

The NHS and Community Care Act, 1990

Recent government policy and legislation

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This is the first in a series of articles to be published serially in the *Psychiatric Bulletin* on recent government policy and legislation. Each article will describe a different piece of legislation and place it in its international perspective, highlighting how it will affect individual psychiatric practice, users of mental health services and the working relationship with purchasers and managers. The articles are aimed at all practising psychiatrists and those in training who wish to familiarise themselves with the important recent legislation that is having a profound effect on the practice of psychiatry in the UK. The legislation that will be covered includes the NHS and Community Care Act, *The Health of the Nation*, community care plans and mental illness specific grant, the care programme approach, discharge and aftercare planning procedures, NHS trusts, fundholding and commissioning general practitioners and the purchaser provider split. There will be a summarising article to reflect common themes and trends. The series was commissioned by Dr Sara Davies and Dr Jeanette Smith, Trainee Editors at the *Psychiatric Bulletin*.

The National Health Service and Community Care Act, 1990, enacts some provisions contained in the *Working for Patients* and *Caring for People* White Papers. The former measures were introduced immediately in 1990 and contain, for example, the legal basis for NHS trusts and fund-holding GPs. Most of the community care sections of the Act were delayed in their implementation until April 1993. The key element is allocating the main coordinating responsibility as 'lead agency' to local social service authorities; they are charged with conducting 'needs assessments' on clients presenting with problems. Whether, however, there is a legal obligation upon social services departments to provide care for people with unmet needs is not yet clear.

Enacted on 29 June 1990 the National Health Service and Community Care Act put on a statutory basis two sets of measures: first, many of the provisions of the *Working for Patients* White Paper, relating mainly to the hospital service and including the legislative framework for NHS trusts and for fund-holding general practices; second, and the theme for this paper, it contained many of the proposals of the *Caring for People* White Paper about how community care provisions should be restructured for the 1990s. The community care section was the culmination of a series of steps over the previous five years. In 1985 the House of Commons Social Services Select Committee, under the chairmanship of Renée Short (hence the 'Short Report' title) produced an authoritative review of community care provisions and made 101 recommendations, concluding with the message that

community care "cannot and should not be done on the cheap". Following this a rapid succession of reports (Audit Commission, 1986; Murphy, 1987; Murphy, 1988; Griffiths, 1988; Secretaries of State, 1989 & 1990) led to the current statutory framework (House of Commons, 1990).

In essence the NHS and Community Care Act requires local social service and health authorities jointly to agree community care plans which clearly indicate the local implementation of needs-based individual care plans for long-term, severe and vulnerable psychiatric patients. The principles of community care practice are: continuity of care, accessible services, staff-patient relationship, titrating support to need, facilitating independence, patient advocacy, and advocacy for services. In practice, at this stage these provisions apply to mental health services mainly in three respects: needs assessment, care management and residential care. It is important to note that although the hospital and GP elements of the Act were implemented immediately in 1990, most of the community care portions were delayed until April 1993.

This paper describes and comments upon the community care components of the Act, suggests how it may relate to the separate policy initiative for the care programme approach, and uses the example of care management to show how the intentions of the Act may conflict with some of its unintended and undesirable consequences.

The Select Committee on Community Care also recommended that "the Government give high

priority to encouraging and monitoring the developing use of keyworkers". Sir Roy Griffiths took up the idea, under a different name, in 1988 in specifying that "no person should be discharged without a clear package of care devised and without being the responsibility of a named care worker" (Griffiths, 1988). He further recommended the appointment of a Minister for Community Care and that the local authority social services department should become the "lead agency" for community care provision, as, he argued, the individuals requiring such care have primarily social rather than health needs. Since 1985 care planning has taken place explicitly within a mixed economy of services provided by statutory, voluntary and for-profit agencies.

Care and case management

The provisions of the 1990 National Health Service and Community Care Act aim to fulfil a number of important principles as noted above. The key objectives are: to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible; to ensure that service providers make practical support for carers a high priority; to make proper assessment of need and good case management the cornerstone of high quality care; to promote the development of a flourishing independent sector alongside good quality public services; to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance; and to secure better value for taxpayers' money by introducing a new funding structure for social care. The key protagonist to coordinate the various components is named the 'care manager'. The Act makes the following statutory requirements of case managers, "where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need to any such services, the authority (a) shall carry out an assessment of his needs for those services and (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services".

There is now great confusion on the distinction between case and care managers, and it is helpful to consider the roots of the two terms. On the foundations of what had been learned in the USA about the core tasks and stages of successful case management i.e. to identify patients (case finding), to assess needs, to design the care package, to co-ordinate service delivery, to monitor service delivery, to evaluate effectiveness of services, to modify the care package, and to repeat cycle unless services no longer needed,

the 1989 White Paper *Caring for People* took the implementation of these ideas further. "Where an individual's needs are complex or significant levels of resources are involved, the Government sees considerable merit in nominating a 'case manager' to take responsibility for ensuring that the individual's needs are regularly reviewed, and resources are managed effectively".

In 1991 'case management' was renamed 'care management' in a Department of Health and Social Services Inspectorate Guidance document, on the grounds that 'case' was regarded as demeaning to the individual, and misleading in that it is the care, and not the case, that is being managed. Care management was at this stage defined as "Any strategy for managing and co-ordinating and reviewing services for the individual client in a way that provides for continuity of care and accountability to both the client and the managing agency".

At that time, however, central guidance made it clear that the version of care management now officially sanctioned was one in which direct service provision was not included, and that a brokerage model was therefore being endorsed. This important change marked the introduction of the purchaser/provider division in social services department practice, with the care manager clearly identified as a purchaser but not a provider of services.

Needs assessment

At the local level, joint health and social services (called joint planning teams or joint community care planning groups) have been established whose functions include writing an annual community care plan and bidding for mental illness specific grants. In terms of implementing these JPTs were charged with the responsibility of arranging for 'assessment and care management' to be implemented in each Borough. The Act requires that people referred to social services departments must receive a 'needs assessment' to establish the nature, degree and urgency of their difficulties, and the types of service which should be provided, and this contains a number of stages (Table 1).

Where an assessment is necessary, the main community care needs assessment is undertaken using a form consisting of a series of headings covering all areas of potential need. These forms are accompanied by a checklist corresponding to these headings, which assessors can use to make a more detailed assessment in certain areas. This model allows the resulting completed form to more personally reflect the needs of a particular individual.

For a more detailed assessment, a specialist evaluation can be requested, to be completed within an agreed timescale, to contribute to the

Table 1. Stages of care management and assessment

Publishing information: making public the needs for which assistance is offered and the arrangements and resources for meeting those needs.
Determining the level of assessment: making an initial identification of need and matching the appropriate level of assessment to that need.
Assessing need: understanding individual needs, relating them to agency policies and priorities, and agreeing the objectives for intervention.
Care planning: negotiating the most appropriate ways of achieving the objectives identified by the assessment of need and incorporating them into an individual care plan.
Implementing the care plan: securing the necessary resources or services.
Monitoring: supporting and controlling the delivery of the care plan on a continuing basis.
Reviewing: reassessing needs and the service outcomes with a view to revising the care plan at specified intervals.

overall assessment of need. Throughout the process carers should be consulted and they also have access to an assessment in their own right where appropriate. Also there is a simple procedure for accessing an advocacy service, should a person being assessed feel that they would benefit from additional support. The overall care management model usually adopted is one of brokerage; however, in practice local variations of this model will allow social workers to continue to offer services through personal contact with patients/clients, where this is considered to be a useful part of the care plan. One model of the specialist assessment is the Camberwell Assessment of Need (CAN) recently developed by PRISM at the Institute of Psychiatry (Table 2).

Such a model of assessment and care management is used across all client groups, but within the mental health services there are a number of additional features, both legislative and professional, that need to be incorporated into any overall structure.

- (a) For mental health services there are a number of assessments which are performed under separate legislation and these will continue as at present, for example compulsory admission to hospital. Although they may not be part of the 1990 Act assessment procedures, if such an assessment results in admission to hospital the hospital discharge policies under the Act will nevertheless still apply.
- (b) Services for people with mental health problems after discharge from hospital need to be seen not only in the context of the 1990 Act but also in the light of Section 117 of the 1983 Mental Health Act and the care programme approach.
- (c) Mental health service access is often not directly through social services departments (unlike services such as those for the elderly), and therefore the bulk of the initial screening is likely to be undertaken by non local authority staff, with a high percentage needing more complex inter-

disciplinary assessments. These assessments may be undertaken by a variety of mental health professionals including social workers, psychiatrists, community psychiatric nurses, and psychologists.

Implications for residential care

One of the key motives behind the current legislative changes was to find a way of both limiting and rationalising expenditure on residential and nursing home care. The 1980s saw expenditure increase from £10m in 1979 to £1 billion by 1989 (Secretaries of State, 1989). This increase in expenditure was accompanied by a substantial rise in the level of private and voluntary sector residential and nursing home provision. Given population projections of a growth in the numbers of

Table 2. Problem areas covered by the Camberwell Assessment of Need

Accommodation
Occupation
Specific psychotic symptoms
Psychological distress
Information about condition and treatment
Non-prescribed drugs
Food and meals
Household skills
Self care and presentations
Safety to self
Safety to others
Money
Childcare
Physical health
Alcohol
Basic education
Company
Telephone
Public transport
Benefits
Sexual relations

elderly people likely to require health and social service support, this increasing cost looked set to continue without the major shift in government policy set out in *Caring for People*.

While this legislation was being drafted, attention was often drawn to the so-called 'perverse incentive' within the system, to support people in residential care rather than in their own homes (Griffiths, 1988). A clear intention of the changes was to enable care managers to buy domiciliary support, rather than residential care where this was both more appropriate and inexpensive. Research in Southwark, however, has suggested that only about 15% of recent referrals to residential care were inappropriate.

Implications for purchasers and providers

The legal changes implemented in April 1993 transferred funding responsibility for residential and nursing home care from the Department of Social Security to local authority social services departments over a phased period of four years. In so doing, these funds immediately became cash limited. Although there have been arguments about the adequacy of the levels of funding transferring to social services departments, it is already becoming clear that there may well be insufficient resources for some client groups. This is most marked in the case of drug and alcohol misuse residential care services, where there is high turnover of clients. This in turn has raised concerns about the viability of such services, and the difficulties which will be caused if many projects have to close while still caring for people. The operation of these arrangements during the first year will be a critical test of how well the care management can succeed, and particularly whether sufficient financial resources are available.

One of the most likely flash points will be as the new joint assessment and care management arrangements progressively become established. Indeed, two issues loom large in that, first, fund holding practices may find their need to buy community services a disincentive from pressing for early discharge, and second, patients in hospital, at no direct personal cost, may also avoid hasty discharge to residential or care homes for which they may face a means-tested charge. In order to minimise the likelihood of future problems, it is clear that further work will be required within hospitals to raise the importance of earlier and more thorough discharge planning, and for there to be inter-agency trouble-shooting arrangements in place should difficulties arise.

Social security budgets are transferred to local authorities according to a formula which discriminates against most inner city London authorities which have few existing private and voluntary providers within their boundaries. On

the other hand, the formula rewards authorities with large numbers of local independent providers and does not allocate resources to authorities from which residents originated. Therefore, Southwark, which exports 70% of those adults needing residential care, will not receive adequate funding to pay for future placements. This is compounded by the greater level of psychiatric morbidity in areas such as Southwark, and by a 11% reduction in NHS funding due to the introduction of a weighted capitation system of funding which is diverting money from inner South London to Kent and Sussex.

In the transfer of funds between clients groups, the Department of Health guidelines indicate that 85% of the social security element of the transfer should be spent on elderly residential care with a further 5% on day care. This clearly leaves the other adult groups starved of resources for residential placements and in Southwark it is therefore proposed to spend 80% of the transferred monies on services for the elderly. Of the remaining 20%, people with mental health problems will receive approximately 6% of the total transfer. This sum is clearly inadequate and despite rigorous prioritisation will lead to some patients/clients having to be supported in the community when their needs could more adequately be met in residential care, the reverse of the originally identified 'perverse incentive'.

The purchaser/provider divisions which have been established within both health and social services authorities occur at different levels. Within social services departments, purchasing work is much more orientated around the individual whereas within the NHS it is orientated around entire service systems. In so far as this affects care management arrangements, it is less critical where social services is the main purchaser of services, for example in the learning difficulties field. It is of much greater importance where the health authority is the main purchaser of community services, for example, mental health. In such cases, the work of the individual care manager will require to be considerably supported by local NHS provider services.

This can best be illustrated in the case of people with long-term and severe mental illness with the most complex needs where most services required are likely to be provided by the health service. Consequently, decisions by the care manager to commit resources will need to be integrated with decisions about the deployment of health resources which will be made in parallel by clinicians. As increasing amounts of mental health care are delivered in a community setting, it is likely that the client will also be under the care of a community consultant psychiatrist with specific discharge and aftercare responsibilities under the Mental Health Act and care

programme approach. As such, integrated working between the care manager and the local mental health multidisciplinary team will be crucial.

Although the purchaser/provider division is at different levels within the NHS and social services, there will need to be mechanisms to ensure that commissioners in both health and social services receive feedback from the ongoing needs assessment work. This will be necessary if NHS services are to change in the light of the more detailed assessment of need, and if care managers are to be supported in progressively buying services which more closely relate to individual needs, especially in those areas where care managers do not hold their own budgets.

Early indications of the Act in practice

The implementation of care management in April 1993 looks set rapidly to become a very clear example of how the admirable intentions of government community care policy founder on the unintended consequences of more powerful forces and contradictions. First, the social security transfer of funds is now apparent as both a means to allow more needs driven services, and as a mechanism to cash-limit expenditure.

Second, this transfer punishes local authorities with few current local residential care homes, and cuts off money for future expansion. Third, the directive that care managers should not themselves give direct care runs counter to the core of good social work practice, and creates the possibility of a new corps of care administrators, withdrawn from field work duties, so reducing the direct care available. Fourth, no central guidance has emerged on how to coordinate, at the local level, care management, care programme and hospital discharge procedures, so inviting a triplication of planning effort (Onyett, 1992; Department of Health & Social Services Inspectorate, 1991; Thornicroft, 1991).

Fifth, conflicting central guidance is emerging about the statutory requirements to provide services for unmet needs revealed by assessment, or even to inform clients about the results of assessment (Laming, 1992). Finally, the health/social care distinction is proving much less clear in practice than in concept, and apocryphal discussions over whether an unkempt client requires a health care bath or a social care bath seem set to characterise long-running boundary disputes between agencies unless specifically addressed in joint planning fora.

If the current volley of reforms is to hit the target, a number of initiatives are required. As needs assessment information is fed into commissioning and planning discussions, it is likely

to highlight the need for district health authorities (and increasingly GP fund holders) to commission many community services jointly. By developing joint commissioning arrangements it will make it more possible to ensure that specific gaps in service provision are filled. Variations in joint commissioning practice between social services, primary care and secondary care health services will need to be piloted and carefully monitored. Agencies will need to agree on definitions of needs, and how people with different levels of need will be prioritised when services are rationed. The health/social division can be narrowed by joint training. Agreed appeals, complaints and arbitration procedures need to be established for users, and for authorities in dispute.

During these changes there is the ever-present danger that insufficient overall funding will drown the potential benefit of the reforms (BMA, 1992, Blom-Cooper & Murphy, 1991). Finally, models of care management will also require detailed tracking and evaluation to show whether the brokerage model is the hub or the rub of community care.

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