Community care reforms: early implications for general practice

THE last five years have seen major shifts in the way in which health and social care are delivered in the United Kingdom. The impact on general practice of changes outlined in the government's white papers *Promoting better health* and *Working for patients* has been all too obvious. The effect of the third white paper *Caring for people*[1] on general practitioners and their patients has been less clear although some evidence is now emerging.

The final phases of the community care reforms outlined in *Caring for people* came into effect on 1 April 1993, two years later than the government had originally intended. The changes were in response to Sir Roy Griffiths' assessment of community care services which highlighted spiralling costs and the insufficient attention paid to users' and carers' preferences.[2] The most important changes introduced by the reforms were that local authorities assumed responsibility for care in the community, with funds being redirected to them from the Department of Social Security; the purchasing and provision of community care were separated and became needs-led rather than service-led, thus giving service users and their carers more choice in the nature of services provided; and there was an emphasis on enabling people to live in their own homes wherever possible by the provision of day care, domiciliary care and respite care.[3]

The focus of the reforms was on the care of elderly patients, those with learning difficulties, with chronic mental illness and with physical disability. These patients form a considerable part of a general practitioner's workload so it was inevitable that the community care reforms would have an impact on the general practitioner and other members of the primary health care team. In *Caring for people* the government recognized the key role played by general practitioners in caring for people in the community and called on them to make a contribution to assessment procedures for community care. It pointed out that under their terms of service general practitioners have a responsibility 'to give advice, as appropriate, in order to enable patients to avail themselves of services provided by the local social services authority'. Their role in the assessment procedure subsequently became a contentious issue. Concern was expressed about the increasing demands being made on general practitioners' time and resources and the possible conflict with their role as the patient's advocate. Guidelines from the General Medical Services Committee[3] stressed that this role should not be threatened and that general practitioners' input into the assessment procedure should be limited to providing information about the patient's health. In a report which made special reference to the perspectives of social services departments, the general practitioner was seen as the initial identifier of the patient's need, referring to and providing further information for social services, as requested. General practitioners were not expected to take the lead role in the patients' assessment.[4]

Evidence from several sources suggests that general practitioners were not well prepared for their role in the implementation of the reforms in spite of guidelines and other documents produced by the Department of Health and local authorities. A nationwide survey of 10 randomly selected health districts in England pointed to major deficiencies in general practitioners' knowledge and an overall lack of preparedness which highlighted their limited involvement in the planning stages.[5] These findings were confirmed by a study of general practitioners in North East Thames Regional Health Authority.[6] They were not alone in their lack of readiness for implementation of the reforms. Community nursing staff also felt ill prepared.[7]

Although emphasis was placed on the general practitioner's role in assessment before the reforms were introduced, a look into a crystal ball in April 1992 might have revealed that the impact of the community care reforms on general practitioners and other members of the primary health care team would extend beyond their role in assessment procedures. Paperwork was likely to increase as the traditional telephone call for a home help for a patient might no longer suffice without a completed request form in some areas; there would be an increase in the number of dependent patients remaining in their own homes; the requirement for assessment and designing a package of care for a patient might lead to a delay in the provision of services; in addition, a delay in discharging patients from hospital might result in admission problems for other patients.

Have these fears been realized and what progress has been made over the past year? The answer clearly depends on who is answering the question. The Audit Commission reported that 'so far implementation has proceeded smoothly with local authorities establishing the necessary infrastructures'.[8] However, the optimism is less evident when the views of the medical profession and organizations representing users and carers are considered. A report by Age Concern highlighted the long wait for assessment, the reduction in the number of home helps available and expressed doubt that patient choice had increased.[9] A survey of doctors carried out by the British Medical Association found that the majority thought that the services for patients had either deteriorated or had not improved. Concerning patients being discharged from hospital, the average time lag between referral to and assessment by social services was three weeks and it was felt that this delay was causing bed blocking.[10] Forty per cent of respondents considered that their workload had increased, largely owing to more administration and an increase in the number of very dependent patients living at home.[10] Similar concerns about paperwork, delay in assessments and failure of community care services to improve were found in a follow-up study of general practitioners in North East Thames Regional Health Authority.[11] The report of a seminar held at the King's Fund Centre identified early signs of service improvement. Improved collaboration between health and social care agencies was noted and the report stated 'general practitioners are becoming more aware and involved in community care' — a conclusion not supported by the surveys already mentioned.[12] However, these reports are based on perceptions rather than hard facts and must be viewed cautiously. In addition, it should be remembered that these are early days and it would be unwise to make premature judgements about changes which were planned to be fully implemented over the course of a decade.[1]

Concerns at a strategic level have also been expressed. The operation of market forces in the National Health Service has tended to place an emphasis on acute care with neglect of continuing care because the latter is perceived to be the responsibility of social services rather than the NHS.[13] Questions have been raised about the adequacy of monies allocated for service provision. If these concerns are realized financial pressures may well lead to attempts to shift responsibility for care from social ser-

vices to health services with patients falling through the gap which has been created.[14] A recent House of Commons committee report highlighted the potential conflict explicit in the reforms between the downward pressure on the budget of social care (previously there was an open-ended commitment to those claiming income support) and the increasing demand on services resulting from detailed assessment and identification of patients' needs.[15]

What of the future? How can the main aims of the community care reforms to make the services more responsive to the needs of patients and their carers and to improve the overall quality of community care be achieved? And what role should the general practitioner play?

First, there is a widely recognized need for closer collaboration between health and social services if the reforms are to succeed[1] and some concern that this may be difficult to achieve.[13] Problems in inter-agency working are not new and have been attributed to a number of factors including differences in the structure and working practices of the NHS and social services and in the occupational culture of health and social care practitioners.[16] The lead up to the reforms certainly highlighted the inadequacy of communication between social services departments and general practitioners, both in terms of collaborative planning and day-to-day telephone access and face-to-face contact.[5,6]

Ways of promoting greater collaboration are being developed. Joint commissioning of health and social care is happening in some areas; the Lyme community care unit has been set up by general practitioners[17] and a fundholding practice has established contracts with their social services department.[18] Alternative strategies are the linking of care managers with general practitioners' surgeries and the attachment of social workers to practices. However, these initiatives are localized and involve the minority of general practitioners and patients; it is to be hoped that they are being evaluated and that the results will be widely disseminated. How can greater collaboration with social workers be achieved by general practitioners in general? Both groups need to make opportunities for more face-to-face meetings; a named contact in social services for each practice and social workers becoming members of the primary health care team are possible way of achieving greater collaboration.[6] An understanding of each other's culture and methods of working are clearly important and could be promoted by joint education and training, secondment of social workers to general practices and members of primary health care teams to social services departments for short periods of time.

The community care reforms provide an opportunity for improving the quality of care for users and their carers for whom the divide between health and social care needs to be bridged. Restructuring the way in which care is delivered, closer collaboration between health and social services practitioners and the provision of adequate resources are key components of improving the quality of care in the community.

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Formulary for self-care

A SLIMMER drug budget, increased prescription charges and the increasing range of medicines obtainable without prescription mean that patients will now buy even more medicines for themselves. They may do so without consulting anyone, they may ask the pharmacist's or doctor's advice, or they may be acting on the doctor's recommendation. A recent survey of over 2000 general practitioners, conducted for the Proprietary Association of Great Britain by the publishers of the *Monthly index of monthly specialities (MIMS)*, found that half of them recommended a product which can be purchased without prescription ('over the counter') at least six times a week, and that 78% believed they would recommend more over the counter medicines in the future.[1] Forty eight per cent of the general practitioners, who in 1993 received a copy of the *OTC Directory*,[2] an illustrated catalogue of branded over the counter