Countdown to Community Care

Community care and the fundholder

Rhidian Morris

This is one of a series of articles looking at the forthcoming changes to community care

Ivybridge Health Centre, Ivybridge, Devon PL21 0AB
Rhidian Morris, *general practitioner*

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According to the government, clearly agreed local arrangements should enable individual general practitioners to make their full contribution to the new system of community care without getting involved in extra bureaucracy.[1] From 1 April the main part of that contribution will be to refer to social services those patients who seem to need social care. Many general practitioners are worried that such referrals will be complex and time consuming and will generate too much extra work. Moreover, general practitioners may also be asked to see patients specifically to help social workers' assessment procedures, and many fear that such consultations will overwork and underpay them.

General practitioner fundholders already use contracts to spell out what they expect from hospital services. From 1 April they will be able to set up contracts for community health services such as district nursing and chiropody, and possibly this might be extended to social aspects of community care. Over the past 14 months Dr Rhidian Morris and his partners in a fundholding practice in Devon have piloted contracts for all aspects of community care. In this article Dr Morris explains how the most radical part of the pilot project—the contract for social care—was set up. He argues that the lessons on communication that came from what was essentially a fundholding project could apply also to non-fundholding practices.

Some doctors have an abysmal lack of knowledge about the range of social services available

The history of relations between general practitioners and social workers is generally poor. The two professions tend to be suspicious of each other, have little understanding of each other's roles, and have very different cultures. Social workers operate in teams, take measured approaches to problems, and rarely take decisions on their own. General practitioners work mainly as individuals supported by primary care teams. They have to make decisions quickly and virtually always alone. They are trained to do this and to be aware that they carry personal legal responsibility for their actions.

When plans for the NHS reforms were announced I quickly became an enthusiastic advocate of general practitioner fundholding, the purchaser-provider split, and the contract system. I had long believed that the primary health care team did not really work but that it could be made to do so by adhering to contracts. In 1991 I started negotiations to run a pilot project of community nursing contracts in my practice. I contracted from the local community unit a nursing team that would be led by general practitioners and would form a true practice based primary health care team. I approached Devon social services to develop a contract for referring patients from our practice for social care assessments.

Lack of knowledge

When I started discussions with the social services department I had an open mind about the service to be delivered. This was just as well, given my abysmal lack of knowledge about the department's range of services. I did not know whether having a contract would make much difference to the service delivered or to relationships between social workers and general practitioners. I simply wanted to see what would happen if I approached the problem with a contractor's mentality. The result was the hardest set of negotiations I have ever encountered, lasting some six months.

The social services managers were two or three years behind those in the NHS in developing contracts, although they were catching up fast. The biggest problem was that their whole philosophy and culture seemed alien. At first there was a lack of trust between us: I thought they were not trying hard enough as we went over and over the same issues; they thought I was trying to take over. I was the sole representative of the general practitioners. The social workers always worked as a team and whenever we met a roomful of people arrived. Their timescales for negotiations and those they proposed for dealing with referrals were much longer than mine. I felt they wanted me to assess people's needs when that was their responsibility. There were even language difficulties. To them an urgent assessment meant "needs doing within

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two days" whereas to me it meant "needs doing immediately."

Although both sides became frustrated, it says much for the social workers' determination that they turned up to meetings and attempted to understand me. The breakthrough came when Plymouth Health Authority sent to the talks its contractor for community services, Chris Whitaker, and Devon Social Services Department sent its community care development officer, Tess Lomax. Chris was a former social worker who understood the social services negotiators and was trusted by them. Tess had a researcher's mind and an objective view.

Tess spent two days in the surgery. She watched how we worked and communicated and how messages and information were received, stored, and sent out. Then she asked me why we treated social services staff differently from everyone else. We did not write letters to them. We never recorded what information we sent them or received from them. This simple observation surprised us and made us change our ways of communicating with social workers.

We decided to use the same system that we used for hospitals, making referrals to team leaders in the same way that we do to consultants. Like consultants, social services' team leaders run teams of frequently changing staff. Rapid turnover in junior staff does not disturb continuity if the working relationship is between the general practitioner and the consultant rather than the house officer. This analogy helped us to see that our previous and unsuccessful requests to have a named social worker attached to the practice had been unrealistic. At the time we had not understood why the team leader had refused this and had asked for referrals to be made directly to her.

Now that we had decided to refer to the team leader (who would be the care manager) we devised a simple referral form and agreed that all communications with and from social services would be made in writing and filed in our patients' notes. The form is very similar to that recommended recently by the BMA. Our referrals followed the same format as those to consultants and included requests for specific services when appropriate. Unlike those to consultants, however, referrals could be made by any member of the primary health care team. The contract followed fairly quickly, and on 1 January 1992 we began the pilot project.

How to do it

In the contract that we negotiated we could not alter the content of the service provided by Devon social services but we could influence the nature and speed of delivery and of communication. The contract had the basic elements of any NHS contract, plus detailed commitments for each of the two parties (box 1).

Box 1

Outline of contract between Ivybridge Health Centre and Devon social services

(1) Aims of contract
(2) Duration of contract
(3) Population to be covered (the practice list)
(4) Brief summary of the six main acts of parliament that apply to social services and to the policy of charging clients for certain services
(5) Grading of referrals by priority
(6) Definitions of assessment and service provision
(7) Procedures for quality assurance
(8) Complaints procedures
(9) Clear description of commitments for each party in the contract

Box 2

Auditing the contract with social services

We looked at the following aspects:

- Number of referrals
- Who is referred (age, sex, whether previously known to social services)
- Who makes referrals
- Urgency, quality, and complexity of referrals
- Speed and complexity of responses, and whether made in writing
- Problems and disabilities found on assessment
- Service input (difference between services requested and offered, time taken to deliver services)
- Consumer follow up
- Contracts with primary health care team
- Problems with contract

The primary health care team contracted to follow set procedures for making referrals (referrers would inform patients, all referrals would include a clear statement of urgency and would be made in writing—even ones made by telephone would be followed up by written requests). Referrers also agreed to pass on relevant new information (giving advance notice to social services of cold admissions to hospital if social care might be needed on discharge, and notifying changes in circumstances of existing social services clients). Finally, leaflets and other information about social services would be displayed in the health centre waiting room.

The social services team contracted to take and act on referrals within specified times (the office would be manned between 9 am and 5 pm and referrals would be taken by a duty officer; urgent referrals would be dealt with within two hours, non-urgent cases would be contacted within five working days). Core assessments would be performed for all referrals and general practitioners would be informed about assessments, services delivered, and closure of cases. Needs for social care would be identified according to the social services department's policy and budgetary constraints. Patients' needs after discharge from hospital would be monitored (separate arrangements would be made with the community health unit and hospital to assess referrals from those sources). Lastly, the social services office would display general practice leaflets and other literature.

Both parties in the contract agreed certain joint commitments, such as observing professional confidentiality, defining an out of hours service, and monitoring the contract. Monitoring included regular meetings—quarterly for the whole social services and primary health care teams and monthly for one general practitioner, the social services team leader (care manager), and the team manager of the community health unit. We also agreed to set up systems for audit (box 2).

All these specifications were written into the contract document. It also contained a brief description of the 30 different social care services offered, the types of patient eligible to use them, and copies of the referral form and the form used to carry out core assessments. The resulting 18 page document might seem complicated but is actually a clear and simple statement of shared commitments.

Monitoring the contract

As soon as we got used to our new channels of communication with the social services team the

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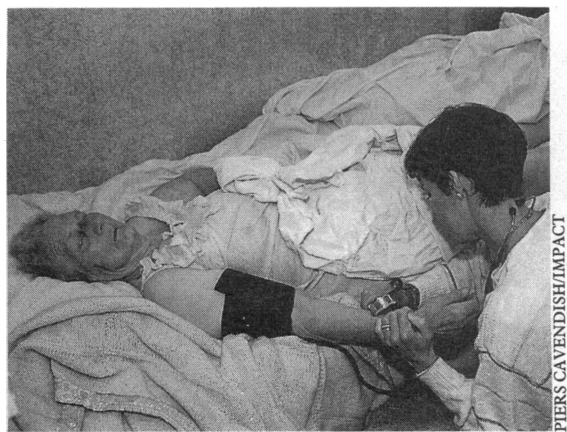
benefits of the contract became evident. Our first audit showed that in 20% of referrals the referrer had given inadequate information; the second showed that in only 7% was information inadequate. At the same time there was an increase of 15% in the complexity of referrals. Similarly, responses to us in writing within six weeks of referral rose from 25% of cases in the first audit to 60% in the second. There was also a change in source of referrals—those from district nurses rising by 34% and those from general practitioners falling by a similar amount. We have no firm data yet on whether delivery of services improved.

To explore relationships between the social services and primary health care teams the psychology department of Plymouth University carried out a questionnaire survey of attitudes. This showed that health visitors had the greatest influence on social workers. It also highlighted a complex network of contracts between the two teams and suggested the need for clear lines of communication. A member of the primary health care team has now been designated liaison officer and all messages are passed to her.

All worth it in the end

Although the contracting process was complex, it was worth while. We can now deal with the main problems that could arise in the new community care system. The Plymouth Community Trust is considering whether nurses and health visitors could order certain aspects of social care after training by the social services department. The aim is not to increase the community nurses' workload but rather to decrease time spent chasing the social work team.

Many general practitioners fear that the community care reforms will increase their own workload, too. We do not believe that general practitioners will be overburdened. In our practice, covering a population of 10 000, we make an average of 1·7 referrals a week. And we have not been asked to see any patients specifically to help social workers' assessments. We already provide medical notes for patients admitted to county council run residential homes and letters of information for those going to private care. Will there really be much change?



Urgent work: to general practitioners "urgent" means "immediate"

Conclusions

I have come through this experience with much greater understanding of social workers. I have learnt a lot from them and I recognise that we think and work in different ways. I have also learnt much from the skills of others: without Chris Whitaker and Tess Lomax we might not have succeeded in improving the way we organise community care. Though other practices may interpret and implement the community care reforms in different ways, I hope that some of the lessons we have learnt will be useful. General practitioners do not have to be fundholders to take a contracting approach to improve communication with social workers.

1 NHS Management Executive. *General practitioners and "Caring for People."* London: HMSO, 1992.

The fortysomething barrier: medicine and age discrimination

Peter Forster

Agism in the medical profession is mainly covert but it is not uncommon. It is widely believed that people become less productive as they get older. However, research has shown that older people have less absenteeism, more job stability, and greater output than younger workers. Job losses, which until recently were unheard of in the NHS, usually affect older people first, resulting in the loss of those with the most skill and experience. With an aging population it is important that the government takes steps to discourage age discrimination in the NHS and Britain as a whole.

British Medical Association, North Western Regional Office, Manchester M20 8RX
Peter Forster, *industrial relations officer*

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Age related assumptions are made throughout a doctor's career. Subjective and usually implicit their manifestations are obvious. From time expired senior registrar who despairs of finding that elusive consultant job to the frustrations of the mature, would be medical student who comes up against the agist admissions policies of many British medical schools. Sometimes the barriers are explicit. In a letter to regional advisers and postgraduate deans in 1988 the chairman of the Joint Committee on Higher Surgical Training stated that trainees aged 35 or over and without the requisite "papers" should be told they are unlikely to succeed in finding a senior registrar post. The doctors retainer scheme sponsored by the Department of Health, which seeks to help doctors stay in touch with medicine so that they can later return to NHS employment, applies only to doctors under 55.[1]

Mature medical students (defined as over 23) account for only 2% of the medical school population. Most universities are dubious about accepting students older than 30. Indeed, in 1990 only 0·42% of preclinical students were over 30; 74% were aged 18-19.[2] When a medical career has to be ended early because of staffing reductions (virtually unheard of in the NHS before the reforms but now planned in the wake of the Tomlinson inquiry) age usually predominates over other factors such as experience and skill. Early retirement and voluntary redundancy schemes often result in the loss of some of the best people. A recent report showed how older workers bear the brunt of economic recession.[3] Older people are always among the first to be made redundant and to retire prematurely yet there is no evidence to show "that redundancy or early retirement are seriously associated with health or any general tendency for workers to become less productive with age." The government, the report adds, "should take a lead by setting a good example in the context of its own

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