ments will provide an early indicator of how well the new community care arrangements are working after 1 April.

Timetable for change

Local authorities are now pressing on with preparations for the changes although, inevitably, there are some who are making more progress than others, prompting the formation of a national "support force" to provide advice and promote good practice.

The implementation of the changes in full at both strategic and operational levels will take many years, and the targets for 1 April 1993 are relatively modest. Health and local authorities must be able to coordinate assessments, especially for discharge from hospital. They must have in place suitable financial arrangements for managing the funds transferred from social security. Finally, they must have negotiated suitable arrangements with private residential and nursing homes, with a requirement to spend at least 85% of the extra money transferred on services not supplied by local authorities. The more profound changes such as care management can be planned at a more leisurely pace.

The theory is now mostly in place with copious guidance from the centre; authorities and practitioners must now make it work. The early signs are that where it works it is worth all the effort, with better patterns of care emerging and a higher quality of life for some of the most disadvantaged members of society. But community care is not an easy or particularly cheap option.

With increasing emphasis on efficiency and best use of scare resources, requiring ever shorter lengths of stay and more rationing, the smooth functioning of the rest of the NHS depends increasingly on suitable provision for long term care. Community care is now the main method of providing such care. It is up to everyone to make it work through better assessments, better hospital discharge arrangements, and better cooperation and organisation all round. Failure to do so could mean that the Cinderella services arrive at the ball still in tatters, with profound implications for the NHS and local government alike.

1 National population projections: mid 1989-based. *OPCS Monitor* 1991;1. (PP2 91/1.)
2 Beardshaw V. *Last on the list: community services for people with physical disabilities.* London: King's Fund Institute, 1988.
3 Audit Commission. *Developing community care for adults with a mental handicap.* London: HMSO, 1989. (Occasional paper No 9.)
4 Audit Commission. *Making a reality of community care.* London: HMSO, 1986.
5 *Laing's Review of Private Health Care 1991/2.* London: Laing and Buisson Publications, 1992.
6 Harrison A. Commentary. In: *Health Care UK 1991.* London: King's Fund Institute, 1992.
7 Secretaries of State for Health, Social Security, Wales, and Scotland. *Caring for people: community care in the next decade and beyond.* London: HMSO, 1989. (Cm 849.)
8 Audit Commission. *Managing the cascade of change.* London: HMSO, 1992.
9 Department of Health. *General practitioners and caring for people.* London: DoH, 1992.
10 Kestenbaum A. *Cash for care: a report on the experience of Independent Living Fund clients.* London: Independent Living Fund, 1992.
11 Department of Health. Discharge of patients from Hospital. London: DoH, 1989. (Health Circular HC (89)5.)

London after Tomlinson

Community care in London: the prospects

Tessa Jowell

Elderly and disabled people have been led to expect great improvements in the quality of community care after April 1993. The choice to live safely at home is to be offered as an alternative to residential care. The financial and organisational relationships are all intended to support this in practice. The Tomlinson recommendations will create instability for providers, and much new and overdue investment in primary and community services is needed if the community care reforms are to work. There are, however, other obstacles looming which pose an even greater threat to the smooth transition after April 1993. The formula by which government money for implementation will be distributed discriminates against London. The sheer complexity of the organisational transformation has also been underestimated; the machinery of government both locally and centrally is ill equipped to maintain the precedence of the consumer. There are examples of good practice in London boroughs, but the dangers of Londoners ending up with the worst of all worlds are great.

"I know that I'm coping if the windows are clean" said Mrs Blackstock, a woman in her late 70s living alone in a council flat in north London. She was being consulted about the kind of community support she would need if, as her frailty increases, she is to be able to continue to live on her own. She needs other help, too, but the state of her windows is her personal test of her own competence. The outcome of the consultation with Mrs Blackstock and other elderly and disabled people and their carers will provide essential information for the London Borough of Islington as it sets about preparing its community care plan.[1]

The community care plan is one of the new requirements placed on local authorities by the Department of Health. It is the local authority's statement of intent for the provision of community care: an audit of what is available, what is needed, and how the local authority will bridge the gap. Mrs Blackstock's observation presents an important challenge to the capacity of local authorities to meet the standards of the new legislation.

The community care reforms form part of the National Health Service and Community Care Act. They have been implemented over three years and have seen the introduction of inspection and registration units independent of social services departments, a new complaints procedure, and the production of community care plans. With effect from April 1993 local authorities will assume lead responsibility for assessing the needs of elderly and disabled people and then commissioning "packages of care" within a preagreed budget, which will then be managed by a care manager. The rhetoric of the policy has promoted a misleading degree of cross party consensus. Only now, as the proposals are being implemented in practice and the sheer scale of the task facing local authorities becomes clear, is the consensus beginning to crumble.

Dilemmas for local authorities

Take Mrs Blackstock's apparently simple request, which in no sense represents all her needs. It highlights the dilemma that will face local authorities: a switch away from widespread low cost individual home care to

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a small but intensive high cost home care service, designed for respite care and post hospital discharges, as a real alternative to residential care. This recasting can be informed by the preferences of elderly users like Mrs Blackstock, but ultimately the choices about the shape of the service are for the politicians. The issues include:

- The balance between a cleaning/shopping service and personal care
- Eligibility criteria
- Level of cover—how many hours over how many days
- Charging policy
- Agreeing the boundary of responsibilities with the district nursing service
- Whether local authorities will continue to provide their own home care services or become merely purchasers
- Comparison of costs of provision.

There is no obstacle to the range of provision or the ease of access to it except the cost. It is this that will set the rigid practical boundary on the extravagant ministerial rhetoric of consumer choice.

The Department of Health is so concerned at the scale of the problems that a support force has been established to galvanise the more dilatory authorities into action. Who the worst performers are is a secret, but it is believed that four are London boroughs. The progress of implementation is being monitored by regular meetings between authorities and the social services inspectorate and regional health authorities. The most recent monitoring report on authorities in the North West Thames region confirmed that, to a great extent, the problems experienced in London are pretty much the same as the problems facing other urban authorities throughout the country.

How London loses financially

A major problem for London, however, has been identified with the publication of the mid-year population estimates derived from the 1991 census results. These are the figures that will be used in calculating the standard spending assessments (or SSAs) for the 1993-4 settlement. They show loss of population in the metropolitan areas generally, but particularly in inner London. The biggest change has occurred in the group aged 85 and over, which has fallen by 11%, while it has increased by 8% in the shire local authorities. This is an important group for SSA purposes as these people receive extra weighting in both of the elderly SSAs concerned with personal social services. Falls in these SSAs will result in heavy losses in grant for the boroughs concerned. Changes in the size of the elderly population will also have a knock on effect on the size of the community care special transitional grant for 1993-4. The Association of Metropolitan Authorities calculates the impact on inner London to be a total loss of over £2·5m, with Southwark alone accounting for £400 000 of this. The reasons for this apparent loss in population are not clear but are consistent with the underregistration of the electoral register.

A further problem lies in the way—particularly hard on London—the government has chosen to distribute the grant to fund community care. On 2 October Virginia Bottomley announced that the £398·6m to be transferred to local authorities from the social security budget will be distributed according to a formula using a 50% SSA based approach: hence the significance of the population loss. The rest will be distributed according to income support data. An additional £140m will be available for set up and other administrative costs and will also be distributed according to

JOHN TWINNING

Keeping community support services running will be a financial juggling act

SSAs. At least 62% of the transitional grant (which covers the combined resources) must be spent in the independent sector. The problem for London is that instead of allocating all the money to the authorities that will have to pay for the private residential fees the government has chosen a distribution formula which gives weight to where the residential places are: so that councils which happen to have large numbers of old peoples' homes in their area will receive more money whether or not they are actually having to foot the bill for the use of the places.

This will hit London authorities particularly hard because a high proportion of elderly people from London boroughs are in residential homes on the south coast and in the south west. The net result will be that authorities in these areas will have more money than they need and London boroughs will not have enough to meet their new responsibilities to their resident elderly populations.

Both the Tomlinson report[2] and the King's Fund report[3] on London's health services point to the grave inadequacies of primary and community health services: too large general practices,[4] a lack of local residential home places, distortions caused by capitation funding, and falling support from voluntary agencies. More recently evidence has emerged of acute hospitals, preparing to bid for trust status, raiding their community health services' budget in order to bring the acute budget out of deficit. This was why one of my constituents, an elderly lady, found herself lying on a trolley in the accident and emergency department of her local hospital. She had fallen and broken her arm. She did not need to be in hospital but there was nobody to put her to bed at home. The district nursing service, which had been cut the year before, had none to send. As a result of scandals like this the management executive has discouraged those trust applications which combine acute and community services.

Structural problems

Any diagnosis of the difficulty of implementing the community care reforms and meeting their ambitious objectives for elderly and disabled and mentally ill people needs to take account of the longstanding structural obstacles which have bedevilled the effective implementation of community care since the search for

alternatives to institutional care first began. There is the obvious mismatch between the boundaries of health authorities, now purchasing authorities, and boroughs. There is also the growing tendency in London, as a way of maximising the health care purchasing power of the local population, to establish purchasing consortia which may well be too large to be sensitive to the specific requirements of local populations in each borough.

The second structural problem is that London local authorities are relatively small units of organisation to see through the scale of change that the reforms entail.[5] The person with the key responsibility for community care—the lead officer—may well be a relatively junior middle manager who is also responsible for implementing the Children Act. While it is important to concentrate resources at the point of delivery, proper management resources are also essential.

Thirdly, there is the question whether the machinery of government, locally and centrally, is capable of turning itself inside out, so that it becomes capable of meeting the multitude of individual needs—like Mrs Blackstock's wish to have her windows clean—as opposed to simply delivering services developed on a set of professional or administrative assumptions. The failure of local authorities to integrate housing into the new community care regimen—or indeed the old one—is one measure of this. Increasingly, housing associations have been the major providers of accommodation to people with special needs. Their capacity to do this is now in jeopardy from the provisions of the Housing and Urban Development Bill, which can make the funding of care and support a responsibility of social services, not housing departments. As Donald Hoodless of the Notting Hill Housing Trust observes, the problem is that the availability of housing suitable to people with special needs is too often either presumed or ignored.

Integration

Integration of policy across a range of government departments is necessary to make community care work in practice: it affects aspects of policies at the Departments of Health, Environment, Social Security, Education, Employment, and Transport. Failure of policy in each has in the past obstructed the development of community care. The government has established a cabinet committee to oversee the implementation of *The Health of the Nation* policy for public health; the same priority must be accorded to the implementation of community care if the objectives are to be realised in practice. This imperative is mirrored at a local level, and it is a great pity that more local authorities are not following Birmingham's lead in declaring community care a corporate responsibility.

Feedback from elderly and disabled people about community care makes the issues clear. Again, the evidence is from Islington, but could be repeated by any similar local authority. If you listen to the consumers of care you learn that what matters are the following.

Adequate housing—This includes a capacity to respond to changes in circumstances—for example, where levels of disability increase. It is also worth recording the number of people coming to see me as their member of parliament who are anxious about the growing frailty of their older relatives, but, because they are council tenants, cannot move any nearer. Caring responsibilities simply do not rank among the draconian rationing criteria that have to be applied by inner London boroughs over housing.

Income—While the correlation between disability and poverty is well established, the complexity of the social security system deters many claimants. Investment in good welfare rights advice is therefore a critical element for a community care system which is responsive to the needs of its consumers. This also raises the issue of direct cash payment to individuals—a popular remedy with many young disabled people and about to be withdrawn with the winding up of the Independent Living Fund.

Adequate information—The confusion for carers was put well by the woman who said, "My problem is not only that I don't know what's available, but I don't know what question to ask in order to find out what is." Making jargon free information available is an important step towards making users and carers feel more powerful in this process. Birmingham City Council, for instance, placed information for carers in local chemists' shops in response to consultation with carers about the most accessible source of information.

Transport—Being able to get around is self evidently a major factor in the quality of life.

The keys to quality

If we match a willingness to learn from the users and consumers to a commitment to quality in certain key areas of delivery then good community care is not far away. The key quality characteristics are:

- Competence in the provider, which instills confidence in the consumer
- Reliability: "One promise is worth thirty maybes"
- Flexibility: people's crises do not conform to the working hours of social workers
- Accessibility: physical access is essential, but so is staff courtesy
- Cultural appropriateness
- Choice, and clarity about the limits of choice
- Redress, with the certainty that complaining will not lead to victimisation.

The danger is that Londoners—older, poorer, and worse housed than many in Britain—will end up with the worst of all worlds. The capping of local authorities has already brought about a reduction in the volume of services available to support them. Targeting, by which the most disabled will get most, conversely means that the less disabled will get nothing. Hospital beds will close but will not be replaced by the services that will enable people to live in their own homes. The shortfall will be picked up by families and relatives, but in London housing shortages and public transport inadequacies make this all the more difficult. On top of that, the prospects for the acute hospitals that survive Tomlinson are uncertain. Unless they can discharge their elderly patients to adequate community care, they will find their beds blocked, they will be unable to meet their contractual obligations to other purchasing authorities, and they will go bust. It is not an inviting prospect.

1 *"I know that I am coping if the windows are clean": a report on consultations with users of community care services.* London: London Borough of Islington, 1991.
2 Inquiry into London's Health Service, Medical Education and Research. *Report.* London: HMSO, 1992. (Tomlinson report.)
3 King's Fund Commission on the Future of London's Acute Health Services. *London Health Care—2010.* London: King's Fund, 1992.
4 Jarman B, Bosanquet N. Primary health care in London—changes since the Acheson report. *BMJ* 1992;305:1130-3.
5 Audit Commission. *Community care: Managing the cascade of change.* London: Audit Commission, 1992.

Correction

Maintaining excellence: the preservation and development of specialised services

We regret that an editorial error occurred in this paper by Liam J Donaldson (21 November, p 1280). In figure 2 the innermost sector of the top right hand segment should have read "Clinical interests" not "Clerical interests."