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**The development of care
in the community**

by

David Hunter

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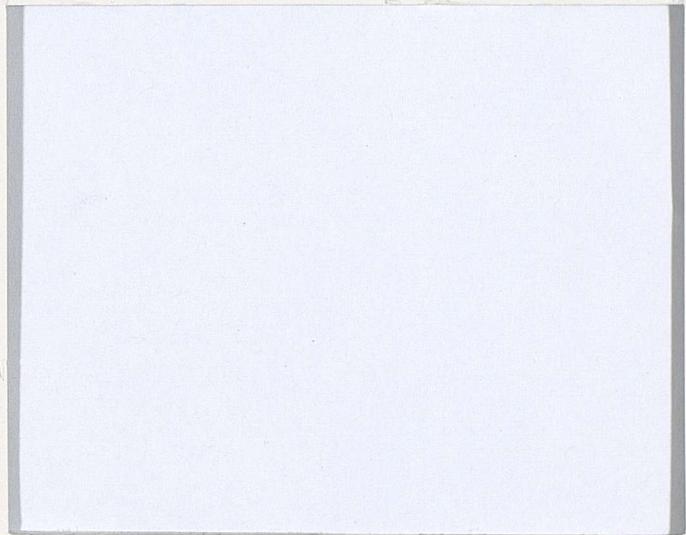
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THE DEVELOPMENT OF CARE IN THE COMMUNITY

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THE DEVELOPMENT OF CARE IN THE COMMUNITY

We have heard an a lot about the NHS reforms over the last year or so and the pace seems to be quickening in respect of what we continue to hear about their impact. A daily diet of media stories about hospital and bed closures, about people waiting on trolleys, in corridors, about waiting lists lengthening, the Patient's Charter and so on is fed us. But we hear considerably less about the impact of the community care reforms which were fully implemented last April, after a three year phasing in of the changes. Yet, I believe that the community care reforms are potentially far more important than the NHS reforms in terms of their impact on most people's lives. More people will be touched at some point or other in their lives by community care services, or lack of them, than will have contact with the NHS in terms of in-patient care. The NHS, despite the reforms, still remains dominated by hospitals, by acute care, by capital buildings. Yet only 10% of the population ever go into hospital as in-patients for any length of time. Most people, however, will come into contact with primary care or community care. We are told by the Government that even within the health policy field the future will lie not with the acute hospitals but with primary and community care, and the so-called strategic shift that is getting under way is ostensibly about creating that critical mass in the primary and community care sectors and the gradual shifting of resources from the acute hospital sector. I'll come back to some of that discussion later because I think it is critically important, not only in respect of the community care reforms as they are currently being implemented but also the direction that they will take in the future.

In my talk this evening, I propose to adopt a fairly pragmatic approach and not dwell on the community care reforms themselves. I'm going to assume, for better or worse, that you're familiar with most of these. I want to do two things. One is provide an interim assessment of how the reforms appear to be bedding down, nine months into the process, reviewing available evidence from the Audit Commission, from the SSI Monitoring Group, and other evidence. Secondly, I want to do some very speculative horizon gazing around what the likely future developments are in regard to community care and what the implications for the interface between health and social care are likely to be - in the process saying a little bit more about that strategic shift I mentioned a moment ago.

Let me begin by quickly reminding ourselves of why we're here in relation to the community care changes - we shouldn't forget that there's really nothing new about the community care policy as a whole. The media leapt up and down on April 1st last year saying, "We have a new community care policy". Well, we don't and we didn't and I shouldn't think we will in the future. The policy in the sense of shifting the focus of care from institutional care to community based, domiciliary home based care, has been around for 50 odd years, at least, as a thrust of central government policy. The problem has rather been one of implementation, that is, making a reality of the policy aspirations across all the different care groups that we continue to call the 'priority services'. There is an inverse relation to the actual priority these care groups ever receive but we continue shamelessly to use the term. Now the means of achieving that policy may have altered in keeping with current fashion, particularly in respect of management theory and policy developments and so on; notions of the purchaser/provider split, the internal market, the mixed economy - indeed, all the lexicon of healthcare reform, is there in the social care reforms. While the

means are perhaps new the policy itself is not and I think it's important to remind ourselves of that.

Now, as I've said, the consistent thrust of policy over the last 50 odd years hasn't been matched by success in terms of the impact of that policy. During the 1980s, in particular, the policy was seriously derailed by a set of perverse incentives, which, as you know, arose because of the indiscriminate use of the private residential care sector, publicly funded by the income support system. Whether wittingly or unwittingly that was the reality and it rather blunted the policy of focusing attention on community home based provision. The reforms announced in 1989 sought to tackle that problem in particular and to refocus government policy, very clearly, on creating a set of services that would be close to people's homes, responsive to their needs, and shift the policy agenda from a service led policy to one that was based on user needs. At their heart, then, the reforms have an emphasis on domiciliary base care. This is to be achieved through a mixed economy of welfare, i.e. the fact that local authority social services departments should be the enablers, the facilitators, the orchestrators of care, but not necessarily the direct providers and that the independent sector, both private and 'not for profit', should be much more actively involved in that process. In addition there should be community care plans, so while planning was seen to be out of fashion in the NHS it was still considered to be important in respect of community care. Community care plans were firmly required and preferably joint plans with health authorities.

When the reforms were introduced there was much speculation over their chances of survival. Much of that speculation was centred on the perception that the financing would be

inadequate to cope with the transfer from income support to local authority social services departments, or if it was adequate, that it would be syphoned off by social services departments either into childcare or some other activity. There was a general fear that the capacity of local authorities to deliver - at a time when local government was not seen to be in particular favour with central government - might not be up to the challenge of actually implementing the changes. A Community Care Support Force was set up by the Department of Health for a six month period, up to last April, to provide a supportive facilitating capability to help local authorities, and health authorities, meet the new agenda and deliver something on time in respect of the 1st April start date. It was something of a troubleshooting hit squad but did not exist to divert people from their chosen path locally. It was there to provide support, guidance, advice, ideas about what might be tackled differently and so on. The Support Force came to the view that there was a mixture of good news and bad news (*box 1*). The agenda set for the current year in respect of what is expected of local authority social services departments (SSDs) and health authorities (HAs) is presented in *box 2*. I'll pick up some of these points later. These are the key headlines in respect of the activities and the processes SSDs and HAs are expected to address and pay attention to.

In the past couple of months or so, a number of audits of progress have appeared and been published and I want to comment on three of them. There is some overlap between them but that is, I think, helpful. I shall go through each of them in turn and then begin to pull together what seem to be some of the key issues for the future. The first is the Audit Commission's Briefing Paper which appeared before Christmas; the second is some work colleagues at the Nuffield Institute did with the King's Fund - simply getting people together to talk about their experiences and record those points; and the third is from the Social

Box 1

COMMUNITY CARE SUPPORT FORCE

Good News

- Minimum can be delivered
- Commitment to change
- Agreements signed
- Many authorities working hard
- Health and Social Services talk more

Bad News

- Difficulties in managing change
- Frequent history of poor relations
- Some health providers and health staff not engaged
- Independent sector often not engaged
- Risks of over monitoring



Services Inspectorate and the Regional Health Authorities Monitoring Group which has also been looking at the impact of the reforms, roughly seven months into the process. All these audits agree that the chaos and catastrophe predicted has been avoided and the Government, understandably, is claiming that to be a success story and I suppose it is of sorts. We are all relieved to learn that there has been no catastrophe - there may be pockets locally of incidents that might have been avoided had the reforms taken a different turn or whatever - but nationally, generally speaking, there has not been a breakdown in care that people expected; and the funds have not run out either - if anything they have been underspent, not overspent which is arguably more alarming. But the real issue is, has there been any change at all in the system? Admittedly it's early days and we're talking about a long term reform agenda which will unfold and unroll over a period of years, but can one detect, after six months, any indication that we're moving away from a situation of what we might call 'dynamic conservatism' - where people are fighting like mad but often just to stay in the same place - or are we actually witnessing the beginnings of a shift in the culture, both organisationally and professionally, in respect of moving from a profession-led, provider-led service, to a user-led one based on assessment of need rather than on fitting people to existing services? Is it a case of all change but no change or are we actually witnessing the start of a genuine change process? I don't have an answer to that question but I think it underpins everything I want to say.

Let me start with the Audit Commission progress report and the summing up of this is that cautious and steady progress has been made, and foundations have been laid for a more user sensitive set of services. I'm not going to dwell on each of these points but I'll comment on some of them. The Audit Commission highlights five areas where it feels further

Box 2

AGENDA FOR 1993/94

- Development of assessment and care management systems
- Increasing involvement of service users and carers in planning and delivery of community care services
- Shift balance of resources towards non-residential care
- Further development of joint planning and commissioning (no unilateral withdrawals)
- Further development of a positive relationship between purchasers and providers
- Improving collaboration with housing authorities



work needs to be done because although a promising start has been made there are still a number of areas where progress is either not happening or is proving incredibly slow (*box 3*). Assessment, not surprisingly, is proving to be one of the trickier areas in respect of moving from the old system, where people were assessed against entry criteria to services and therefore were closely matched to the budgets available for those services, to a system whereby they are assessed on the basis of some notion of need - whether derived from local analysis of census data in a community or based on individual assessments of need for service. The Audit Commission feels, and it comes through the other audits as well, that there is a need for moving away still from a thicket of existing services to extend choice and open up the range of options that people might actually want in order to meet the needs that were being identified. There is a danger of assessment becoming terribly cumbersome, bureaucratic, rule bound and defensive to the extent that those doing the assessments feel that if they do not have clear documentation of the face-to-face encounter with the user, it might leave them open to legal action in respect of not having assessed the need appropriately and being seen to be putting budgetary and financial resource considerations over and above the perception of the user that he or she had a particular need for care. It is a very difficult balancing act actually to identify real needs and then in some sense put them alongside resources available.

Everyone is at the starting point of that process. In respect of developing budget planning, the feeling here was that in many local authorities there was a need to be a bit braver, a bit more into risk taking in respect of identifying needs more extensively and being quite clear about what the eligibility criteria were for particular care groups. There was still uncertainty around what those criteria were and therefore no basis on which to gauge

Box 3

AUDIT COMMISSION: PROGRESS REPORT

- Sharpening assessment procedures
- Developing budget planning
- Delegating budgets
- Planning and controlling expenditure
- Developing commissioning



performance or judge progress. In the case of delegating budgets, more than a quarter of local authorities still control the budgets from the centre of the authority and they are not devolved to departments, or even within departments, and that I think must create problems in terms of effective care management and effective matching of people to resources in respect of needs. There were issues about lack of financial control, a need to get a grip on that, in particular the management of the special transitional grant - I'll say a bit more about that later - which is the funding from the Income Support system that has been made available to local authority social services departments over a four year run in period. It is ring-fenced for community care. Finally, there are problems about developing the purchasing/commissioning role of local authorities. Unlike the health service, there has been much less progress in creating that separation, that split between purchaser and provider. No doubt local government will get there just when the health service has begun to retreat and if you consider all the talk about partnership and mature relations between purchasers and providers, you begin to see that retreat is already, to some extent, under way. But I mustn't be cynical. Much of local government has already produced that split in other areas of activity, it is only in social services where there is less progress and maybe for good reasons.

The next piece of audit evidence is the work my colleagues at the Institute did with the King's Fund Centre and they divided this into two sections: things going well and causes for concern. Things going well (*box 4*) - and this is only documenting and reporting what people said to us and, obviously, maybe people here or other people who were not at these seminars would have different views - did demonstrate that there were some improvements. The developments were patchy but alternatives to residential care, in particular, were being investigated; people were conscious of the need to give individuals choice, both within the

Box 4

**NUFFIELD INSTITUTE/
KING'S FUND CENTRE:
PROGRESS REPORT**

THINGS GOING WELL

- Early signs of service improvements
- Improved collaboration between health and social care agencies
- Hospital discharge systems and practices



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residential care sector and between that sector and alternative provision; and there was greater flexibility in local authority home care services. Home carers were prepared to take on tasks and operate more flexibly in the evenings and at weekends than had hitherto been the case. So, some loosening up of professional practice could be discerned. Secondly, there was evidence of improved collaboration between health and social care agencies. Going back to that Support Force point, there was certainly more dialogue between agencies, more talk, despite concern that the reforms would drive the agencies apart and despite concern, particularly on the local authority side, that the health service was so obsessed and wrapped up in its own reform agenda that it wouldn't have time to talk. That hasn't been the case in practice. Many successful examples of joint commissioning, joint purchasing across health and social services and within primary care can be pointed to. Again, progress was uneven but there was certainly some indication that there was some improvement. Thirdly, hospital discharge - although people saw this as a key area for concern - and it may still become one, and I think probably will - at the present time there isn't any evidence that people are blocking beds or are having their assessments delayed as a result of conveniently being in a hospital bed. It isn't the case that there's any major problem in that area but I think that's something to watch out for in future.

In terms of causes for concern (*box 5*), perhaps the most worrying aspect - though maybe not the most surprising given the enormity of the change involved - is the issue about, how one can demonstrate improvements for users and carers. There is still considerable uncertainty and confusion around about what involving users and carers actually means in practice. There's certainly uncertainty and confusion among users and carers about the reforms and I suspect very few actually understand what they are or mean for them. In fact,

Box 5

**NUFFIELD INSTITUTE/
KING'S FUND CENTRE:
PROGRESS REPORT**

CAUSES FOR CONCERN

- No real improvements for users and carers
- Services changing little in practice
- Blurred rights and responsibilities
- Less expenditure than expected: families having to bear brunt?



if it is the case that many staff don't understand the reforms then one wouldn't expect to be surprised if users and carers also had that difficulty. Again, that's a point, I think, to come back to. But there is still, within the system, a lot of confusion and ignorance, about what the reforms are ostensibly about. In terms of users and carers, many don't know where to go for help and advice. There has been increased demand on advice services, and one can point to levels of activity having risen there. There are concerns about the increased costs to users and carers because services provided under local authority SSDs are not free, as they would be if provided under the health service. So, there are issues about whether, in fact, those costs aren't being pushed onto users and carers directly as a result of charging for services that were formerly free. And there's an issue about whether the contracts that exist in some areas - block contracts, for example, for a given number of places or for people going into residential care - actually allow for the choice that was ostensibly one of the key themes of the changes.

There is then the issue about services changing little in practice. Certainly there has been a very slow growth in the shift from residential care to day and domiciliary services. While there may be local exceptions, across the country as a whole it seems to be a major concern. That applies to carers as well since a key thrust of the reforms was that carer support services would be a priority and, again, the evidence seems to be that there's been no appreciable improvement in those services. Blurred rights and responsibilities represent a crucial area because whatever was wrong with the former Income Support system, people at least felt and knew that they had a right to a form of care. It may have been an inappropriate form of care but they both had a right to it and funding was built in for that form of care to be provided. Under the present system, users and carers are still unclear

about their entitlements under the new arrangements which amount to a marked shift from the pre-1993 system. There are also still turf battles going on between health and local authorities about whose responsibility it is to look after particular individuals in respect of who carries the funding liability for the care of an individual and who will pay for what. The final point is the issue about expenditure. There is no evidence that there has been an increase in spending on day, domiciliary and respite care and that raises a question: "Who's doing the caring in that context?" Is it the case that we've in a sense hidden the problem rather than solved it? We've simply pushed it, shunted it, onto families and within those families onto women in the main who are bearing the brunt of care, as they have done in the past but perhaps more intensively now. I think that must be a major cause for concern.

Let me turn to the final piece of evidence which is the SSI RHA report and highlight some of the points that are different from those already picked up (*box 6*). The issue about local authority structures and systems refers to concern about whether local authority SSDs should be providing services as well as purchasing/commissioning them. Issues about who should be taking the responsibility for that - should it be the local authority or should it be the independent sector? If it's the independent sector, should it be voluntary organisations or 'for profit' organisations? Training remains a priority for the SSI and the RHAs but they were concerned that basic awareness training of the reforms themselves wasn't going on with staff; that many staff were quite ignorant of the changes. There is a final point about care management and care packages. Most care management, they found, was being done by social workers or people employed by SSDs; it wasn't being undertaken by community nurses or people in the health sector. There was no pattern, various models were being tried out across the country and again there was concern about how you can have effective care

Box 6

SSI/RHA COMMUNITY CARE NATIONAL MONITORING GROUP:

KEY THEMES

- Local authority structure and systems
- Training
- Assessment
- Care management and care packages
- Contracting and market management
- Special transitional grant
- Hospital discharge
- Continuing care
- Users and carers
- Role of GPs and PHCTs
- Impact on community health services
- Housing and homelessness



management if you haven't resolved the purchaser/provider position and you haven't resolved the delegated budget position. The whole issue of contracting and market management raised two matters. One was, whether contracts were sufficiently sensitive to give individuals choice, or whether they inhibited that choice or constrained it; and secondly, little progress had been made on involving the independent sector in many areas - sometimes for political reasons with local authority members in particular not wanting to have their services provided privately by the independent sector, but often because local authorities found it difficult to know who to relate to in the independent sector, since that sector tends to be very diffused and fragmented in respect of its activities. So there is concern about how the independent sector can be brought into the planning system and about the whole area of market management over the STG, the point here being that the government has insisted that 85% of this grant has to be spent in the independent sector. Now for some areas of the country that has proved to be quite difficult simply because there isn't an independent sector actually to do business amounting to 85% of the budget. That has created a problem, particularly in trying to get the desired shift from residential to day and domiciliary care, where you've got an independent sector that hasn't yet come to the view that it ought to be diversifying out of residential care and into day and domiciliary care. So that's been a double bind for local authorities: a) there isn't any independent sector to speak of in some areas, or it's very uneven or undeveloped, and b) the independent sector itself hasn't made the culture change or the change from residential care to domiciliary, home based care. It is, hard, therefore, to see how spending 85% of the budget will actually implement the policy that's expected of local authorities.

Hospital discharge is once again not seen to be a problem. In continuing care, the issue is that the NHS mustn't pull out unilaterally of providing long term care beds but must do so only where there's agreement between health and social services. The evidence seems to be that people are behaving themselves. I'm not sure whether that's the case universally but certainly in terms of the monitoring exercise there was no perception that the health service was acting incorrectly, or unilaterally, in pulling out of continuing care except where that had been agreed with the local authority. Users and carers: again the point was made that their involvement is still marginal. The role of GPs and primary healthcare teams is still patchy and their impact on community health services very mixed. Housing and homelessness - a perception exists that housing is crucial to community care but there is actually not a lot of involvement in practice. For example, housing is not involved in the assessment process. There is some increase in activity there but not a lot. It is considered important but is not always embraced or incorporated into community care planning or the assessment process, and homelessness is generally ignored.

Out of those three bits of evidence one can isolate five key themes. First of all there is no breakdown. As we've said, the reforms are being managed, certainly effectively as far as the government is concerned in that no obvious 'hot spots' are emerging that need to be dealt with - in contrast, perhaps, to some of the NHS changes. Secondly, little change is evident in the services available. They are still very much in steady state mode in respect of the present configuration of care and therefore are hardly leading the revolution in care that the Government promised back in early 1993 and last year. All the hype surrounding the changes, I think, has been shown to be exactly that. Thirdly, problems continue over assessment. Assessment is a big area about which there is still a lot of uncertainty around the

optimal balance between identifying need and matching it to resources, and combining that with establishing clear eligibility criteria for services. The purchaser/provider split continues to be underdeveloped in social services, and, finally, users and carers are still not much involved in planning or decision making. Yet, in some respects that was the most revolutionary aspect of the changes, namely, that users and carers were not just going to be consulted but were to be actively involved in being participants in planning, and in the assessment process in respect of priorities and decisions.

Let me now turn briefly to some priority areas for future development and then speculate a little bit about the future. Some of the priority areas set out (*box 7*) involve picking up themes I've already mentioned. There is no doubt that the issue of assessment is going to have to be addressed, and in a sense, the issue here is for the NHS and social services to establish, in a way that hasn't yet been done, some clear criteria about who is doing what in that process. So the issue about assessment concerns the degree of jointness of that assessment between services but also about how users and carers can be involved in that process in a way they haven't been hitherto and about sorting out the eligibility criteria for services on the basis of identified need. Another priority area, care management, is ostensibly seen to offer greater flexibility in terms of providing opportunities for individual users to exercise choice. Again, can care management work effectively without delegated budgets and without clarity about what the role is in relation to those resources? Continuing care may not be a problem nationally but I think it is a problem in some areas locally and I think it could become an acute problem in the next year or two with the increasing squeeze on resources in the health sector. With health authorities being asked, in some cases, to take two, three, five million pounds or more out of the system, that's going to create real pressure

Box 7

PRIORITY AREAS FOR FUTURE DEVELOPMENT

- Assessment
- Care management
- Responsibilities for continuing care
- Local authority role as enabler
- Market management
- Strategic shift
- Managing reprovision
- Organisational capacity and momentum
- Collaboration



on actually moving quite swiftly to close continuing care beds. And it is not just London that's confronting those problems, all major urban areas are similarly affected. There is an issue about the local authority role as enabler: again, is it there to provide or is it there to purchase, commission, plan, facilitate? And to what extent should local authorities move out of service provision altogether? Is that something the Government is going to push hard or is it something which will be left to local decision? For its part the independent sector is still very suspicious of local authorities for the reasons I mentioned earlier, and some bodies perceive the issue to be a political one, not a practical managerial one, of how you involve the independent sector in planning and assessment procedures. So there is an issue about what the actual local authority role will be in future.

An issue exists about market management in respect of the impact and influence of community care plans. I expect many of you have been involved in producing community care plans or have had the pleasure of reading and digesting them. It's still not clear to what extent those plans will actually, in a detailed way, guide implementation and move away from a system of aspirations and wish lists for developments, to those that are clearly allied to budgets and the resources available to implement those plans. I suspect there's still some maturing to be done in the development of community care plans: a good start may have been made, particularly in relation to producing joint plans with health authorities, but as we all know from the experience with joint planning, that can be easier said than done. The point about the strategic shift merits attention. If we are talking seriously about a shift from acute to primary and community care, then what are the implications for the reforms of that shift? The policy of closing long stay hospitals is continuing. Indeed, it is quickening pace to ease the pressure on health service budgets but there's an issue about developing

appropriate community care services to match the need for the health service actually to close long stay institutions. The point about organisational capacity and momentum takes us back to the point about frontline staff. It seems to me that there's a need - and it hasn't been achieved yet - fully to engage those members of staff. It's partly a training issue, it's partly a management issue but, again, I think it's fine for Directors of Social Services and people at the top of the office to be aware of what's going on but if you look at what is happening on the frontline there's a very different perception, a very different understanding of what the reforms are about. Finally on collaboration - and picking up the point about community care plans - if we look at the means of joint planning, and I think it is relevant to community care plans, it's relevant in so far as it's warning us not to get obsessed with structure as we did with joint planning. You remember all that stuff about JCCs, JCPTs, HCPTs and so on that took up endless amounts of time but often with little effect? There is a concern about that, a concern about neglecting the political skills involved in actually making a plan work at the end of the day and particularly a plan that involves cutting across professional and agency boundaries. A key element of the reforms is that we shouldn't forget that user outcomes are the test, at the end of the day, of a successful plan. And finally, as we did with joint planning, we shouldn't get focused on simply being concerned about the joint finance element, the new money, which might be around in the system to implement or pump prime that plan. We ought to be concerned about base budgets, about mainstream funding, about how we can actually shift the agenda towards something new and different.

Out of all that, I believe there are still some risk areas and I want to highlight five here (*box 8*). First, I still think there's an issue about hospital discharges and I think the pressures on hospitals to move people out quicker are going to grow. It is after all the basis

Box 8

RISK AREAS

- Impact on hospital discharges
- Impact on contracted hospital activity
- Impact on community based health services
- Impact of guidance on care provided in nursing or residential care homes
- Future impact on closure of long stay institutions



of the efficiency index on which health authorities and hospitals and so on are monitored and while that's being reviewed, quicker throughput is clearly in the interests of Trusts trying to balance their books and manage what for many is a very stressful time financially. So, while the issue of discharges may not be a problem now I don't think it's gone away and we should keep that in mind as being a potential hot spot.

The second point is about the continuing care contraction of beds in the long stay NHS sector and again, while all this is supposed to be handled on a gentleman's agreement between consenting adults across health and local authority boundaries, the potential for unilateral action is great and we shouldn't lose sight of that. I think there's still an issue about community health services. There's uncertainty among people in those services as to quite where they belong in the system and for many who see the health service becoming much more of an acute service rather than a service concerned with the chronic sick, there must be an issue about where they feel they belong in that system. There's still an issue about care provided in nursing and residential homes and about whether people are inappropriately ending up in them. Again, it's an issue of balancing need with personal choice and so on, but I think there are issues about that sector still. Then, finally, what in terms of the reprovision programme is going to be the impact of the closure programme on those particular care groups? We all know the problems around mentally ill people and others who fall through the net and although the attempt to avoid that is now being taken seriously, there must still be concern about people slipping through the system.

What about the longer term? In the last few minutes let me state what I think might happen over the next few years. Let me go back to Roy Griffiths, who said in his community

care review in 1988, "I have the occasional sinking feeling that there is nothing as outdated as to provide today's solutions to today's problem; there is a need to experiment with a whole variety of initiatives." More so now than even we thought a year or two ago, the future of community care is actually intimately bound up with developments in the NHS and, in particular, the much heralded strategic shift from hospitals to primary care and community care. A quote from the King's Fund (*box 9*) is typical of what you can pick up in any policy document in relation to developments in healthcare. We need to turn the pyramid upside down, which has at the top specialised care and at the bottom home based care, and see specialised care as being the end of the line, not the beginning of the process, and home based care and community hospitals, polyclinics, primary care teams/centres, whatever term you want to use, being much more the frontline of care, recognising that for many people it is the vehicle through which they receive all their care with the district general hospital dissolving into something quite different, something between the specialist centre, the specialist tertiary centre and the polyclinic community based facility. It seems to me that we are on the threshold of a revolution, not just in medicine (medicine is partly driving the revolution) but in other spheres too - economics, social trends, demographic trends - it's not just medical technology that's driving the move towards day surgery, towards minimally invasive treatment and so on. All of that is, when you put it together, creating quite a momentum which not everyone is aware of, certainly in the NHS and in social services and community care. Those who are aware of these developments are concerned about what the impact of the shift will be in respect of having to operate double running costs to allow the shift to occur from the acute sector to the community and primary care sectors at a time when budgets in both sectors are being squeezed extremely hard.

Box 9

"The picture of the delivery of care begins to turn upside down. Instead of the hospital being the main feature, primary and community care become the central focus and require access to a range of facilities".

("Medical advances - the future shape of acute services" King's Fund 1992)



The issue for the future is this: if medicine is a huge assumption, then the strategic shift in health and social care is similarly a huge assumption. We've all jumped on this bandwagon of thinking that primary care and community care might be better than acute care, and it might be but where's the evidence. We still don't know what the key components of the shift are or how it will actually be funded or whether it will actually work in terms of improved outcomes for users and carers. Technological, social and economic forces are driving us down a road which may be the right one to take but we haven't got the R&D evidence. We've got the R&D strategy and it's rapidly trying to run along behind the policy, but it seems to me it should be out in front informing that policy; at the moment it is not doing that. We haven't yet got a proper R&D strategy in social services although that gap is about to be filled.

As we move towards the end of the decade and into the next century, we're certainly going to be talking, if the Government has it's way, about more GP and primary healthcare activity. We're going to be talking about hospitals looking very different and we are going to be talking about empowering users with services being more user centred. Whether we'll ever get there is not clear, but we'll certainly be talking about brokerage roles, advocacy roles and so on. We will be talking quite radically about changing the workforce in terms of the skill mix and reprofiling the workforce in relation to new roles in community care activity. Hopefully we might move from form to function, we might actually begin to think what we want organisations to do instead of reorganising them without being clear about their purpose which is always great fun but at the end of the day doesn't inspire confidence about what the policy is. So we might need to begin to think what that policy shift means and what organisations are needed to implement it. I suggest we are possibly heading for further

structural realignment - not just because it's a British disease constantly to reorganise structures - but also because the structures may be inherently unstable. There are a number of models one could adopt and many of these are lying around out there somewhere and are being thought about and talked about. One might be a new primary and social care agency and there are experiments in primary care that could lead quite easily to that. There might be some sort of merger between health and social services and I won't say which way that might go but one can speculate that it could legitimately go either way, certainly on the purchasing side. We just need to remind ourselves of the fact that we're in a process of continual change and that the reforms implemented on the 1st April 1993 are not the end of the line by any means. The one certainty in all this is that the future promises to be as turbulent as the past and I just hope that we're more successful at managing it.

Thank you.

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