Caring for People: Problems and Progress in Implementation

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Introduction

The U.K. government set out its policy for improving the management and delivery of community care services in the White Paper *Caring for People: Community Care in the Next Decade and Beyond*, published in 1989. These reforms were due to be fully implemented on 1st April 1993. This briefing paper reports on the introduction and implementation of these reforms. No attempt is made to draw parallels between our own system and that of the United Kingdom — indeed such parallels are difficult to draw, in that we are not comparing like with like.

What the two systems can be said to have in common, however, is that they are both grappling with new ways of delivering community services to the most needy members of society — the elderly, people with mental illnesses, people with learning difficulties and the very young — and often in the most challenging of circumstances. The U.K. system just launched will make a fascinating case study when it comes to a final determination of the future structure of community care in this country. We should be prepared to benefit from their experiences and to learn from their mistakes. This paper first sets out the background to the reforms and the considers some key issues and difficulties in their implementation before concluding on the general implications of the reforms.

Background

In the U.K., and indeed in this country, the meaning of the term 'community care' has evolved over the years. The principles of community care contained in U.K. policy statements in the immediate post-war period include:

- Ensuring that individuals remain integrated with their families, friends and neighbours;
- A social pattern of care in non-institutional settings and the provision of support in the home from a wide range of services;
- Preventive measures to ensure that family breakdown and admission to a residential institution does not occur.

In the U.K., about £6 billion is spent annually on providing long-term community care and domiciliary services. It has been derived up to now from three principal sources:

- Health Service funds (most of these tending to be eaten up by the large hospitals and primary care nursing services);
- local authority funds derived from the community charge or other local taxation, business rates and revenue support grant from central government;
social security benefits paid by the Department of Social Security (there were many benefits, for example housing benefit; attendance allowance; benefit for those receiving residential home care or nursing home care; and benefits to claimants allowing them to buy care in residential homes. In comparison, the allowance paid to individuals looked after at home by relatives was quite small, thus encouraging residential rather than domiciliary care).

By the 1970s, the belief that community based care is generally preferable was almost universally held, and the debate turned to the question of how care could best be provided in this context. While much has been written about the optimum provision of care in the community, this paper will concern itself mainly with the White Paper, *Caring for People* published in 1989.


**Report of Audit Commission**

The Audit Commission concluded that progress towards achieving the objectives of community care was slow and uneven across the U.K. Its authors identified five obstacles to account for this state of affairs:

- compartmentalised health and local government budgets which hampered the desired shift in resources from health to social services, and did not match the requirements of community care policies;
- the absence of bridging finance to meet the transitional costs involved in shifting from institutional to community care;
- the distorting effects of public funding of private residential care (estimated at around £1 billion per year and growing) which offered incentives for residential rather than domiciliary care;
- delays, difficulties and boundary problems caused by a fragmented organisational structure;
- the absence of staffing and training arrangements to ensure an appropriate supply of trained community-based staff and to ease the transfer of staff into the community.

The Audit Commission clearly believed that the overall level of government expenditure could provide acceptable levels of care to priority groups and that the problem was a misallocation rather than a shortfall of resources.

**Griffiths Review**

The findings of the Commission prompted the 1988 review of community care by Sir Roy Griffiths, who identified three key principles which should underpin community care policy:

- the effective targeting of resources;
more voice and choice for the consumer, so that those in need of help are taken seriously and can choose from a wide range of services;

- a suitable domestic environment so that, wherever possible, people can remain in their own homes.

Griffith's brief did not include an assessment of the overall adequacy of care funding, but he did propose that all community care resources held by the NHS and local authorities should be ring-fenced to avoid the misappropriation of funds from primary to secondary health care, or from social care to other local authority purposes.

The Griffiths proposals were subsequently endorsed by the U.K. government in Caring for People. Briefly, the key objectives of the White Paper are as follows:

1. To promote the development of domiciliary day and respite services to enable people to live in their own homes wherever feasible and sensible.

2. To ensure that service providers make practical support for carers a high priority.

3. To make proper assessment of need and good care management the cornerstone of high quality care

4. To promote the development of a flourishing independent sector alongside good quality public services

5. To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance

6. To secure better value for taxpayers' money by introducing a new funding structure for social care.

The White Paper presented a new concept of case management, whereby each person requiring care must be assessed, often by a multidisciplinary team, prior to the preparation of their individual care package. Clients' own views are to be taken into account, but they will no longer receive payment from the Social Security office. Instead the money is to be administered by the social services departments of local authorities. These will use means tests to establish the eligibility of clients and to provide a more sensitive and economical use of funds.

The doctrine of separating purchasing and providing is prominent in the White Paper. Social services departments are encouraged to give up their direct management of residential accommodation and to buy what they need from the independent sector. To ensure standards are maintained in this 'arm's length' arrangement, they must set up inspection and regulation systems along the lines of those used in relation to private nursing homes.

As the Audit Commission recommended, the White Paper allocates the key role to social services departments. These departments must now take on the prime responsibility for people living in the community and needing care, using health service staff in a specialist role. The problems of people discharged from longstay mental illness hospitals were acknowledged. A
new grant was introduced to enable social services departments to improve community services in advance of such people being discharged.

In short, then, the main changes introduced by the White Paper are:

- Clear responsibility is vested in local authorities;
- There is a clear purchaser/provider split;
- Necessary funding will transfer from social security to local authorities;
- Choice is a key element of any package of care;
- There are disincentives to the provision of residential care;
- All authorities are now required to have community care plans;
- Individual care plans must be in place;
- Care management is a necessary component;
- There are to be separately funded mental health grants.

The combination of values embodied in *Caring for People* made it acceptable to both the left and the right sides of the political divide. This was in sharp contrast to *Working for Patients* which was producing divisive and acrimonious debate at the time. The reasons for this can be seen in the inclusion of concepts of client empowerment and the demystification of professional roles, which made it attractive to the left. However, the promotion of the private sector, the notion of lower-cost solutions and the emphasis on informal care made it acceptable to the Right.*

**Timetable**
The reforms have been introduced in three phases:

In April 1991, local authority complaints procedures and inspection units were set up and the mental illness and drug and alcohol services specific grants were made available.

Since April 1992, community care plans have been published.

From April 1993, Department of Social Services funds are being transferred to local authorities; the new funding structure for people seeking public support for residential and nursing home care comes into effect, and local authorities become responsible for assessing the care needs of individuals and for arranging appropriate care, including residential and nursing home care.
Implementation

This section looks at the difficulties facing those charged with the implementation of the reforms of the White Paper. Like all policies, the U.K. community care initiatives will stand or fall on how successfully they are implemented. This paper will suggest that perfect implementation in any part of the public policy arena is an impossible dream. This is not to lend a note of pessimism to the discussion, rather to approach it in a spirit of realism.

A short article by Gunn (1978) sets out ten preconditions necessary to achieve perfect implementation. The argument is, of course, that all ten preconditions are unlikely to be satisfied simultaneously in the execution of any policy, leading to imperfect implementation. The preconditions are:

1. that circumstances external to the implementing agency do not impose crippling constraints;
2. that adequate time and sufficient resources are made available to the programme;
3. that not only are there no constraints in terms of overall resources but also that, at each stage in the implementation process, the required combination of resources is actually available;
4. that the policy to be implemented is based upon a valid theory of cause and effect;
5. that the relationship between cause and effect is direct and that there are few, if any, intervening links;
6. that there is a single implementing agency which need not depend upon other agencies for success or, if other agencies must be involved, that the dependency relationships are minimal in number and importance;
7. that there is complete understanding of, and agreement upon, the objectives to be achieved; and that these conditions persist throughout the implementation process;
8. that in moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant;
9. that there is perfect communication among, and co-ordination of, the various elements involved in the programme;
10. that those in authority can demand and obtain perfect obedience.

Gunn's list was devised with the purpose of providing advice to those at the top on how to minimise implementation difficulties. Reality being what it is, there are likely to be problems in all ten areas. However we will content ourselves with examining two points on his list—No. 2 and No. 6—to highlight the various pitfalls which faced Caring for People in the countdown to its implementation date of April 1993.
According to Gunn, *Perfect implementation demands that adequate time and sufficient resources are made available to the programme.* (Precondition 2)

Adequate Time?
There appears to be universal agreement that the timetable set for the implementation of the White Paper was very tight. In March 1992, a letter from Andrew Foster (then Deputy Chief Executive of the NHS Management Executive) to Regional General Managers set out a number of key tasks on which local authorities, working closely with health and other agencies, would need to concentrate in order to fulfil the requirements of the new community care legislation.

The tasks were:
- Agreeing the basis for required assessment systems for individuals.
- Clarifying and agreeing arrangements for continuing care for new clients in residential and nursing homes including arrangements for respite care.
- Ensuring the robustness and mutual acceptability of discharge arrangements.
- Clarifying roles of GPs and primary health care teams.
- Ensuring that adequate purchasing and charging arrangements were in place in respect of individuals who will be receiving residential or nursing home care.
- Ensuring that financial and other management systems can meet the new demands likely after 1 April 1993.
- Ensuring that staff are suitably trained, wherever appropriate on a joint basis.
- Informing the public of the arrangements made by the authority for assessment and the provision of care.

This was clearly an ambitious schedule, unlikely to be achieved without skimping on quality. It certainly could not be achieved in this country in such a short time span. The consensus view among those called upon to implement the programme in the U.K. was that adequate time was not made available. Health service managers, already reeling from the implementation of *Caring for Patients* and *The Health of the Nation*, were hurtled straight into the implementation of yet another set of fundamental changes.

Adequate Resources?
Were sufficient resources made available? When the White Paper was first published, the main criticism was the lack of convincing financial detail, and this did not seem to have changed at all prior to the implementation date.
The basic amounts involved, as finally announced by the Secretary of State last Autumn, are set out in this table.

**Table II**

<table>
<thead>
<tr>
<th>Year</th>
<th>DSS (£m)</th>
<th>Infrastructure Grant (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993-4</td>
<td>399</td>
<td>140</td>
</tr>
<tr>
<td>1994-5</td>
<td>651</td>
<td>not known</td>
</tr>
<tr>
<td>1995-6</td>
<td>518</td>
<td>not known</td>
</tr>
</tbody>
</table>

As can be seen from the table, there is a precise indication of the amount to be transferred from the social security budget for the next three years, but no clear indication of future 'infrastructure' funding beyond 1993–94. Together, these two elements of funding have been termed the 'special transitional grant', and in the short term it has been decided that they will be afforded a degree of ring-fenced protection which will be phased out in the fourth and final year of this arrangement.

A very important assumption in *Caring for People* is that there is a perverse incentive (created by the Residential Homes Act of 1984) which led to the inappropriate admission of large numbers of people to inpatient care. Under this act, Department of Social Security benefits could be used to fund nursing and residential care, but the same benefits could not be used to fund more flexible domiciliary support.

Between 1979 and 1986, the number of older people in private and voluntary homes in England and Wales more than doubled to almost 110,000. This level of provision costs the public purse over £1000 million - i.e one-fifth of total expenditure of social services for all client groups. Ever since the Audit Commission report of 1986 which compared the cost of domiciliary-based geriatric care (£135 per week) with NHS inpatient care (£295 per week), it has been widely assumed that community care is more economical and that costs can be reduced by extending this form of care to more people.

**Numbers Involved**

According to Hudson, disputes over the adequacy of funding have tended to focus upon whether the transferred amounts match the estimated numbers of elderly and disabled people likely to require assessment under the new arrangements. The Department of Health funding is based upon an estimate of 110,000 people coming forward for care in 1993–94 – an underestimate of 12,000, according to the local authority associations, which sought 1993–94 funding of £634m in social security transfers and £194m in start-up costs. On these figures, the shortfall amounts to £289m in 1993 alone.
A further serious cost consideration seems to be the refusal of the Department of Health to allow for the current shortfall between the actual cost of private residential and nursing home care and the fees payable by the Department of Social Security — an amount estimated to stand at £146m for 1993–94. Obviously, if the transfer of money to local authorities was not adequate, the new system will have begun in deficit, with inadequate resources to fund existing needs, not to mention the development of new services.

Hudson argues that the scale of the transfer leaves untouched the inadequate basis on which personal social services activity is generally funded. The first problem is the apparent official underestimate of current local need. Second, the Department of Health is increasingly equivocal about the long-standing estimate of an annual two per cent growth in demand for personal social services caused by demographic and other social pressures.

It seem therefore that adequate time and sufficient resources have not been made available to the programme of implementation. Since the success of the community care policies depends first and foremost on resources and commitment to resources, *Caring for People* is teetering on shaky ground.

According to Gunn, *Perfect implementation demands that there is a single implementing agency which need not depend upon other agencies for success or, if other agencies must be involved, that the dependency relationships are minimal in number and importance.*

(Precondition 6)

Need for Collaboration
It is clear that this can never be the case when it comes to implementing *Caring for People*. Instead of a single agency, there is a multi-agency approach to service development, including not just health and social services but also GPs. Local authorities are the designated lead agencies but successful implementation of *Caring for People* is very dependent upon effective collaboration amongst agencies. Dependency relationships are large in number and of enormous importance, and it is clear that the interdependence of the health and social care reforms increases the need for collaboration between health and local authorities.

The community care reforms do not remove the main existing responsibilities of social services departments, the N.H.S. and housing departments for the services they provide. The reforms will, however, mean that over time all these authorities will need to work together more closely and more effectively to create care packages that will enable people to continue to live independently in their own homes or in homely environments.

The difficulties in delineating health and social care are to be found at all interfaces of the services, not merely at the residential care/nursing home/hospital juncture. Demographic factors, such as the increased life expectancy of the elderly population, are important here. So too is the continued emphasis on preventing or deferring residential admission in favour of maintaining people in the community. This emphasis has generated almost a new client group, which is the province neither of health nor social care. This is the client group of borderline people, the partly sick and partly well, who are perceived as too sick for residential support but
not ill enough for hospital care. This hazy boundary and disputed no-man's land between health and social care is likely to be the Achilles' heel of the community care reforms.

How Should Agencies Collaborate?

Official and semi-official publications stress the importance of effective collaboration between health and social care agencies in the new community care world, but give little indication as to how this is to be achieved. Previous attempts have been acknowledged to be ineffective, yet the Department of Health seems unwilling to give a clear lead on future collaborative strategy. Local agencies are encouraged to distinguish between their own 'healthcare' and 'social care' activities, but there is no attempt centrally to define and distinguish terminology and activity.

In 1990 the House of Commons social services committee raised concerns about arrangements for collaboration between health and local authorities, both in terms of planning and service delivery. The committee underlined the lack of positive incentives to encourage effective collaboration. Indeed, the incentives operating were viewed as more likely to reinforce rigid demarcation of health and social care needs. It appears that the atmosphere on the ground is one of continued uncertainty, with both health and local authorities reluctant to make commitments which may prove extremely costly.

Recent experiences of health and local authority managers suggest that the ability of authorities to work together continues to be hampered by cultural difficulties which have practical consequences. In particular, the focus of health commissioning and contracting has been at macro level, while the social services emphasis has been very much on the development of services at the individual level, which has created confusion over language and priorities. It is argued that despite the universal recognition of the need for authorities to work together, the Department of Health has still not provided a framework within which true joint commissioning and the appropriate allocation of finances to meet the full range of client needs can occur.

There is no doubt that co-ordination of service delivery is hindered by separate management structures in the health and social services. Not only do these services have different political priorities, but the joint planning system often fails to make progress because of different styles of decision-making and accountability. Health service general managers now have more authority to implement decisions more quickly. Local authority staff have relatively little delegated responsibility and must often refer decisions to committees of members.

GP Involvement

Under the heading of 'working together', attention should also be given to the Family Health Service Authorities (FHSAs) which are responsible for the provision of general practitioner services, normally on a district basis. It looks increasingly likely that FHSAs will play a leading role in community care. Not only do they have a general duty to manage family practitioner services, they also monitor GP contracts, which now involve the screening of all patients over 75. There is growing recognition of the major role to be played by GPs through their primary care responsibilities and access to resources.

Extension of GP fundholding implies that GPs will be more likely to get involved in the commissioning of services, including commissioning for patients also in need of social care. There is potential for tension between the commissioning activities and preferences of social
service care managers and those of GPs, and a need for one-to-one contact to clarify expectations about what is wanted from joint or closer working.

Whatever type of co-ordination is attempted, the chances of success will be greater where health and local authority boundaries are co-terminous, which is not always the case. It does not seem however that health authority/FHSA co-terminosity will be a significant factor.

As decision makers become more aware of the consequences of *Caring for People*, it should become easier to ensure that the appropriate joint working groups are set up and develop a co-ordinated approach. A clear communication strategy will also be vital. If the various joint working groups are organised and motivated, it could be argued that the implementation process will drive itself. However, as there are many working groups with input into the *Caring for People* reforms, it is essential to have a joint community care steering group to oversee the implementation process.

Problems of collaboration and co-operative working may thus be the rock upon which *Caring for People* ultimately perishes. The potential for "multi-organisational sub-optimisation" is vast, and unless the problems are sorted out through concerted programmes of team-building and improved communications, the various agencies will remain unhappy bedfellows. The successful implementation of the reforms ultimately depends upon good inter-organisational relationships.

**Conclusion**

The successful implementation of the *Caring for People* reforms presents the NHS with arguably the greatest challenge it has ever faced. *Caring for People* has often been low on the NHS agenda, but, following April 1993, that is starting to change. After a period of viewing community care as an issue for social services in their capacity as lead agencies, the NHS is beginning to regard the reforms as having major implications for its future. The introduction of large purchasing consortia on the one hand and of locality purchasing on the other and the attempts to foster joint or unified commissioning between health authorities and FHSAs mean that the health services landscape continues to shift at an alarming rate.

The real questions arising from the emerging implementation difficulties must be directed at the long-term sustainability of the reforms. According to Hunter\(^\text{19}\), policy makers, managers and practitioners are already looking beyond the *Caring for People* changes and are developing alternative configurations for the effective delivery of community care. Key challenges centre around three main themes:

- The complexity and interconnectedness of the community care changes and the NHS reforms,
- the fragility of the new arrangements,
- the impressive amount of thinking and innovative practice around the country to develop new ways of meeting needs.
A recent discussion paper distributed by the NHS Management Executive takes as its thesis another set of themes which are also becoming more familiar - the existence of separate agency and service budgets, the current organisational fragmentation between agencies, and the desire for equity of service provision. These issues are seen to pose insurmountable obstacles which the reforms currently being implemented will not - indeed cannot - overcome. The authors of the discussion paper\(^1\) suggest that the infrastructure being developed to secure implementation of community care will prove defective and that obstacles will remain unresolved. A fundamental rethink is regarded as being unavoidable. Its outcome is likely to be a single organisational structure for all social, health and welfare needs and a more integrated approach to financing the necessary care to meet these needs.

Not surprisingly, many managers feel that with all the effort devoted to implementing the 1991 NHS reforms, there could not possibly be an even greater challenge to come. Unfortunately, however, it seems that whatever lies beyond 1993, stability and consolidation are unlikely to figure prominently in the vocabulary of community care.

**Lessons for Ireland**

Implementation of the reforms has only begun so comment on lessons for Ireland must be cautious. One point of convergence between the two countries is the complex series of reforms developing in both. The British reforms have been outlined in this paper. In Ireland, one can for example refer to:

- the proposed changes in public health following on the Hickey report;
- the recent changes in general practice organisation;
- the current legislative changes in relation to nursing homes.

The British experience points emphatically to a need for synchronisation of policies and approaches in relation to these various reforms; and to the provision of adequate time and resources for them.

Several of the key tasks outlined on pp 8–9 are also of relevance to Ireland. These include:

- ensuring that financial and other management systems are adequate to the tasks imposed on them;
- ensuring appropriate staff training;
- informing the public of new arrangements for the provision of care; and
- ensuring adequate collaboration between agencies and between GPs and other personnel.
References


