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Comment

Implementing *Caring for People?* Draft guidance circulars from the Department of Health

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Throughout the 1980s concern mounted over the provision of health and personal social services. As a result of inflation, an expansion in demand and technical advances, the increasingly expensive hospital services became more and more obviously threadbare, while the perceived failures of the community care movement were widely canvassed. As the decade ended the Government embarked on two bold initiatives aimed at increasing the efficiency, effectiveness and accountability of health and social care. These proposals, set out in the White Papers *Caring for People* (HMSO, 1989a) and *Working for Patients* (HMSO, 1989b), have now become law in the National Health Service and Community Care Act 1990. Another paper (pp. 641–645) somewhat critically reviews *Caring for People* from a psychiatric perspective (Holloway, 1990). At the heart of the 'reforms' is an attempt to create the conditions of a market. To achieve this a sharp distinction is to be drawn between the purchasers of care (Health Authorities, Local Social Services Authorities and Family Health Services Authorities) and service providers, with whom the purchasers will let contracts. It is envisaged that eventually a plethora of providers will compete within a "mixed economy of care", becoming ever more efficient.

Until recently Ministers were confident that full implementation would take place on 1 April 1991. Now, because of concerns over the impact of implementing *Caring for People* on local authority budgets (and Poll Tax charges), it appears that the community care proposals will be phased in over three years. This delay has been roundly condemned by pressure groups, social services directors and opposition politicians. However a more measured approach to the reform of community care may bring substantial benefits.

Both White Papers are examples of a policy-making process within which sweeping changes are ordained before their detailed implications have been thought through. Even commentators broadly favourable to the community care proposals have identified "flaws and oversimplifications inherent in the broad sweeps of [the Secretary of State's] brush" (Godber & Higgins, 1990). A series of implementation documents intended to clarify the proposals in *Caring for People* and provide detailed direction to local authorities have now been issued in draft form. They cover planning; assessment and case management; purchasing and contracting; inspection units; and complaints procedures.

The NHS and Community Care Act places on local authorities a responsibility to "prepare and publish a plan for the provision of community care services in their area" and consult with the relevant district health authorities, family health services authorities, local housing authorities and voluntary organisations. The draft guidance on planning repeatedly stresses the importance of working with health authorities in the development of community care plans, but refuses to be prescriptive about the planning machinery. This must in part reflect uncertainty within the Department of Health about the way planning will in future be conducted within the NHS. Local authority social services departments are expected "to develop planning agreements or joint plans" with DHAs and FHSAs "founded on the purchasing function which will be central to each of the authorities' roles". A "common approach to planning" and "shared principles" are expected, with agreement on "common goals ... focused on the general aim of supporting people at home wherever possible". Authorities are to reach agreement on the commissioning and funding of health and social care services, to develop policies on "key operational areas such as client access, assessment procedures, hospital discharge arrangements, case management and consultation with users and carers" and "where possible [agree] contract specifications for securing joint working between service providers". This represents a fairly substantial agenda, which must be applied across the whole range of community care client groups.

It would appear that these planning agreements are to be the bridge that will span the artificial health/social care divide introduced in *Caring for People*. Difficulties in developing planning agreements are primly acknowledged. The Regional Health

Authority and Social Services Inspectorate will, "using their experience from other areas", provide a conciliation service! The guidance sets out the scope and content of the Community Care Plans, which will be monitored by the Social Services Inspectorate. The SSI will provide "advice and guidance" as necessary. Ultimately the Secretary of State has the power to intervene and wield his stick. The carrot for joint planning is the rather mysterious mental illness specific grant, the "subject of separate guidance".

One important area to be dealt with in the Community Care Plans is the assessment of need and case management. Again the draft guidance on the topic stresses that ministers do not intend to be prescriptive. The assessment process is scarcely even sketched in, although it will be "in the round". It is, however, clear that the case manager will lie on the purchaser side of the great divide. The SSI is to issue a "practice guide" during 1991 based on development work currently under way. We must hope that the SSI is firing on all cylinders. At the moment the intended scope of the system of assessment and case management and its detailed functioning remains obscure, although undoubtedly the document is written with the need to divert elderly frail people away from expensive residential care firmly in mind.

Quite rightly the guidance emphasises the importance of the context within which assessment and case management take place. It will be particularly important that there are successful local planning agreements and agreements on collaborative working between the social services authority, which has statutory responsibility for assessment, and the plethora of other involved agencies. It is confidently stated that case management has its greatest impact when the processes involved (listed as identification of need, assessment, care planning, arrangements for service provision, monitoring and review) are carried out by single case managers who have a measure of control over a devolved budget. In fact evidence suggests that case management *per se* is no magical solution to the problems of community care for the mentally ill: what is required is "the collaboration and close personal involvement of well-trained professionals from various disciplines, and well-trained para-professionals" (Stein, 1990).

Hospital discharge procedures will "have to be reviewed locally in the light of the new responsibilities local authorities will have". Surprisingly it is stated that "no changes are being made in the procedures for admission to hospital". This will not in practice be true, since the total service system will, over time, be radically altered. For example we are told that "the patient should not leave hospital until a package of community care services has been agreed with the patient, their carers and all the authorities concerned". This injunction threatens to bring in-patient psychiatric care shuddering to a halt, and one fears that hospitals will become increasingly reluctant to accept patients who may prove difficult to discharge, particularly those who are homeless. Further guidance on discharge planning in psychiatric hospitals will be forthcoming. It is to be hoped that it will be drafted by people familiar with the realities of providing psychiatric services to deprived communities.

Three other draft guidance circulars set out arrangements for the setting up of arms-length inspection units to oversee residential care in the public, private and voluntary sectors, the implementation of complaints procedures and the purchasing and contracting of services. The "enabling" role of local authorities is emphasised, with the expectation that a number of high quality providers will emerge to offer choice in service provision. Advice is offered on managing the purchasing process, including the drafting of the service specifications, negotiating contracts and selecting service providers. This will become familiar ground to all health professionals as the 'contract culture' takes root, although we providers will find ourselves on the other side of the bargaining table.

Caring for People is far from perfect (Holloway, 1990). Key weaknesses (lack of ring-fencing, failure to address the specific needs of the mentally ill, the incomprehensible health/social care divide, lack of clarity over assessment and case management, ideological preoccupation with a mixed economy of care) are either not addressed or fudged by the draft implementation documents. Delay in implementing the proposals buys us all a little time. It is vital that this time is well used. Some of the more dubious propositions in the White Paper could be subjected to empirical evaluation. The Department of Health might take a long hard look at their ideas about assessment and case management, and perhaps do some critical reading of the literature on case management for the mentally ill. Psychiatrists need to articulate a clear and compelling model for the future of community mental illness services, and communicate this model to senior officers within health and social services. The price of failure is a retreat to the asylum.

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