Who will be 'caring for people'?

THE health service is not alone in undergoing a period of rapid change: the white paper *Caring for people*,[1] now incorporated into the National Health Service and community care act, is causing a similar upheaval in local authority social services departments. The origins and main elements of the new community care proposals are outlined here, together with a discussion of their potential effects on general practice and primary health care. The role of the case manager is also discussed.

During the 1980s there was a shift towards care in the community. Problems arose for people with chronic mental illness, where the rapid programme of hospital closures was not accompanied by adequate alternative community based resources.[2] At the same time, the relative ease of obtaining funding from the Department of Health and Social Security for private residential and nursing care for the expanding frail elderly population created a 'perverse incentive' away from domiciliary care.[3]

Sir Roy Griffiths produced a report for the government making recommendations for dealing with these problems, and suggested administrative structures within which community care might work more effectively.[4] *Caring for people* and the subsequent act are the delayed official responses to his report. Implementation of *Caring for people* was originally planned for April 1991 but has now been postponed until 1993.

The main aims of the community care proposals are to enable people with chronic illness to live in their own homes, to provide support for carers and a proper assessment of need, and to clarify the responsibilities of health and welfare agencies. Local authority social services departments have been given the major responsibility for implementing these changes. The purchaser–provider model has been applied, where social services departments will become the purchasers of care in most cases (the situation with mental illness is not yet clear) and will look to the health, voluntary and private sectors, as well as their own resources, in their search for suitable providers.

The central figures in the process will be the case managers, who will be appointed by social services departments, and will have their own budget. Case managers will be expected to oversee the process of needs assessment, and to put together a package of care best suited to the needs of their individual clients. There are obvious parallels here with fund holding in general practice — in both cases financial and management responsibility has been devolved from central to local level, and the scope for providing care has been widened beyond conventional boundaries.

While broadly welcomed by most political, health and welfare organizations, *Caring for people* poses problems. Some health agencies have been sceptical of the wisdom of giving so much responsibility to social services departments.[5] For social services departments, it involves enormous organizational changes at a time when morale is low and funding scarce. Griffiths' recommendation that part of the local authority budget be reserved solely for community care was initially not included by the government; it will be interesting to see whether the recommendation is adopted later. Some individuals within social services departments consider that although the community care proposals appear inviting, given the scale of the problems and the limited resources available, they are likely to prove difficult or impossible to implement. For the proposals to work, they will need adequate funding levels and creative, competent activity by social services departments.

Caring for people will encourage the evolutionary trend from institutional towards community care, and as such it will lead to increased demands on the primary health care team, particularly in the management of mental illness[6,7] and the problems of frail elderly people.[8,9] But it will also have other, more specific, implications.

Doctors, whether community or hospital based, will have an obligation to refer all patient problems needing social resources to their local case manager. This means not only requests for home help or occupational therapy, as at present, but also potential referrals to nursing homes. The case manager will make an assessment and will make the final decision as to whether residential or domiciliary care is more appropriate. This appears to involve a significant transfer of decision making from medical to social services.

General practitioners must begin to consider their response. The increasing burden of care for the new vulnerable groups will necessitate extra consultation time, and contingency plans for this need to be made. General practitioners may wish to work with colleagues in social services and public health departments (using their skills in health needs assessment) in drawing up care plans.

The 1990 contract for general practitioners and the development of fund-holding practices are of relevance to these changes and both can be used to develop links with *Caring for people*. First, the annual health checks for those aged over 75 years are a rich source of information on the social, as well as the health needs, of elderly people.[10] Such information is likely to be useful for case managers. Projects in north London and on Merseyside are currently investigating the potential of computerized assessments of the elderly to provide such linkage.[11,12] Secondly, the three-year adult health checks can enable general practitioners to identify other at risk groups, such as mentally ill people, mentally and physically handicapped patients, and also their carers. Once identified, it is possible for general practitioners and case managers to plan interventions. A study to evaluate this use of the three-year health checks is underway in Edinburgh (Porter M, University of Edinburgh, personal communication).

It may be feasible for case managers, although employed by social services departments, to work within primary health care teams; such a scheme is being tested in Bradford. The King's Fund Centre has set up a pilot project with two fundholding practices in which a local authority case manager is based in each practice and controls the social services budget for the practice population (Girling J, University of Manchester, personal communication).

Further experiments are possible. Although case managers are employed by social services departments, it is not clear that they must be social workers. In principle, therefore, it would be feasible for a general practitioner, practice nurse or health visitor to become a case manager on behalf of the local authority. More radically, it would be possible for case management to be devolved to a representative of a patient group — this might be most appropriate for physically disabled people — or to a voluntary agency such as Age Concern. This could mean different case managers for different client groups rather than one per practice. Whether a social services department will have the courage to try such an approach remains to be seen.

It is possible that the changes taking place in both the health and social services may offer the opportunity for new and better ways of working, for an approach to patient care based on a greater appreciation of need, and a commitment to community based services. Whether such changes develop depends on

political goodwill and financial provision from the centre, including adequate funding for research.[13] They will also depend on the interest and creativity of all those working in the community.

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Controlling your vocabulary

A NEW year and a new feature in the *Journal*: at the end of the summary for each paper is a list of keywords. This idea is not new and has been used by many academic journals. However, what is new is that the keywords used here are taken from the Royal College of General Practitioners' GP-LIT thesaurus, a list of keywords dedicated to general practice used by the College's librarians to index material for GP-LIT. GP-LIT is a computerized database, which was started in 1985, dedicated to general practice and allied material.

A thesaurus is a structured list of approved terminology with signposts (non-preferred terms) from words and phrases that cannot be used to those that can (preferred terms), for example AGED use ELDERLY. This technique is called controlled vocabulary, a method of controlling the words and phrases in order to allow easier and more effective keywording (indexing) and searching (retrieval) of records from catalogues, filing systems, databases or other information systems. The example most familiar in medicine is the medical subject headings (MeSH) used to search the National Library of Medicine's database, MedLine.[1-3]

The alternative to using a controlled vocabulary is to use free text searching. This means that to search a database, all the words or phrases that describe a concept or object are thought of and a search is undertaken using those words. Using the example of a WASTE-PAPER BIN, this could involve searching for the following words and phrases: BIN, WASTE-PAPER BIN, WASTE-PAPER BASKET, DUSTBIN, TRASH CAN, GARBAGE CAN, and so on. This is inefficient and one can never guarantee that all the alternatives have been thought of. A controlled vocabulary, however, allows efficient searching by selecting the term that will be used.

There are international standards[4,5] and instructions[6] for the construction of thesauri and guides to indexing.[7-9] A thesaurus is structured around relationships — generic or hierarchical, and associated. Generic relationships, indicated by either 'broader term' or 'narrower term' are concepts or objects that are a species or type of another concept or object. Associated relationships, indicated by 'related term' are concepts or objects that are connected, but are not a species or type of another concept or object. As a simple example, MICE are a type of RODENT and therefore a narrower term of RODENT. A MOUSE-TRAP is not a type of mouse but a method of pest control and is therefore a related term of MICE but a narrower term of PEST CONTROL METHODS. Generic relationships in thesauri can also be constructed by the creation of hierarchical tree structures. On the printed page these look similar to a classification of diseases.

The Royal College of General Practitioners has been collecting literature on general practice since the late 1950s and is a unique source of information. Before the computerized database, GP-LIT, was started in 1985, bibliographical records were created for a card catalogue, and it is hoped to transfer these records onto the new database. GP-LIT currently contains over 20 000 bibliographical records of books, pamphlets, articles and chapters from the world's literature. A thesaurus of appropriate terminology, the GP-LIT thesaurus, which was begun at the same time to keyword (index) these records, now stands at approximately 5000 words and phrases (preferred terms) and 1500 signposts (non-preferred terms).

GP-LIT and the GP-LIT thesaurus are complementary to existing commercially available databases and thesauri in both content and terminology. The keywords used reflect the concerns of general practice, especially as practised in the United Kingdom, and therefore activities such as consultation, referral, audit and practice organization are well represented. For example, to search for material about referral using MedLine, the keywords that could be used are FAMILY PRACTICE together with REFERRAL AND CONSULTATION; after this one would have to employ a free text search. The GP-LIT thesaurus, however, contains over 20 keywords and phrases connected with the activities of referral and consultation.

Many general practitioners have their own collections of literature and all training practices must now have a library. As these collections grow, the need to organize and retrieve this material becomes more important and Margaret Hammond, in her book *The practice library,*[10] describes how to do this. Advances in computer technology have made personal and general practice computer systems a reality for many general practitioners and they may be tempted to record details of such collections on a computer database. Once recorded, such infor-