and social care provision.</td>
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<tr>
<td>Services in Southern Derbyshire aim to dovetail into and enhance related provision.</td>
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<tr>
<td><strong>HOSPITALS</strong></td>
</tr>
<tr>
<td>• An expanding range of 'hospital at home' services offers more choice to users and facilitates earlier discharge.</td>
</tr>
<tr>
<td>• 'Waiting list money' has been used to 'pump prime' the service by offering early discharges for patients with a fractured neck of femur ~ speeding throughput and improving rehabilitation.</td>
</tr>
<tr>
<td>• Patients to be discharged needing complex care arrangements are identified and allocated a care manager to ensure their services are co-ordinated efficiently.</td>
</tr>
<tr>
<td><strong>FAMILY HEALTH SERVICES AUTHORITIES</strong></td>
</tr>
<tr>
<td>• In response to increased resources at GP surgeries with more practice nurses, the CHS now concentrates on those who cannot leave home ~ particularly frail or confused elderly people.</td>
</tr>
<tr>
<td><strong>SOCIAL SERVICES</strong></td>
</tr>
<tr>
<td>• To co-ordinate care with social services an 'Elderly Persons Integrated Care Scheme' (EPICS) has been set up effectively combining health and social care resources.</td>
</tr>
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91. Better quality care, wider choice, improved clinical outcomes and improved cost effectiveness can all be achieved by careful positioning of resources. By taking a wider perspective of where funds might be placed, greater potential can be realised. As well as keeping people out
of expensive in-patient beds, community support can lead to earlier discharges and more effective rehabilitation (Case study 2).

**Case Study 2**

**QUALITY, CHOICE AND EFFECTIVENESS THROUGH COMMUNITY SERVICES**

Community support can keep people out of expensive in-patient beds...

Offering wider choice and quality, West Glamorgan Social service department's 'Staying at Home' project has a direct impact on both hospital and residential services by supporting elderly people in a variety of ways to stay in their own homes.

- 50 people, who would otherwise be admitted for institutional care, receive intensive domiciliary care.

- Day to day co-ordination is provided through 'care diaries' updated by all staff and held at the client's house. Each has a care programme regularly reviewed to keep abreast of changing needs. Reviews take place with the clients in their home to emphasise that the service is built around their needs and that they are in control.

- A sophisticated 'Lifeline' alarm scheme keeps 5000 people in 24 hour touch with services. Basic information is stored on each user both assisting responses and providing needs data for service planning. The system is also triggered by smoke detectors.

- Health Visitors, based in social service area offices, undertake a preventative screening programme to identify people 'at risk' and co-ordinate care with health services. Social services respond to health visitor requests for the installation of alarms without further assessment. Assessment procedures are common and agreed across agencies.

- Age Concern are funded to develop complementary schemes. They run a 'Lifeline' friend programme to help clients make full use of their alarms, a 'Cold-line' providing advice and practical assistance through the winter months, and a broader information and advice service.

- Extra funds are available to provide a higher number of adaptations to houses. A development fund allows for the purchase of smaller items that assist home living such as microwave ovens.

...and promote more effective rehabilitation.

A research project at Northwick Park hospital provided a group of elderly in-patients in all specialties with limited but targeted interventions from a team of advisors, without specialist qualifications, employed by the social services department (Ref. 19). Their rôle was to check that practical arrangements were in place prior to discharge and to encourage the patients back at home to regain their (temporarily) lost independence. Patients received a maximum involvement of only 12 hours in total but were half as likely to be re-admitted during the 18 months after discharge as the control group. Furthermore, those who did require a further in-patient stay were far less likely to be re-admitted on an emergency basis. This scheme not only produced obvious health gain but did so at considerably reduced cost.
NEW JOINT PLANNING INITIATIVES

92. Whilst few would dispute the importance of effective inter-agency collaboration, past exhortations to 'work together' have only produced gains under the most favourable of conditions. However, the NHS and Community Care Act together with the recent papers on community nursing, FHSAs, and integrating primary and secondary care from the 'centre', have all contributed to an air of opportunity for better joint working (Ref. 20,21,22). This opportunity has been further helped by the enhanced rôle of FHSAs – especially the creation of a general management function. By giving top managers more ability to follow through on policy decisions, policy development becomes a more fruitful exercise.

93. DGMs should not approach collaboration in a piece-meal fashion, but address it as a topic in its own right and develop a strategy dedicated to its achievement (Exhibit 20). Critical areas should be identified by calculating the costs of collaborative failure and the gains of success in areas of joint concern. Obstacles – whether geographical, political, economic, structural or professional – must also be identified, so a way forward can be planned. Such a strategy should aim to optimise the local balance of care, clarify respective rôles and responsibilities, share vision, and progress areas of opportunity which would benefit from a corporate approach.

Exhibit 20
A STRATEGY FOR COLLABORATION
DGMs should develop a strategy for collaboration

94. The agenda for joint working is enormous and it is essential that priorities are defined. These should be a sub-set of the existing district priorities. Having identified the topics, decisions can then be made on how they are to be tackled (Case Study 3, overleaf).
Case Study 3

CHOOSING PRIORITIES AND DEVELOPING AN EFFECTIVE APPROACH

Having identified the topics, decisions can then be made on how they are to be tackled.

Oxfordshire DHA identified six priority areas for needs-assessment for 1991-2: accidents, anxiety and depression, cancer, coronary heart disease, elective surgery, and long term disablement. Each topic was considered across all age groups, types of activity and aspects of care, including prevention, primary and secondary care, health and social care boundaries and health promotion. The projects were undertaken in three phases, the first being an information gathering exercise, in which epidemiology was considered in the light of local information, and a background paper prepared. A multi-disciplinary/agency group was assembled for the second stage; current services were examined against identified needs and improvements were recommended. Recommendations, both long and short term, are being implemented in the third and final phase.

95. Some districts and their partners have decided to merge functions, premises and posts wherever possible to promote joint working. A single director of planning has been appointed by Cornwall and Isles of Scilly DHA and FHSA who will be preparing a single health plan for the county. Barking, Havering and Brentwood DHA and Barking and Havering FHSA are running a 'Unified Commissioning Project' which aims to produce a single commissioning plan for primary and community care services by April 1992.

96. Another way of improving the co-ordination of care is through shared information. Using parent- or patient-held records, such as the co-operation cards long used in maternity services, is one simple and effective method. In the future, districts should develop patient-based information systems and aim to do so on a joint basis. Problems caused by information sharing, such as potential breaches in confidentiality, are surmountable where co-operative working relationships are fostered between agencies and professionals. Systems which permit each agency common access to limited but essential information on clients and their respective involvement are being developed in both England and Wales although they are not ready for use yet. Information sharing is further improved by common assessment procedures agreed between DHAs, FHSAs and SSDs.

97. In some areas, the difficulties inherent in joint working have been overcome by a clear vision of the services required supported by the commitment of managers and members. In particular there have been notable successes in the fields of mental health and learning disabilities, where concepts such as 'normalisation' have been understood, accepted and adopted for the creation of new patterns of service. In Somerset, a clear joint vision on mental health and learning disabilities has been translated into continuing service improvements for users. The respective strategies enjoy the consistent support of members and top management from the DHA and local authority. Where responsibilities are planned to shift towards the SSD, resources have been identified and secured to follow. Officers are therefore able to develop and progress plans in a financially 'secure' environment.
98. Lessons from good joint working indicate the importance of gaining the support of leaders towards a shared and understood set of goals. Further gains are made when resources are earmarked and protected. By creating more and bigger 'resource pools', the negative effects of a separate funding system are diminished. Some areas are considering such a strategy so as to avoid the complexities in dividing health and social care, especially in services for elderly people.

99. Financial mechanisms could be developed to enable gross savings made through effective joint working to be spread between agencies, rather than to benefit one while increasing the cost for another. This would enable the development of an expanding joint pool providing an incentive for joint 'value for money' initiatives. However, where initiatives produce direct improvements for the user rather than a release of funds, there is no such financial incentive. In such cases, new incentives are required.

100. Steps like these will take authorities a long way towards a more integrated approach to community care. But co-ordination between the three key agencies could be dramatically simplified by one further step – reducing them to two by combining health authorities. Current Department of Health and Welsh Office policy aims to promote closer working amongst commissioning agencies. Pilot projects are being set up that will test out some of the recommendations made above. The merger of DHAs and FHSAs has been put forward as a long term possibility:

'Larger Districts might eventually become candidates for mergers with Family Practitioner Committees'. (Working for Patients, January 1989).

Taking that step will require a great deal of care and considerable planning. Safeguards to prevent the domination of provision by acute hospitals will need to be devised, for example. But the unification of the health service, through the creation of a single commissioning authority, is the next logical move, and the sooner a decision is made, the earlier work can start.

CO-ORDINATING OPERATIONAL ARRANGEMENTS

101. Since the organisational arrangements for providing health and social care are far from straightforward, it is hardly surprising that restructuring is a widely discussed solution. Unfortunately the debate is often distorted by personal or professional interest. And with no evidence that any one structure is better than another, discussions are difficult to progress. But developing the new commissioning arrangements would seem to offer fresh opportunities for co-ordinating care and for ensuring that services relate more closely to needs (Exhibit 21, overleaf) without the need to resort to restructuring.

102. In most cases, organising care is a straightforward matter of referring to the relevant professional and booking an appointment. The appropriate way to purchase these general services is through monitored block contracts with provider units left to the details of arranging care. Contracts for entire client groups can be agreed with single agencies. For example, services for people with learning disabilities could be organised through social services, or physical disability services through a client-run 'centre for independent living'.
POSSIBLE COMMISSIONING ARRANGEMENTS
The new commissioning arrangements offer fresh opportunities for co-ordinating care and relating services more closely to needs.

103. For individual clients who require a complex or expensive package of services, districts should consider setting up a ‘care management’ function in conjunction with social services (Exhibit 22). Care managers would act as local agents for commissioning authorities brought in to assess individual needs and devise, purchase and monitor individually tailored care packages.

104. Where populations are sufficiently stable, attaching care managers to GP practice lists and primary health care teams would further improve liaison between agencies. Even greater effect could be gained if single care managers, holding budgets from health and local authorities, purchased both health and social care – an approach being developed in Cornwall and Bradford where the local SSD and DHA are planning to allocate budgets to care managers based in GP practices. Some individuals, such as people with learning disabilities or mental health problems, would need specialist care managers. In such cases the care managers would relate to much larger population bases and perhaps be attached to specialist teams.

105. Alternatively, funds could be delegated on an agency basis so one provider is able to commission services for individuals from others. Maternity services, for example, could be commissioned by the primary health care team. A keyworker, acting as an advocate and taking specialist advice as necessary, would ensure that post- and ante-natal care together with the type of delivery was best suited to the mother.
Whatever decisions are eventually taken, it is essential that an optimum overall balance of services is secured. This goal for collaboration can only be achieved when separate commissioning agencies act effectively as a single commissioner. As long as services are funded through discrete routes and controlled by separate bodies with different priorities and accountabilities, this goal is likely to be difficult to attain. Without the absolute commitment of leading members and managers from each authority it will not be achieved.

**CLARIFYING RÔLES**

107. Efficient day-to-day management of care across professional, unit and agency boundaries, should start from agreed roles and liaison procedures between staff. And these must
reflect strategic policy decisions on agency roles and responsibilities. Two critical areas are discharge planning and multi-disciplinary teamwork.

108. **Hospital discharge** guidance was issued by the Department of Health in February 1989. It required districts to review discharge procedures and monitor their effectiveness (reference 23). Early discharge planning – pre-admission in non-emergency cases – and the nomination of a single member of staff to co-ordinate discharge organisation were advised. In critical cases, this person must check to see that planned services have actually materialised. Procedures should be monitored so that breakdown can be identified and rectified. Ensuring families and patients receive adequate information on discharge arrangements and aftercare will require routine review. Revised discharge procedures should be clear and understood by all – including patients and carers (Case Study 4).

### Case Study 4

**A CLEAR DISCHARGE PROCEDURE**

Procedures must be clear and simple to understand so staff and clients know exactly what they have to do.

In Southern Derbyshire, patients discharged from hospital are divided into three categories:

1st) More able patients, with straightforward needs who have GPs with practice nurses, are issued with a yellow card giving details and timing of aftercare treatment required. It is their responsibility to arrange this care by contacting their GP surgery. For example, the type of patient in this category might require wound checks or suture removal.

2nd) Those who require a more detailed package of care receive a discharge pack which includes a copy of the letter sent to the district nursing service outlining the treatment received and what is required in the community. A district nurse is assigned to ensure that an appropriate package is assembled. It is this nurse’s responsibility to see that care is effective, properly co-ordinated across agencies and regularly reviewed.

3rd) The discharge team co-ordinating these procedures have a further category of patient who requires full hospital-at-home services. Here a care manager in the discharge team builds up a fully-costed care package in conjunction with patients, carers, GPs and others. An appropriate budget is then transferred to the community site for local management.

109. Resolving the deep problems that afflict **multi-disciplinary teams** is perhaps the greatest challenge. Any solution has to result in the liberation of skills and increased flexibility between professional roles. At the same time, it has to allow for proper accountability in these new activities to ensure that they effectively meet those needs identified and targeted.

110. Achieving success will require an arrangement between commissioners and provider teams that is simultaneously 'loose' and 'tight'. District health authority commissioners, in partnership with FHSAs and local authorities as appropriate, must set out ‘tight’ specifications for providers detailing the client-group to be served and the services to be provided. Providers should be allowed plenty of scope on how to best respond. In doing so, community units must decide how they are going to manage service development and service delivery. It is sensible that these two activities share a single focal point and community units should choose the optimum position for each service. This may mean delegating business planning and management to a team
level. Primary health and other care teams could produce simple business plans on a team basis that cover the spectrum of work to be provided. These should be more dynamic documents than the static and descriptive 'operational policies' that many teams work to. The aim of such an approach would be to improve team cohesion and rôle clarity, and to unlock professional skills and creativity. Plans should include possible changes in team composition and offer commissioners alternatives to existing provision. As well as setting out overall aims and objectives, it should describe the services to be provided 'in-house', the staff required and their respective contributions, and services to be provided through contracts managed with other providers. Separate agreements would be held with units employing staff seconded to the team. The wider freedom enjoyed by the team to respond to need should be matched by a more rigorous accountability to ensure contract compliance. As well as leading, co-ordinating and setting key values into a delegated planning system, community unit managers should sample caseloads, action taken and monitor overall workload to ensure that the commissioner's requirements are being met.

111. The primary health care team is usually the first point of contact between the public and the health service and a long term relationship often develops. Organising a wide range of care from here – such as maternity services mentioned above – should help improve the delivery of 'a seamless service' to users. The seeds of this approach have already been sown by the development of GP fundholding. But that does not preclude the approach being adopted by other community teams, whether focused on GP practice populations, neighbourhoods or specific client groups.

112. Some of the services provided 'in-house' can be managed through protocols that help clarify roles and responsibilities, and ensure that best practice in patient care is consistently followed. Developments in this field have covered conditions such as hypertension, diabetes and asthma as well as screening tasks such as the new patient health checks. The most advanced examples extend beyond the primary care team embracing hospital services – as reported in the recent Audit Commission report 'Lying in Wait' (Case Study 5).

### Case Study 5

**A PROTOCOL FOR MANAGING ASTHMA**

Protocols help ensure best practice is consistently followed.

A Buckinghamshire GP has developed a computer-based protocol which guides the care of patients with asthma. It has been agreed with the consultant at the district general hospital and takes GPs, practice nurses and district nurses through each person's care. At each step the practitioner is required to undertake certain procedures and is informed of their next action. Under certain circumstances this means referring on to others. Relevant tests are automatically ordered so that the next practitioner has the results ready when the patient arrives.

Early successes have led to the development of a programme that helps GPs to produce new protocols on their computer systems. Over 200 GPs are now using this and a library of protocols is being established by enthusiasts.
113. Leadership is vital. At the very least, one person should have responsibility for co-ordinating the plan and acting as the point of contact with other providers and commissioners.

**MANAGING THE TEAM: IMPROVING PRODUCTIVITY**

114. There is no doubt that demand for community health services is growing, especially from elderly people. To help meet that growing demand, resources will have to be managed more effectively with value for money sought at every level.

**GETTING THE RIGHT MIX**

115. The first step is to ensure the right mix of staff, so that relatively expensive and scarce skills are properly used. Decisions are best made when drawing up individual care packages. The practitioners or care managers responsible must ensure that the most cost effective care packages are planned to meet client needs. They can be assisted by clear guidance from their managers on the competencies expected from each grade. This does not automatically mean that all basic tasks have to be carried out by lower graded staff. It could be more cost effective (and more satisfactory for the patient) to deploy a highly qualified nurse, for example, to carry out a range of basic tasks together with a single complex procedure, rather than two staff on two separate occasions. Unqualified staff can also have their skills boosted with training and by using protocols for example. An examination of work to be undertaken and grades required should be made; and future information systems should indicate the service actually delivered to each client to provide an ongoing review. New skills will be required if community health services are to offer an alternative to some in-patient services and these should also be taken into account. Most importantly, the successful implementation of a skill mix review will depend to a large extent on the manner in which it is undertaken – achieving the best conclusion means involving those staff whose work is being examined.

116. More generally, providers must ensure that there are sufficient qualified people who, with sensible spans of control and good information support, are able to manage the workforce effectively. Altering the grade mix must not leave the service undermanaged. If extra funds are needed to boost management, they may be released by increasing the proportion of less qualified staff.

117. Where complex or costly packages require a care management approach, commissioning authorities are directly involved. But the organisation of care for the bulk of clients is the day to day business of provider units. The role of commissioning authorities in this instance is to be specific in contracts on quality, rather than on staff, unless a certain grade or type of staff is required to undertake a particular task. Contracts could stipulate, for example, that where clients need footcare, they must be assessed by a State Registered chiropodist. Decisions about subsequent work being undertaken by either a qualified chiropodist or a footcare assistant should then be a matter for the assessor and provider unit – provided that minimum quality standards are met.

118. Since the opportunity cost of a rich grade or skill mix can be considerable, commissioners should compare the costs of care with other districts and encourage providers to justify their current allocation of resources. As mentioned, RHAs, together with the Department of Health and Welsh Office, could help here by co-ordinating the standardisation of care costs so that meaningful comparisons can be made between providers.
FREEING STAFF TIME

119. Home visiting is a much valued aspect of community services, but it is costly in terms of human resources, so effective targeting is important (Case Study 6). For many it is the only option. For some, such as people with mental health problems, it may be the best care option in therapeutic terms. And for those living in areas poorly served by affordable public transport, alternatives may prove too costly. Districts should analyse all clients who receive domiciliary services to ensure that those able to attend GP surgeries or health centre clinics, with the exception of those mentioned above, do so. By reducing staff travelling, and the need for individual sterile supplies packs on occasions, treating people in clinics can be far cheaper than in the home. Furthermore, services can be delivered in better-equipped surroundings; and attendance at a clinic, following a series of home treatments, is seen by many practitioners as therapeutically beneficial. Many clinics will have to improve if they are to become worthy replacements for the personal services enjoyed by many at home. But by using clinics wherever possible, the home visiting service can be concentrated on those who need it most.

Case Study 6

EXTENDING SERVICES BY USING CLINICS

Home visiting is costly so effective targeting is important.

With a waiting list of 450 patients, Bassetlaw DHA reviewed its chiropody service and revealed that 15 per cent of its clients were receiving expensive domiciliary visits. Appointments to local clinics were offered to this group and 75 per cent of them were able to receive treatment in a clinic instead. As a result, chiropody services were offered to a further 300 clients reducing the waiting list by two thirds (reference 24).

A similar exercise in Oxfordshire DHA showed that a clinic treatment cost half as much as a domiciliary visit and treatment in a mobile clinic was three quarters of the cost.

120. Reviews should take into account the increased level of activity performed within GP surgeries especially by practice nurses. This is likely to entail regular collection of activity and client information within GP practices so that accurate analysis can be made. Co-ordination of effort here may well result in districts targeting clients who are unable to attend GP clinics.

121. Clearly care must be taken to ensure that increasing the use of clinics does not reduce access to services and assessments of mobility should be undertaken when this is a possibility. Attendance levels and numbers of 'no access visits' can be used by staff as indicators when considering the suitability of each client for either a clinic or home appointment.

122. Some districts have shown that imaginative use of equipment and technology can have a great effect in both reducing the need for home visits and increasing client independence. Telephone calls are made to reduce the number of routine check-up visits for selected clients. Community midwives are also using telecommunication equipment to monitor foetal distress in clients' homes. Pressure relieving aids, showers and other aids and adaptations can have a dramatic impact on a client's independence.

123. The supply of aids and adaptations can best be co-ordinated with districts and local authorities jointly commissioning a single provider – possibly with its own assessment team.
Quality and speed of performance would be assessed by clients and community staff and reported back to both commissioners for action. Alternatively, a care manager, with budgets that can buy from both sides of the 'capital/revenue divide', could expedite this often tedious process. Services would be purchased or hired directly from a range of suppliers assessed for quality in terms of user satisfaction, turnaround time and after-sales service.

124. It is not only large pieces of equipment and building alterations that play a major rôle in the delivery of care. Community pharmacists can give advice on a number of products which assist individuals in self-medication, avoiding the need for a home visit or continuation of an inpatient stay. Examples include dispensers which accurately apply a given quantity of eye ointment, or bubble packs custom-made to suit an individual's medication regimen.

MANAGING CASELOADS

125. The point of service delivery should be the focus for improvements in management capability. Not only should first line management be developed, but the concepts and techniques of management should be extended to all practitioners. They must develop 'self management' skills and be able to demonstrate to supervisors that the continuous judgements they make when allocating personal resources are made with an eye to maximising their overall impact in meeting need. Caseloads should be managed and the responsibility must rest with the individual practitioner with supervisors ensuring that this happens in an appropriate fashion. This will require good information and supervision – particularly for those who are inexperienced caseload managers.

IMPROVING MANAGEMENT ARRANGEMENTS

126. Improved management capability at the front line can be further enhanced by devolving budgets and authority. Only when clinicians and their managers are aware of the costs of care can they make better decisions on its organisation. But senior managers and commissioners must be sure that the benefits of delegating such control are realised and that the objectives of maintaining quality, appropriateness, and value in the delivery of care are met.

127. This all requires the efficient use of information systems which meet the needs of managers at every level, and support a process of accountability that is far from adequate at the moment. Provider units should review their current systems critically to see how well they meet the objectives of improving care. There may be no need for expensive new systems. Instead there should be more effective use of existing software and hardware wherever possible.

128. Managers should receive reports from activity, financial and personnel systems that are timely, 'user friendly' and, above all, informative. Clinicians should receive information on their caseloads and other clinical activities which allows comparisons with their peers.

129. Most importantly, managers need to allocate more time to seeing individual staff to appraise the quality and quantity of their contributions to care. It is at this point of contact that information translates into action. Without such contact, there is no management. Information systems must point out individuals who are going adrift and form the starting point of a dialogue about their work. Case load management in particular requires this oversight. In simple and regular 'one-to-one' meetings, staff should be supported, have development needs identified and have

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their efforts endorsed and rewarded. Meetings should be at regular intervals with the frequency varying from person to person, depending on experience in their rôle and their current performance. But all staff should be seen at least twice a year. User feedback, how time has been apportioned and how caseloads have been managed are three key agenda items.

ASSURING QUALITY

130. The main objective of community services must be to deliver the best quality care to the right users as effectively and efficiently as possible within the resources available. If DHAs and their provider units have a clear vision of what they are trying to deliver for their clients and how they are to do it, then they have made a good start to providing high quality outcomes. But good management cannot in itself produce quality, which has to come from clinical expertise and from the clinicians themselves. To ensure this, 'quality', like 'collaboration', warrants a strategy of its own encompassing the full spectrum of community health services. Measures to assure quality should be agreed by both commissioners and providers and reflected in contracts. The starting point must be clinical audit – both internal and external – and the evaluation of users' and carers' perceptions (Exhibit 23).

Exhibit 23
USING FEEDBACK TO IMPROVE SERVICES
The starting points must be clinical audit and users' and carers' perceptions.
CLINICAL AUDIT

131. There has been much encouraging work already on clinical audit, with increasing numbers of districts using peer review systems such as District Nurse and Health Visitor ‘Monitor’. Such systems cannot give a full picture of how well services are delivered, but they nonetheless produce valuable insights into clinical performance whilst creating an incentive to maintain high standards.

132. The process could be strengthened by combining ‘internal peers’ with ‘external peers’, perhaps organised on an exchange basis. Mixed teams could report to both commissioner and providers, improving the objectivity of the review whilst retaining the knowledge gained from acting as an inspector of others’ performance. Audit should also be considered on a team basis to measure overall team performance rather than disconnected, individual professional activities.

USERS’ AND CARERS’ PERCEPTIONS

133. One essential view on the delivery of care must come from the recipients of healthcare themselves. And user satisfaction should extend beyond clinical outcome to encompass the total experience of care.

134. Testing users’ views requires a sensitive approach. The users of community services are often isolated and highly dependent on the support they receive and therefore reluctant to criticise it. Carers are also key in this process and again sensitivity is required as carers’ and users’ requirements may sometimes conflict – such as when carers need respite care that users do not want. It is also difficult for clients to know that they are getting substandard treatment when they are unaware of what they should expect. Collecting views will also elicit positive remarks and praise – equally important in both ensuring a balanced picture and providing extra motivation.

135. If commissioners and providers are to know that their community services are of a satisfactory standard from a user’s point of view, they have to take three actions:

i) agree clear standards that relate to specified aspects of service delivery and communicate these to each user;

ii) agree the objectives and programmes of care relating to particular clients with those clients; and

iii) provide and encourage the use of open communication channels through which users can voice their concerns both in confidence and with confidence.

136. Providers and commissioners should also sample views on particular service areas. This can be done on a routine and systematic basis or as a targeted and deeper analysis of an individual service. Some districts undertake routine enquiries, with supervisors questioning a selection of users over the telephone. Others have supervisors sharing caseloads with their staff so that they can get closer to clients and ensure they are getting what is required. A single-handed GP in Newcastle has issued satisfaction questionnaires to 200 patients every year since 1980. Proving an invaluable training aid, the information received has resulted in a number of service improvements. The survey, which currently covers the GP, practice nurse and receptionist, is to be widened to take in the district nurse and health visitor and provide a complete team perspective. A research project, run by
Newcastle University, is examining the approach extending it to a further five practices. Community health councils also provide useful feedback with some conducting detailed studies into specific areas of district performance.

137. Another source of information already exists in districts. The maintenance of a local complaints procedure is a statutory responsibility of the NHS. Although they are primarily designed as a last resort through which users may lodge grievances and seek recompense or corrective action, they also produce useful feedback on how services are viewed and where they can break down. A public service has a duty to make users aware of their rights and ought to take a positive attitude in encouraging complaints as a way of improving the service.

138. However, there is no point in eliciting feedback unless the service is prepared to act on it, and some districts clearly take complaints more seriously than others (Exhibit 24). A common reason cited for pursuing a complaint is that the complainant wishes to be sure that similar mistakes are not made in the future. This worthy goal cannot be achieved if the DHAs and providers do not actively follow up complaints and have the confidence to accept and learn from their mistakes. St Helens and Knowsley DHA operate an efficient complaints system and undertook service reviews of 30% of the complaints investigated over a three year period. Oxford DHA carried out reviews on 35%.

Exhibit 24
RESPONSE TO COMPLAINTS RESULTING IN A SERVICE REVIEW
Some districts take complaints more seriously than others.

Note: Analysis over 3 year period, 1988/90
Source: Audit Commission survey

CREATING A LEARNING CULTURE

139. The latter point holds true for all feedback received. If any of these forms of internal and external audit are to provide useful starting points for service improvements, organisations have to be receptive to and appreciative of criticism. This requires a cultural shift for much of the NHS away from a defensive style and towards greater openness about performance. Supportive management must foster an approach which accepts the occurrence of errors but which is determined to reduce them. Such a change will present a considerable challenge at a time when
the public are increasingly prepared to resort to litigation, and when a greater openness with users makes them more aware of shortcomings.

140. The reflective and improving practitioner or manager can only operate in an environment that nourishes such an approach. Staff are unlikely to seek out areas for improvements in performance or elicit important but critical feedback from users, if the presentation of any weaknesses or failings puts them at risk.

141. Units that can learn from their mistakes are organisations that become better performers. As a result, they will become more confident. This confidence will help them to develop the openness between practitioners, managers and users required to gain sufficient insight of their performance to inform further improvement.

CONCLUSION

142. In summary, community health services and their commissioning authorities must develop a clear vision which sets out future roles in relation to changing needs and demands and to other local services. Other provision is best taken into account if this vision is developed and shared with FHSAs and SSDs. Effective collaborative arrangements must be developed at an operational level to ensure 'seamlessness'. Co-operation should aim to deliver an optimum balance of care provision to both populations and individuals in terms of effectiveness, appropriateness, value for money and quality. To develop, adapt, sustain and deliver such a vision whilst guaranteeing efficiency, effectiveness, and quality will require the commitment of first rate and well informed leaders, both in commissioning and providing services. Commissioning authorities should ensure that provider units have a clear strategy to assure quality, that services are organised to maximise productivity, and that management arrangements are organised to provide adequate supervision to a largely dispersed workforce.

143. These imperatives represent a considerable challenge for community health services and district health authorities. An agenda for change is required if they are to be tackled systematically. This agenda is the subject of the next chapter.
3. The Audit and Recommended Action

Addressing the issues set out in this report will require concerted action from a number of players if community health services are to develop appropriately. The more important recommendations and areas for action to emerge from the Commission analysis are:

DEPARTMENT OF HEALTH AND WELSH OFFICE
— Devise ways of making the ‘pooling’ of local resources more effective and extensive so that where agencies combine resources to improve the overall delivery of care, virement between agency budget heads is possible.
— Create effective incentives and sanctions to promote joint working so that interagency co-operation can no longer remain an optional extra.

REGIONAL HEALTH AUTHORITIES
— Disseminate good practice and facilitate developments through the review system. Promote the development of a health intelligence function that provides relevant information on local needs, demography, cost improvements, and advances in clinical practice.
— Co-ordinate the development of standardised information on costs to allow inter-provider comparisons.

DISTRICT HEALTH AUTHORITY COMMISSIONERS
— Take steps to improve co-operation between authorities. Take other agencies’ services into account when planning, sharing and agreeing vision, rôles and responsibilities. Pay particular attention to changes in responsibilities resulting from the NHS and Community Care Act. Develop a strategy for collaboration based on the need of the user for ‘seamless’ care. Secure the full support and commitment of authority members for building a collaborative approach.
— Develop a fresh vision and strategy for community health services in partnership with other agencies firmly based on the needs of the users. View community health services as an active component of an integrated health service rather than a separate element. Explore ways of improving overall cost effectiveness and quality by making more extensive use of community services.
— Ensure that future leaders are trained and experienced in both hospital and community settings.
— Involve users and their carers to improve the district’s need assessment, help secure wider support for any changes to the balance of services, and to make services purchased through block contracts more responsive to need.
— Maintain a constructive and open dialogue with providers to gain from their knowledge and experience and to give early warning of impending changes in service requirements.

— Consider alternative commissioning arrangements such as devolved commissioning to care managers, or to intermediaries acting on an agency basis such primary health care teams, social service departments and user groups.

— Align commissioning arrangements, sharing appointments, plans, premises and facilities, wherever appropriate.

— Develop care management in partnership with social service departments, basing populations on GP practice lists where geography and population stability make it feasible.

— Improve care co-ordination by agreeing common assessment procedures and by backing them up with shared, client-based information systems.

— Reach firm local agreements with SSDs about respective contributions to disability equipment services including the resource contribution from each authority.

— Challenge providers on issues such as grade mix and the use of clinics. Ask them to demonstrate the rationale behind their arrangements and the relative benefits to users. Stipulate requirements for certain grades or types of staff to undertake specific duties in contracts where it is important to ensure quality.

— Develop a strategy for quality assurance which tests the effectiveness of services and assesses how well they are received by users. Keep channels of communication open with both users and providers so problems can be addressed as they are identified. Check to see that providers are responding to feedback. Make sure that users are aware of clear standards of care wherever possible so they know when quality is insufficient.

— Undertake independent reviews in areas of concern, possibly carried out by community health councils. Create service development groups of users and carers to take improvements forward and ensure that the new services better match their needs.

PROVIDER UNITS

— Maintain a constructive dialogue with commissioners to both inform the commissioning process and to receive first hand information of future commissioning intentions.

— Adapt and improve services in the light of operational experience and knowledge of developments in clinical practice. Set out a clear future direction for services in business plans.

— Share client information across professional and agency boundaries, bearing in mind the need for confidentiality of patient records.

— Develop team business plans that reflect service agreements with commissioners. Use protocols wherever possible.

— Ensure that discharge procedures are clear and easily understood by all – including patients – by asking them. In critical cases, give one person responsibility for ensuring that all planned services have materialised – care managers for example.
— Review management arrangements giving priority to the needs of front-line supervisors. Make sure that they have regular one-to-one contact with staff so that caseloads are reviewed, training needs identified and staff are encouraged and supported.

— Develop a more managerial culture throughout the service promoting self-management amongst clinicians, devolving budgets and generally cultivating a greater degree of quality and cost-consciousness at all levels.

— Check that the skills and grades of staff match the duties performed and adjust so that the right staff mix is available for deployment. Provide guidance on the competencies expected of each grade and allow front line supervisors to decide which staff to use for a client's care.

— Examine workload to ensure that patients who can travel to GP surgeries or health centre clinics do so, encouraging mobility and releasing resources for patients for whom home visits are the only option. Make imaginative use of equipment and the latest techniques and technology.

— Review information systems to see if they are being fully used. Check to see if they are able to support increased self-management by clinicians of caseloads and personal activity, and the supervision of those activities.

— Make sure that future systems are client – rather than service – based, and are capable of producing the timely and useful information that is required.

— Develop a quality assurance strategy which allows DHAs ready access to relevant service information. Include clinical audit, feedback from users, and, most importantly, create an eagerness to respond to knowledge of performance. Demonstrate the action taken in response to feedback, such as complaints, to encourage the public to make further comments.

— Use some method of clinical audit in all service areas. Strengthen peer review systems by involving external peers, perhaps on an exchange basis, to gain a more detached perspective.

— Encourage the public to express their views. Seek them on a routine basis, either over the telephone, through questionnaires, or by managers 'sampling' their staffs' work. Take a sensitive approach to ensure that information offered is honest and comprehensive. Guarantee confidentiality where appropriate.

— Agree clear standards of care for each service with commissioners.

— Providers should agree individual objectives and programmes of care with service users so that they are clear about the service they can expect. Those standards that are relevant should also be communicated to the user.

— Investigate areas of poor performance and involve groups of users when re-designing services.

— Develop a 'learning culture' whereby criticism is encouraged and managers take a more supportive and constructive approach when areas of weakness are identified.

AUDITCOMMISSION

Over this year, the Commission's auditors will be reviewing community health services in each district health authority in England and Wales. An overview of the district will explore seven broad areas. Following this, some will be selected for more focused consideration. They are:
1. **Vision and Need** – is there a vision for the future, which takes account of the challenges and opportunities facing community health services, and which is shared with the local authority and FHSA? Is analysis of need being used to question historical resource patterns i.e. are effective services being targeted on areas of greatest need?

2. **Strategic planning between districts and local authorities** – to what extent are the health authority and local authority collaborating particularly in respect of the movement of people from long stay institutions and of preparations for the forthcoming changes in community care?

3. **Strategic planning with FHSAs** – are the health authority and FHSA collaborating to provide complementary services which avoid unnecessary duplication and which maximise health gain?

4. **Care co-ordination** – are health services for individuals co-ordinated in such a way as to allow more people with additional health care needs to be looked after in the community?

5. **Managing service delivery** – is the field workforce being adequately managed?

6. **Information systems** – are management decisions based upon useful management information?

7. **Quality assurance** – are quality systems continually improving the services delivered to clients?

These audits, together with this report, can help districts to identify and address problem areas. The result should be a local strategy for the development of community health services. This strategy should then translate into the commissioning plans of district health authorities, the business plans of providers units, and deliver the effective community services the public requires.
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8. Audit Commission, Developing Community Care for Adults with a Mental Handicap, 1989.


Appendix

DATA SOURCES

EXHIBIT 3
Health and Personal Social Statistics for England, 1991; and Health and Personal Social
Statistics for Wales, 1990. School nursing figure is for 1987/88 and excludes Wales.

EXHIBIT 7
Community health services expenditure has been taken from financial return FR13 for
1989/90. The Jarman underprivileged area score, which combines eight population factors into
a single measure, was supplied by Professor Brian Jarman of St Mary's Hospital, Paddington.
Health Services Indicators (DN23) provided the number of district nurses per 100,000 population
aged 75+.

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Somerset
Southern Derbyshire
St Helens and Knowlsey

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