RESTRICTED - MANAGEMENT

ACTION NOTE

NHS EXECUTIVE BOARD MEETING
6/7 JULY 1995

Present:

Liam Donaldson
Ken Jarrold
Alan Langlands
Alasdair Liddell
Yvonne Moores
Colin Reeves
Chris Spry
Robert Tinston

Brian Edwards
Ron Kerr
Tony Laurance
Keith McLean
Bob Nicholls
John Shaw
Barbara Stocking
Graham Winyard

Helen McCallum
Wendy Prichard
Sue Probert

Apologies for absence: Michael Peckham

Secretariat: Tim Sands
Lesley Hilton

Attending for specific items:

Item 2 :	Ms Langridge
Item 4 & 5:	Mr Kenny
Item 5 :	Dr K von Degenberg
Item 6 :	Dr Mann
Item 11:	Dr Adam
Item 13:	Ms Exley
	Ms Roach
Item 14:	Mr Laming
	Mr Luce
	Dr Adam
	Ms Wolstenholme
	Mr Jenkins
	Ms Riley

BUSINESS MEETING

1. MATTERS ARISING/INTRODUCTORY REMARKS:

1.1 The new Ministers briefing had been revised following the appointment of Mr Dorrell as Secretary of State; a copy would be sent to Regional Directors and Chairmen.

ACTION 1: Secretariat to send revised new Minister's briefing to Regional Directors and Chairmen.

1.2 **Role of the Regional Chairmen** - Mr Shaw asked that the Role of the Regional Chairmen should be disseminated by Regional Directors and Chairmen in line with the local arrangements.

1.3 **MAKING A DIFFERENCE** - Mr Shaw advised the Board that the recent report on volunteering in the NHS had been received with enthusiasm by the former SofS, although officials had advised cautioning taking it forward. There was a well established tradition of volunteering in the NHS and any measures which were seen to alter the balance between voluntary work and that of paid staff might cause damage industrial relations,particularly at the present time. It was agreed that Mr Shaw circulate an action plan to the Board in the autumn before putting it to the new SofS in the autumn.

ACTION 2: Mr Shaw to circulate an action plan to the Board in the autumn before putting it to SofS.

2 EB(95)61 OPPORTUNITY 2000: WOMEN IN THE NHS -SUMMARY

2.1 Mr Jarrold introduced this paper supported by the head of the Women's Unit Caroline Langridge. The paper set out the progress to date in implementing programmes and initiatives to achieve the eight Opportunity 2000 goals set for the NHS in the first three year period to 31 December 1994. The NHS had achieved considerable success in all areas covered in the goals, except in the number of women consultants. Building on the success and achieved thus far the paper proposed a new set of goals for the next three year period to September 1998. The paper proposed the setting up of a single Equal opportunities Unit within the HR Directorate bringing together the work on gender, race and disability. Mr Jarrold said that care would be necessary when setting up the new unit to ensure that the contribution of the Women's Unit was clearly safe guarded. To this effect the paper proposed that when the present head of the Women's Unit left the post her successor be appointed as head of the Women's Unit with a brief to establish the Equal Opportunities Unit.

2.2 There was some debate over the level of some of the goals set for the next three year period. Whilst it was recognised that unreachable goals were a disincentive it was felt that;

- the medical goal was especially low in view of the fact this was already an area of poor performance;
- the timescale set would unfortunately miss the appointments round due in October/November 1998. With this in mind it was felt that if a longer timescale were considered it might be possible to increase from 43% to 50% the goal for membership regarding the representation of women as members of authorities and trusts in line with the suggestion from NAHAT;

- support for the goal covering part time/job sharing needed to be more robust.

2.3 In wider discussion the following points were made:

- it was acknowledged that the NHS had been amongst the most successful organisations in both the public and private sectors [acknowledged as the best by Valerie Hammond], however there was no place for complacency;

- it would be desirable to publicise this success by, for example entering the Opportunity 2000 Awards;

- there was concern that the goals would be viewed as "targets" rather than an acceptable minimum. It was important that every effort was made to achieve the maximum in this area;

- there was evidence to suggest that women were reluctant to put themselves forward for management positions in areas where the "long hours" culture prevailed. Women who already occupy top positions were ideally placed to lead the shift to shorter more acceptable working patterns.

2.4 The proposed Equal Opportunities Unit would need to maintain the momentum of the Women's Unit. Issues around the inequality of opportunity for black people and those with disabilities would be particularly challenging. There was a shortage of role models in this sector of the workforce which made the task more difficult, and it was anticipated that a series of dedicated programmes focusing on the black community in particular would be required over a period of at least five years before any substantial improvements could be measured.

2.5 In conclusion CE said that the Board appreciated the substantial achievements gained by the Women's Unit in this important area and remained committed to the initiative. The Board supported the proposals set out in the paper.

ACTION 3: Mr Jarrold and Ms Langridge to proceed with the proposals as set out in the paper.

3 **NATIONAL BLOOD AUTHORITY:**

3.1 Mr Shaw brought to the Board's attention the forthcoming publication of plans for the re-organisation of the Blood Transfusion Service. This had been commissioned following complaints that in some areas blood supplies had been inadequate and the service had fallen short of that required.Consultation and independent assessment had taken place and the National Blood Authority was now publishing its final report proposals. The report proposed new two new blood banks, one in Lincolnshire and the other in London in order to ensure the supply of blood within 2 hours of request. The initial investment required would be £3.75m, which would bring savings of approximately £10m from 1998/99.

3.2 Whilst the report did not recommend the closure of any centres it did propose the removal of processing and testing services from some centres which might lead to job losses. The situation regarding possible staff reductions required careful handling, but the feeling was that up to now the BTA handled the situation badly. Directors were anxious that the proposals were robust and if required would stand up to judicial review.

3.3 There was concern within the NBA that it did not feel an integrated part of the mainstream NHS. Regional Directors were asked to consider ways to assist in this integration through carefully planned meetings with NBA zonal managers. Regional Directors were also asked to encourage understanding and support locally for the changes and to discourage ill-informed publicity. CE said that careful consideration should be given to the handling of the announcement of the report in an effort to minimise adverse reactions.

ACTION 4: Regional Directors to consider inviting Mr Adney, head of the NBA to meet with HA and trust CEs. They are also asked to encourage support for the changes at a local level whilst discouraging ill-informed publicity.

ACTION 5: Mr Shaw to consider the careful handling of the announcement.

4 EB(95)56 BRINGING "QUALITY" INTO THE BUSINESS STRATEGY:

4.1 Mr Shaw introduced this paper supported by Mr Kenny. The paper followed up the Board's discussion of this issue and Mr Shaw's subsequent discussion with Mr Liddell and Dr Winyard about ways to integrate quality into the NHS Executive's wider strategic framework. Three further issues were also addressed in the paper:

- whether the centre should have a wider developmental role;
- what form should that role take;
- operationally separate, but a wider issue the need for an internal Executive quality strategy.

Mr Shaw said that the main thrust of the paper was responsiveness. It recognised that whilst quality was the responsibility of all staff and as such should be a core requirement, a small resource should be provided within HQ to act as a specific focal point to provide support to Ministers; ensure that the work that is necessary gets done and that the various strands of work involved interconnect properly. This might take the form of a twice yearly review of progress in the context of an information item for the Board. Ultimately, however the responsibility for delivering the quality agenda would lie with everybody. The NHS Executive would need to practice what it preached with regard to its business processes.

4.2 In discussion the following points were made:

- the efficiency index was a disincentive to a quality service;

- there was support for the idea of viewing quality not as a separate issue but rather as a core strategic approach which resulted from encompassed effectiveness, efficiency and responsiveness;

- a major Quality Strategy with a capital Q would require large resources and be viewed as yet another burden by those in the field where many good initiatives already exist. Examples such as SIGMA and Clinical Pathways in the West Midlands region, and quality networks amongst senior NHS managers. A better approach would be to expand upon and coordinate existing initiatives;

- the NHS was looking to the centre to provide a steer on how to develop quality as an overarching principle, particularly in areas such as clinical effectiveness and research;

- Equally there was no value in seeking to move forward a quality initiative half-heartedly.

- it was recognised that in order to drive forward quality as a core principle the centre must also provide a quality service. Training initiatives such as Investors in People as an integrated part of the overall change management programme should be driven forward, however it was accepted that this would have cost implications for both HQ and ROs;

- it would be necessary to look further at the implications of forming a small loans fund to finance projects.

4.3 In conclusion Mr Jarrold said that the Board were in broad agreement with the proposals contained in paragraphs 18 and 19, provided the coordinating role was strictly informal. They endorsed the medium input approach to the centre's role set out in paragraph 16 and the development of a quality programme within the Executive not as a separate initiative but as part of the overall change management programme. Mr Reeves was asked to explore the implications of establishing a small loans fund in the context of the wider issues involved.

ACTION 6: Mr Shaw and Mr Kenny to carry the work forward in light of the comments received.

ACTION 7: Mr Reeves to explore the implications of establishing a small loans fund in the context of the wider issues involved.

5 EB(95)62 ACCREDITATION OF NHS SERVICES:

5.1 Mr Shaw and Mr Edwards introduced this paper assisted by Mr Kenny and Dr von

Degenberg. This subject was last raised at the ME/RGMS meeting in December 1993, when it had been agreed that it would be raised again once the outcome of the ongoing research was available. The current national policy was that Ministers had given mild encouragement to the development of Accreditation, but that wished to be consulted before any stronger action was contemplated.

5.2 The research study was now complete. There had been two seminars on the subject bringing together professionals and managers to explore the options and the way forward, which had concluded that a hands off, coordinating approach for the NHS Executive would be useful. This approach also had the broad agreement of representatives of the Royal Colleges and the NHS. The number of bodies offering accreditation was increasing. The paper proposed that the Executive should encourage bodies to work together to develop common standards. Consideration was also given to offering guidance to the NHS, offering more encouragement for the use of accreditation services. This could be achieved by establishing a coordinating committee of purchasers and providers to report developments and system wide costs, to create a mechanism for "blending" standards and to "accredit" accreditation schemes.

5.3 In discussion the following points were made:

- those currently engaged in accreditation were fiercely independent, therefore the issue would need careful handling if measures taken were not to be seen as a prescriptive. A bottom up approach would be helpful, enabling the service to develop this work. It would also be put to the CSAG;

- The approach on the Accreditation of Pathology Services might be used for other specialities;

- it would be necessary to build in the requirement for continuous improvement in any accreditation system so it did not just provide a snapshot of performance at a specific given time;

- in view of the current Ministerial approach of "mild encouragement" consideration would need to be given as to how to take this forward;

- it was accepted that accreditation worked well in narrow areas, however reservations were expressed at attempts to apply the same principles to complex organisations.

5.4 In summary Mr Jarrold said that the Board were in broad agreement which best captured the with the thrust of the paper. He suggested that an alternative to the preferred option might be to encourage the establishment by the service of a system of quality control for accreditation schemes, and to ensure that it happened. It would be necessary to secure wider management/clinical involvement and commitment to ensure the success of any proposals.

ACTION 8: Mr Shaw and Mr Edwards to take the work forward in the light

of the comments received.

6 EB(95)63 CLINICAL EFFECTIVENESS

6.1 Dr Winyard introduced this paper assisted by Dr Mann. The paper followed on from an earlier discussion of strategic issues and contained a comprehensive action plan to develop a framework for cost effectiveness of clinical services. The paper set out a number of proposals which would:

- establish a steering group;
- bring outside experts through the establishment of an external group to be used as a sounding board and to provide advice on implementation;
- issue an annual EL drawing on the Action Plan for use in the Autumn contract negotiations;
- reduce overlap by means of a mapping exercise;
- set success measures for the next three years and enable the review of progress and make use of new evidence on getting research into clinical practice.

6.2 In discussion the following points were made:

- efforts must be made to ensure that links with the patient partnership initiative were strengthened and that information on effectiveness is aimed at patients;
- the evidence showed that change was best effected by empowering the field. It was felt that in a devolved health service the document was too prescriptive in tone and should be more facilitative in approach. There was more expertise in this area in the NHS the Executive and this should be recognised;
- there was value in adopting a more selective approach concentrating on the medium term priorities contained in the Priorities and Planning Guidance;
- in view of the current negotiations with the BMA on C distinction awards it might be possible to put more stringent criteria forward in respect of clinical audit to receive awards. This would encourage leadership and commitment to evidence based practice;
- there was evidence to suggest that some doctors chose to opt out from participating in clinical audit, whereas it was actually a requirement. participate in audit;
- it was recognised that post medical education and training in audit and evidence based clinical practice needed a boost. There had been a temporary staffing problem in HCD-METS which would be resolved in the autumn when

work on this should resume. It would also be desirable to engage ROs in education and training.

6.3 In summary Mr Jarrold said that there was general support for the paper, however it needed to adopt a more facilitative approach and reflect the current moves towards partnerships with patients. The Board would like to see more practical examples of good practice. More consideration needed to be given to boosting clinical audit and education and training, and to ways of introducing participation in clinical audit into the criteria on which distinction awards were to be based.

ACTION 9: Dr Winyard and Dr Mann to carry the work forward in the light of the discussion.

ACTION 10: Dr Winyard and Mr Jarrold to explore ways of making the most of education and training resources available in ROs.

7 EB(95)74 PROFESSIONAL ROLES IN ANAESTHETICS SERVICES

7.1 Mrs Moores introduced this paper which described the interest of NHS Trusts in the roles of non physicians in anaesthetics, and the concerns of the Royal College of Anaesthetists together with the limited action taken to date by the Department of Health. Directors were asked to consider a way forward which would optimise the range and availability of anaesthetic services for patients,ensure collaboration not confrontation between professional groups and employers and produce a beneficial outcome to a difficult problem. Mrs Moores was to chair a meeting of all interested parties, and it would be helpful if she could give a national steer to the profession and educational establishments.

7.2 In discussion the following points were made:

- the phrase "nurse anaesthetist" had been perceived as threatening by the Royal College of Anaesthetists.

- it would be helpful if this could be set in the wider context of change in anaesthetic services in general which were under considerable strain because of a shortage of consultants and contractual restrictions which had resulted in some full time anaesthetists working more than three sessions per week;

- service boundary change had already taken place successfully with the implementation of the Changing Childbirth policy. It would be useful to draw parallels between this and future service boundary changes;

- there would be fierce opposition from the Royal College to any proposals for changing restrictive practices and therefore it would be necessary to adopt a robust approach in the meeting;

- it would be crucial to gather adequate reliable information from countries already employing nurse anaesthetists to ensure an adequate level of education

and training and a safe level of practice;

- even if the scoping study went ahead there was an 18 months short term problem which needed to be addressed separately.

7.3 In conclusion Mr Jarrold said that Trusts in particular were seeking leadership on this issue,and it had to be forthcoming. The Board gave their support to CNO and urged her to be firm with the Royal College and not to be deflected by their support for restrictive practices. Further examination of the issue would be necessary, and it was suggested that NAHAT and the Trust Federation could be helpful in gathering information from overseas.

ACTION 11: Mrs Moores to hold a firm line at the meeting next Thursday with all of the interested parties.

ACTION 12: Mrs Moores to proceed with the scoping study, ensuring that adequate information is gathered from overseas.

8 EB(95)75 REVIEW OF EMERGENCY SERVICES:

8.1 In his introduction Dr Winyard explained that this issue had been a particular concern of the former Secretary of State and as such had been driven forward without consultation with the Board. A submission had already been sent to M(H) for consideration. The board felt that a submission was premature and full consideration by the Board was needed.

8.1 During a preliminary discussion of the issues involved the following points were raised:

- there were valuable lessons to be learnt following the Review of Cancer Services;
- the submission failed to take account of all the work underway in this area;
- the implications of the decisions taken about London's hospitals were not sufficiently explored in the submission;
- account needed to be taken of local authority and voluntary sector input;
- there was concern that the only region currently involved in the proposed work was Anglia and Oxford which did not have a large metropolitan centre;
- there was evidence to suggest that Private Finance investment would not be forthcoming in schemes which did not include A&E departments which was clearly of some significance in securing funding for new projects;
- it was not clear whether or not the review included high profile areas such as medical emergencies and children's services;

- it would be helpful to conduct the first stage of the review in house followed perhaps by an Expert Advisory Group;

- a revised submission should contain a clear statement of the problem accompanied by robust supporting evidence.

8.3 In conclusion Mr Jarrold said that the Board would like the submission to be withdrawn. Where as it was important that a review be conducted, the Board were not convinced that such a highly visible review was the best way forward.

ACTION 14: Dr Winyard to withdraw the submission pending further consideration of the issue by the Board.

ACTION 15: Dr Winyard to re-consider the submission and return to the Board.

9 EB(95)65 CORE VALUES: NHS EXECUTIVE RESPONSE

9.1 The paper represented an informal low key response to the consultation document. Dr Winyard said that the matter would be considered further at an informal workshop held jointly by members of the CMO/CE Working Group including representatives of the BMA and Royal Colleges.

10 EB(95)66 MEDICAL STAFFING ISSUES

10.1 Dr Winyard introduced this paper which reflected the progress made during the Board's strategic session on Human Resources in May. The paper set out proposals for new arrangements for the implementation of hospital medical staffing policy. There had been a reluctance by the medical profession to consider new arrangements, however the picture had changed markedly following a series of informal meetings between the Executive, the profession and NHS managers and in particular a fruitful meeting between M(H) and senior members of the profession on 9 May. The proposals had been generally very well received and there appeared to be a realistic prospect of being able to implement the new policies and arrangements as outlined in the paper. He hoped to begin implementation in the Autumn. Dr Winyard said that work would continue on developing the new arrangements and that a detailed action plan would be available in the next few weeks. A further paper on this issue would be considered by the Policy Board on 26 July.

10.1 In discussion the following points were made:

- there was evidence to suggest that many trusts had run down their medical workforce, planning capacity and it would be necessary to redevelop this capacity;

- in view of current pay negotiations for doctors and dentists it would be necessary to consider carefully the timing of the introduction of the new arrangements;

- it had been reported that the new arrangements would be cost neutral as it was anticipated that relaxing controls would drive the cost of doctors down. However, there was concern at regional level that the new arrangements would have resource implications which had not been fully costed;

- Regional Directors were asked to report examples of good practices in their regions;

- better information was required, particularly at regional level;

- discussions of the new arrangements with Trust CEs would involve ROs in a considerable amount of extra work;

- the perverse incentives surrounding early retirement of consultants as seen in London still existed.

10.2 Dr Winyard said that the new arrangements would be on the agenda for the forthcoming meeting of AGMETS and would be launched through a series of roadshows. An article would be written for Human Resources in the NHS setting out the main thrust of the changes.

10.3 In summary Mr Jarrold said that the Board were in general agreement with the proposals set out in the paper. However, it would be important to recognise that:

- the new arrangements would not be cost neutral;

- the full involvement of trusts would be needed for the effective implementation of the arrangements;

- the impact on ROs should not be underestimated.

It was agreed that the education and training interface with ROs and recruitment of medical staff required more substantive discussion.

ACTION 16: Dr Winyard to commission an article for Human Resources in the NHS to be sent to Directors for information.

ACTION 17: Dr Winyard to prepare papers for discussion on the education and training interface with ROs and the recruitment of medical staff.

11 EB(95)64 MENTAL HEALTH: EARLY PRIORITIES FOR THE NHS

11.1 Dr Adam supported Mr Liddell in introducing this paper which synthesised the Board's discussion at the June strategic session. The priorities in Annex 4 of the paper had been cross referenced against the priorities of the Priorities and Planning Guidance which had recently been published. Reflecting the majority view which emphasised the advantages of the "waiting list approach" the paper proposed an overarching priority which "demonstrated sustained improvement in the mental health

services provided for those with the most serious illness". There were, however two obvious disadvantages to this approach; the current inability to fully measure performance, and the emphasis on specialist services. Dr Adam said that in view of the heavy reliance on the primary care sector it would be necessary to return to the Board at a future date to assess the situation and discuss ways of ensuring the total involvement of GPs in this field. The proposals were the first stage in a longer term development of mental health services and were intended to be the first threshold that every health authority must cross.

11.2 In discussion the following points were made:

- if the performance management criteria were too rigorous this may have the opposite effect to that intended by bearing down on hard pressed staff;
- it was felt that the tone of the challenges was still too top down; if there was to be ownership by the field there would need to be a recognition of local priorities;
- If the early stages of illness were diagnosed and treated appropriately by the primary care sector it was possible the incidence of serious illness would reduce. However, GPs would need adequate training;
- a joint Langlands/Laming letter would lend weight to the proposals;
- Whilst the need to concentrate on those with the most serious mental illnesses was understood,it was important to recognise that a comprehensive local service could only be provided where the full range of illness was treated;

11.3 In conclusion Mr Jarrold said that the Board supported the proposals which had summarised the concerns voiced at the strategic session from mental health professionals, and user group representatives. There was general support for focusing on several mental illnesses whilst recognising the need to develop primary care services. The Board were anxious that performance management be sensitive to real situations. It was important to recognise there was a threshold every district must achieve but the balance of services above that was not a matter for presumption.

ACTION 18: Mr Liddell and Dr Adam to take the work forward in the light of the comments received.

ACTION 19: Mr Liddell to bring a paper to the Board to discuss the involvement of Primary Care in the proposals.

12 ANY OTHER BUSINESS:

12.1 **Minutes of Last Meeting: EB(95)60 Quarterly Monitoring: Q4** - para 5.2 referred to work under way with West Midlands RO on the collection of Fast Track information following concerns about stopping the collection of monthly data. It was felt that the proposed system of purchasers sending their data direct to HQ would put

ROs at a disadvantage, and that ROs should be initial recipients. Mr Reeves would consult with Mr Garland on this.

ACTION 20: Mr Reeves and Mr Garland to examine the proposals in the light of the comment.

12.2 **GP Out of Hours Payments** - Mr Jarrold updated the Board on the latest position. As expected the offer had been rejected by the profession.

12.3 **Pay** - Mr Jarrold updated the Board on the latest position. Further negotiations were expected, and he asked Directors to send any thoughts they might have to him as soon as possible.

13 **ORGANISATIONAL DEVELOPMENT:**

13.1 Margaret Exley, the management consultant in charge of the Organisational Development of wider Department and Sally Roach the consultant for the NHS Executive presented the findings from the first phase of the project. They set out the results of a series of personal interviews across all grades of the Department working in Leeds London and RO. The overall findings were summarised in the phrase "the whole is less than the sum of the parts". There was a general feeling that change was on the whole welcomed staff, but that so far it had lacked direction and coordination. They listed six realistic objectives for the next 12 months and suggested ways in which these might be achieved.

13.2 Mr Spry outlined the main points which had emerged from a meeting of the NHS Executive Change Management Steering Group. He set out the group's diagnosis of the problem, the shape of the future organisation and ways of achieving it.

13.3 There followed a lengthy and wide ranging discussion, the main points of which were:

- There was a clear need for change and this should not be ducked;
- in order to identify the role of the centre the needs of one group of our primary customers, purchasers and providers would have to be established;
- the focus of the DMB should be on the "big picture" rather than on management issues;
- there was some debate as to whether or not it was desirable to seek to merge the different cultures which existed in HQ and ROs into a new culture or whether to encourage diversity. It would be necessary for ROs and HQ to work through the differences and decide if they were legitimate;
- It was not the intention to make HQ and the eight ROs are homogenous block;
- staff should be encouraged to celebrate the strengths of the organisations they come from the NHSME and the RHAs;

- the best way to achieve effective team building across the Executive is by working on real problems. However the prospect is diagonal slice groupings which could also make a contribution;

- it was important to acknowledge the degree of difficulty and the depth of distrust felt by staff at all levels of the organisation;

- it was important to solve the practical problems surrounding the terms and conditions of RO staff and provide a coherent HR approach;

- it was important to have a clear understanding of the NHS is and ministerial expectations of the Executive;

- it would be helpful to identify a critical mass of staff who had experience of both RO and HQ cultures and ways of working and in order to draw on their experience;

- it would be important to provide people a training for those with no experience of working with other organisations, drawing on the experience of those who understand both cultures;

- a good model of single centre working existed in the handling of communicable disease;

- there was a need to demonstrate some early gains to encourage staff to commit themselves to longer term goals;

- an internal communications were needed which were genuinely based on openness;

- in future line mangers should be more involved in job evaluation;

- it was crucial that fairness was seen as a fundamental principle for the Executive;

- there was more resistance to change form middle/ senior managers than staff who were more prepared to change.

14 STRATEGIC SESSION: COMMUNITY CARE

14.1 An overview paper and a number of background papers had been prepared for the session:

- EB(95)67 Overview Paper;
- EB(95)68 Overview of the Development of Community Care;
- EB(95)69 Monitoring and Management of Implementation of the Continuing Care Guidance;

- EB(95)70 Continuing Care Investment - Indicative Analysis;
- EB(95)71 Impact of GP Fundholding on Social Care Policies;
- EB(95)72 Regulation and Inspection Issues;
- EB(95)73 Factors Influencing Community Care Strategy.

Mr Liddell introduced this session assisted by Dr Adam, Ms Wolstenholme and Mr Jenkins. He said that there was a growing sense of urgency to address the concerns surrounding the provision of community care. In order to tackle this it was important to gain a sense of what was wrong with the current arrangements and identify the weaknesses. Before they divided into smaller working groups Mr Laming, Chief Inspector of the Social Services Inspectorate and Mr Luce, head of Community Services and Liz Wolstenholme of the NHS Executive outlined some key background issues.

14.2 Mr Luce gave the Board a central overview of the current position on the Community Care reforms; future developments in the context of the legislatory framework; areas currently under examination by central government and the current direction of the community care movement.

The assessment of the success of the reforms varied widely; there was continuous optimism on the part of the Audit Commission and the various agencies involved, but this was countered by pessimism on the part of the BMA and other professionals. However, the overall view was that the new arrangements had held together well, providing the support necessary to keep clients in their own homes. Where as inter agency links had improved, there was still room for further development and cooperation. The current local authority settlement was very tight, and the Department had sought an attempt to make plans for the implications of tight budgetary control in Social Services and to other Departments.

The Carers Act would be implemented April 1996. Legislation was currently being prepared to give local authorities the power to make payments to enable clients to buy the services they wanted, giving them control over their own circumstances.

Central Government was also looking at some of the wider issues in this area. The way forward being adopted was to move away from the notion of implementing caring for people to seeing it as a permanent feature of the landscape; part of a progressive movement. The department was looking to support the field in making progress through innovation.

14.3 Mr Laming spoke about the diversity of local government.

Local authorities varied widely in size (180k-1.5m), competence, internal management arrangements and vision. Their discretion was considerably restricted by capping. Future boundary changes were altering their size (generally reducing), and the smallest would have to form purchasing consortia in order to provide the full range of services. There was a perception that the NHS was involved in a massive cost shifting exercise from central to local government. The range of services provided by local authorities was ever growing and recent alliances between GPs and

Social Services Departments had resulted in the provision of 24 hour domiciliary care.

The current net spend due to private and voluntary contributions on PSS was reported as £6.6bn, however the actual figure spent was much higher. The ageing population has huge financial implications. The over 85s age group social care costs were 15 times as much as the 64-75 age group, whereas it was only 3 times for the NHS Insurance schemes to provide private continuing care cover were available but the take up rate was very slow.

Mr Laming felt that the NHS and SSDs were ahead of the other in different areas;

SSDs were ahead of the NHS in;

- consulting and involving carers/user groups,
- working in partnership with others,
- working with a variety of providers.

The NHS were ahead of SSDs in;

- centrally driven processes for prevention and promotion of health,
- workforce planning and training,
- development and quality of information systems.

Areas where continued collaboration was needed were;

- joint planning of services,
- development of better assessment procedures,
- multi disciplinary working on more complex cases,
- clarifying roles and responsibilities,
- setting priorities,
- displaying a united front regarding the eligibility criteria,
- engaging GPs in Planning and provision of services,
- winning the confidence of local communities.

14.4 Ms Wolstenholme set out the areas of risk, monitoring and support and bottom line issues associated with the implementation of Continuing Care Guidance.

Areas of risk:

- complicated process often poorly managed;
- the difference between the perceptions and realities of the change;
- provider/professional support was often weak and their was considerable ignorance among GPs;
- there were concerns about equity between adjacent areas.

Monitoring and support:

- the visibility of the process;
- it would be best on the triple test (LA/NHS agreements, centrally prescribed objectives, the public view);
- joint RO/SSI monitoring;
- national consistency needed;
- There was an issue about developing a means of quantifying provision without resorting to bed norms.

Bottom line issues needing to be achieved were:

- realistic but challenging investment programmes;
- equity;
- robust agreements with LAs;
- influencing the public debate through effective communication;
- involving GP Fundholders, ensuring they did not just purchase services for those who came through the surgery door;
- firm eligibility criteria.

The Community Care Team had developed a three dimensional mapping technique for placing HAS with regard to the provision of continuing and community services. This should be a useful performance management tool. The public were aware of where shortfalls existed.

14.5 Directors divided into groups for further discussion. There was a brief reporting back from the groups:

Group A - Opportunities/threats on the health/social care interface:

- Debate needed to be initiated on Public expectations.It was easier to generate good public debate at a local level however, it would be harder at national level;

- There was an information deficit; the public were not in possession of the facts;

- the new LAs would be nearer in size to HA purchasing localities and there were opportunities for delegating purchasing;

- there would be opportunities for more local initiatives.

Group B - Management of Issues arising from implementation of the continuing care guidance:

- There was a need to reemphasise the NHS's commitment to continuing care, effective treatment, assessment and rehabilitation demonstrated by local policies and eligibility;

- it would be necessary to ensure that the new SofS was made fully aware of the implications of issues such as local government settlements and bed blocking;

- GPs would have a significant influence over how the guidance would be perceived;

- It was important to local champion the good end of medical leadership: for example good geriatric services could have a dramatic impact.

Group C - Community care in a primary care led NHS:

- A useful objective would be to set a target of having a case manager attached to every GP practice. This could be piloted by having a scheme in one LA in each RO area, part funded by the NHS;

- it would be helpful to issue a leaflet setting out the key points of the Continuing Care Guidance. This had been considered, but there was ministerial concern that this would have the effect of putting the issue back on the public agenda: A way forward might be a core text which could be adapted locally into a briefing pack addressing local needs and concerns.

14.6 There was a general discussion during which the following points were made:

- it would be difficult to obtain the confidence of the public without demonstrating commitment through continued investment. Because of regional variations it would be impossible to give absolutes regarding the level of investment, however explicit and obvious examples of reinvestment would be needed;

- future investment should not be based on historic patterns but reflect the new shape of services;

- the level of success would depend on PES settlements;

- there was some concern that monitoring arrangements were too detailed and time consuming.

14.7 In conclusion CE emphasised the importance of getting this right. It was not the time to worry about "light touch" issues. Implementation of the guidance would need to be quite directional and must be supported by hard data. A checklist would shortly be used to help ROs evaluate the effectiveness of the eligibility criteria. There would also be guidance on the models of care and on engaging GPs. These would be working documents to support local implementation. The monitoring framework would be put to ministers and issued to the service very soon.

ACTION 21: **Mr Liddell to take the work forward in the light of the discussion.**