

Building Bridges

*Bridging the Health and
Social Care Divide in Wales*

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Research by Cardiff Law School
In conjunction with the
Wales Office of Research and Development
for Health and Social care

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Index

Part I:	Introduction	1
Part II	Executive Summary	5
Part III:	National Issues	9
	The legal divide	9
	Budget pooling	9
	The Welsh Office	10
	<i>Mixed messages</i>	10
	<i>Further Welsh Office guidance</i>	11
	<i>Dissemination of information</i>	12
PART IV	Organisational Issues	14
	Personal relations	14
	Local government & health authority reform	15
	<i>Trust reconfiguration</i>	17
	Size Mismatches	19
	Cultural Differences	20
	The Locality Presence	21
	History	21
	Information Sharing	22
	<i>Joint strategic planning</i>	22
	<i>Joint mapping</i>	23
	<i>Information exchange arrangements</i>	24
	Inter-Authority Networks	25
	Common needs initiatives	26
	<i>Joint training</i>	26
	<i>Office sharing</i>	27
	Continuing Care Statements	28
PART V:	The Key Local Interfaces	31
	Hospital discharge procedures	31
	Respite care services	33
	Rehabilitation services	35
	Continuing inpatient care	36
	Specialist nursing/ residential home support	36
	Primary health services to people's own homes	38
	GP involvement in inter-agency working	39
	Hospice/ palliative healthcare services	41
	Bibliography	42
	Welsh Office Guidance ~ an annotated summary	45

Part I Introduction

This report¹ results from a research which was carried out between November 1997 and July 1998 with funding support from the Wales Office for the Research and Development of Health and Social Care. The survey sought to provide a review of the practical everyday successes and difficulties experienced by Welsh social services departments and health authorities in forging collaborative joint-working relationships to meet the continuing care needs of older people.

Personal interviews with senior officers from the five health authorities and ten social services departments took place between November 1997 and March 1998. The findings from these interviews informed the detailed questionnaires which were then sent to the remaining twelve local authorities, nine of which responded. Accordingly, the report is based upon the views expressed by a senior officer from each health authority in Wales and by senior officers from nineteen of the twenty-two Welsh social services departments.

In the research study we have not sought to concentrate upon the detail of the continuing care statements. Instead we have taken stock of the wider situation as the fundamental reform proposals in the White Paper *NHS Wales: putting the patients first* were being digested. We have endeavoured to analyse how authorities in Wales are bridging the divide to ensure that the seamless service exists in practice².

In the full research study³ we investigated the extent to which local collaborative initiatives had been fostered by health and social services authorities in Wales and concluded that such initiatives were not common. This is not, however, unique to Wales (*see for example* Nuffield Institute (1993) where it was noted that in England 'such initiatives were hard to spot'); the barriers to joint working identified in this report are substantial.

Those local collaborative initiatives that have occurred have for the most part been developed in relative isolation and in spite of, rather than because of, the existing structures. This again mirrors experience elsewhere in Britain: (*see for instance* Davidson and Hunter (1994) where it was noted that many of the most successful examples of such initiatives have emerged from innovations that have bypassed or have only been loosely accountable to formal organisational structures; and DHSS (1986) which noted that at the primary care level the imaginative and effective schemes initiated by social workers/ community nurses were developed in an unco-ordinated way). Furthermore, it is a problem already noted by the Social Services Inspectorate for Wales (Welsh Office 1996e) which found that, although social services departments had been hampered in forging formal relationships because of local/ health authority reorganisation, they had often managed to 'establish constructive relationships with health authorities and trusts finding individuals with whom they could do business' even when this was not possible via formal structures

Although it was suggested to us by a health authority respondent that such initiatives as exist in Wales are likely to be in 'middle-class leafy areas', it is again beyond the scope of this study to ascertain if such an inequality exists. The existing research would suggest that this may well be the case⁴.

¹ An abridged version of the full research survey published as 'A snapshot survey of social services responses to the continuing care needs of older people in Wales' (1998). The full report includes an analysis of 5 local collaborative health / social services initiatives that have taken place in Wales and a fuller literature review.

² A number of researchers have sought to categorise the various obstacles to effective joint working, by analysing the macro/ micro organisational interfaces (*see for example* Hunter et al. 1998) or by identifying the theoretical barriers (*for instance* Wistow and Hardy 1991) consider five impediments: structural, procedural, financial, professional status, legitimacy).

³ See footnote 1 above.

⁴ See, for example, Townsend et al. 1982 but compare Benzeval et al. 1995 and O'Donnell and Propper 1991

The task faced by social services and health authority personnel in Wales is, of course, daunting. The twenty-two unitary authorities and five health authorities charged with delivering community care do so within a nation of great variations. Not only do the 2,921,100 people living in Wales (Welsh Office 1997a) have one of the worst life expectancies in Europe (Welsh Office 1998b), but also the mortality rate itself varies widely from region to region. The life expectancy in some areas of the south Wales valleys is, for instance, about five years less than in some other parts of Wales (Welsh Office 1997b); the death rate from strokes, for instance, is almost a quarter higher in Merthyr Tydfil than in Anglesey (Monaghan 1998) or indeed Blaenau Gwent (Welsh Office 1998b).

Whilst each health authority serves broadly equivalent populations in numerical terms (ranging from Bro Taf HA with 726,800 to Dyfed Powys HA with 475,500 (Welsh Office 1996f)), their geographical coverage varies greatly, with two health authorities alone covering three quarters of the land mass of Wales. Health authorities must forge collaborative relationships with local authorities of markedly different character. Bro Taf HA area, for instance, contains the smallest and largest unitary authorities in Wales (Merthyr Tydfil with a population of 58,770 and Cardiff with 309,4400 (Welsh Office 1996f)). Likewise, North Wales HA area contains Conwy, which has the highest percentage of the Welsh population above 75 years of age (11.7%), and Flintshire which contains the second lowest (at 6.4%).⁵

These widely differing demographic and morbidity characteristics make the planning and delivery of health and social care services a significant challenge. In addition Welsh health and local authorities have had to cope with the major reforms they both underwent in the mid 1990s, and are now dealing with the new climate of reform engendered by the proposed Welsh Assembly, healthcare trust reconfiguration, and the creation of local health groups (Welsh Office 1998a).

Despite the daunting nature of their task of delivering community care, what has impressed us in our close contact with health and social care professionals is their dedication to meeting the needs of patients and service users and their collective determination to bridge the organisational divide.

⁵ The lowest being Caerphilly CBC with 6.0%

Part II Executive Summary

This research survey was undertaken between November 1997 and November 1998 with funding support from Wales Office of Research & Development for Health and Social Care. The survey sought to provide an up-to-date ‘snapshot’ review of the practical everyday successes and difficulties experienced by Welsh social services departments and health authorities in forging collaborative working relationships to meet the continuing care needs of older people.

Key Findings

1 The establishment of good personal relationships between key health and social services officers is the single most important factor facilitating constructive inter-agency collaboration

Significant obstacles exist to the establishment of good personal relationships. Both health authority and social services staff are over-stretched and health authorities in particular do not appear to have sufficient personnel to enable good personal relationships to be developed with each constituent local authority. The separateness of the two authorities is exacerbated by a failure to develop potential ‘shoulder rubbing’ activities, such as joint training, and office sharing (*page 14*).

2 Recent organisational upheavals (such as local government and health authority reform) have crippled strategic planning and severely damaged inter-agency relationships.

It is essential that any further organisational upheavals particularly within the Welsh Office and health authorities be kept to the absolute minimum (*page 15*). The ability of health and social services to harmonise their planning and commissioning functions is inversely proportional to the degree of organisational upheaval they experience.

Most local authorities consider that trust reconfiguration will not however cause significant harm to their strategic relationships with their health authority (*page 16*).

3 Social services’ isolation

The effect of Local Government Reform in 1996 has been to create a larger number of smaller social services departments in Wales. Whilst this fragmentation probably required the Welsh Office to adopt an enhanced role in promoting common standards, information exchange and networking, the perception of social services officers is that the Welsh Office’s role has in fact diminished. Social services departments particularly require:

- i) access to a significantly improved information network to facilitate meetings with other officers of the same grade/ specialist areas to discuss

common problems and create a network of contacts to enable future collaboration (*page 24*);

- ii) exchange information concerning innovative service development and strategic planning initiatives in Wales and elsewhere (*page 25*);
- iii) regular access to the Welsh Office community care section officers and information resources (*page 24*).

4 Community hospitals appear to be of fundamental importance in ensuring an adequate discharge by the NHS of its continuing care responsibilities.

Continuing care services for older people such as respite care, palliative healthcare, and rehabilitation are considered to be significantly better in areas where community hospital beds are available. Such hospitals do appear to be one of the great strengths of Wales in relation to the delivery of continuing healthcare services (*pages 33 - 35*).

5 Practical examples of successful joint planning and commissioning initiatives between health and social services in Wales are almost non-existent.

The human resource difficulties of both health and social services are such that they have not developed (and in the short / medium term are unlikely to develop) procedures for sharing strategic public health / community care needs information. They therefore look to the Welsh Office to instigate a pilot project which will

- (i) establish a set of common procedures, and
- (ii) produce a blueprint on how such collaborative joint mapping could be initiated (*see page 23*).

6. Winter pressures money and budget pooling

Local authorities consider that the existing powers under s28A NHS 1977 for limited budget pooling, are inadequate and that primary legislation is the only mechanism to resolve the present difficulties (*see page 9*).

Winter Pressures monies have generally not helped foster good inter-authority collaboration. Joint planning arrangements between health and social services authorities were generally too undeveloped to respond to the short time-scales specified in the grants (*see page 9*).

7 Further Welsh Office guidance

Welsh Office advice is considered to be helpful, and local authorities in particular would value further guidance especially concerning the continuing care criteria (*see page 11*). The local authority demands of the Welsh Office that emerge from the research study appear to be relatively modest. If human resources within the Welsh Office permit, then the servicing of these demands is likely to lead to tangible improvement in inter-agency collaboration.

8 Joint initiatives

Notwithstanding the general awareness by both health authorities and social services of inadequacies in their strategic planning for and delivery of continuing care services, and the existence of alternative and innovative ways of delivering such services (as for instance promoted by the Audit Commission ~ see for instance page 31), innovative developments in Wales have been slow and their impact remains at best 'local' (*see page 3*). There is a major need for the Welsh Office to pilot and then disseminate best practice to enable such schemes to be fully developed.

9 Information exchange and inter-agency networking

There is very little expectation by local authorities of openness in the exchange of information; the expectation is of secrecy (*see pages 21 - 22*).

92% of the local authorities that responded to this question (68% of all survey respondents) expressed significant dissatisfaction with the information exchange arrangements within Wales. This is an area where input of Welsh Office resources could pay disproportionate dividends (*see page 1 and 24*).

10 Joint training

In the context of the Manual Handling Operations Regulations 1992, our survey findings suggest that there is considerable scope (i) for adopting unified local/health authority manual handling assessments and interpretation and (ii) for all staff involved in such manual handling to undergo joint training (*see pages 26*). Assessment training should be a joint exercise with professionals from all authorities attending the same training sessions and sharing their experiences, rather than each authority arranging separate events. Even where the issue is unlikely to cause inter-agency conflict, shared training events would appear to be an obvious way of building confidence between the different agencies; this is particularly important for encouraging GPs to develop closer working relationships with local authority social care personnel (*see page 27 and pages 39 - 41*).

11 Multi-agency primary care teams for hospital discharge

Whilst there was considerable interest shown by health authorities and local authorities in the development of multi-agency primary care/ community care teams, they generally pointed to their insufficient human resources as a reason for not taking steps to develop such a team. This again is an area where there may be a role for a Welsh Office-supported pilot project which could establish a set of common procedures and produce a blueprint as to how such multi-agency primary care/ community care teams can be developed, managed, and funded (*see page 30*).

12 Respite care services

There was general acceptance by local authorities that if health authorities were to invest in new community hospitals they would inevitably have to disinvest elsewhere. Several local authority and health authority survey respondents

indicated that they considered the most viable option to be the use of specialist independent nursing homes in combination with a multi-disciplinary community assessment team. However, no respondent was actually able to provide an example of steps being taken to realise the proposed type of provision. Again, this is an area where a pilot project, initiated or assisted by the Welsh Office, could act as a useful blueprint for local authorities and health authorities as to how to commission such a service (*see pages 34*).

13 Joint appointments

The size disparities (in human resources) between health and social services' authorities means that certain key health authority officers can play a crucial role in shaping the inter-agency relationship. Consideration should be given to whether it is possible for certain posts to be the subject of 'joint appointment' (*see page 17 - 19*)

14 A locality presence for health authorities.

The development of a locality based commissioning presence by a health authority has led to significant improvements in the inter-authority relationships and is strongly supported by local authorities (*pages 20 – 21*).

15 Evaluation of incontinence services and inter-authority responsibilities

The level and detail of health authority concern disclosed in our survey suggests that this is an issue that warrants further evaluation post-WOC 27/93 (*see pages 36 - 37*).

16 National model required for specialist equipment in the domiciliary setting

Specialist equipment in the domiciliary setting was generally considered to be a service area causing unnecessary friction and consuming disproportionate staff time; survey findings suggest that it would be particularly helpful for the Welsh Office to promote a model protocol for funding and organising joint equipment stores (*see pages 38 - 39*).

17 Welsh Language and other cultural differences

The overwhelming majority of respondents did not consider that there were any ethnic minority, gender or language issues which evidenced a difference of approach to these issues by health or social services authorities (*see page 20*). Certain 'professional cultural' prejudices about the behaviour of the other authority were disclosed (*see pages 19 -20*) as were certain historical/political legacies (*page 21*).

Part III National Issues

III.1 The Legal Divide

‘We have different priorities for limited resources and are legally prohibited from having a joint approach to funding. We therefore have to adopt a parallel approach and all the time try to build bridges to bridge a gap created by the law.’

Health authority

Several studies have highlighted the legal impediments to joint working and the need for primary legislation in order to improve the relationship between health and social services. Henwood (1992) considers and endorses the Audit Commission’s identification of (i) a number of legal impediments that restrict good practice and (ii) the need for change to primary legislation in order to improve the relationship between health and social services (Audit Commission 1986)⁶.

The courts have acknowledged that health and social services authorities, find themselves in an unenviable legal position, commenting that ‘even an unequivocal set of statutory duties cannot produce money where there is none or by itself repair gaps in the availability of finance’⁷.

Six local authorities and two health authorities expressed their frustration at having to operate in such an invidious legal situation, and in particular seven of these eight authorities highlighted the legal impediments to budget sharing.

III.2 Budget pooling

The survey was carried out shortly after the Welsh Office had allotted extra ‘winter pressures money’ to health authorities in an effort to restrain what was expected to be a major demand for hospital beds during winter 1997-98. The grant, in principle, had the potential to foster joint working. The survey responses suggest that in those areas where there was a generally tense relationship between health and social services the monies probably exacerbated the relationship problems rather than helping to ease them. The grant required health authorities to respond within short time limits and was ‘one-off’ in nature; accordingly it allowed little flexibility in its distribution⁸. Where relationships were undeveloped health authorities were forced to make what were essentially unilateral decisions which (not surprisingly) then reinforced the constituent local authorities’ opinion that the health authority was not acting in partnership. The initiative clearly called for substantial collaboration with social services, but the time-scales meant that if a good joint working relationship was not already in existence, no significant liaison or consultation could be undertaken within the time available⁹. Local authorities and health authorities were generally at one in their assessments of the shortcomings of the grant arrangements:

‘The local authority put forward an innovative proposal for use of the winter pressures money, which was ignored; this put back relationships; we give the health authority the benefit of the doubt this time.’

Local authority

‘The winter pressures money is one of the few examples we have of joint planning. Given the Welsh Office time limit for proposals/ grant distribution and one-off nature there was little creative that could be done with it.’

⁶ See also Clements (1997a) & (1997b); Parsloe (1993) which are considered in greater detail in the full report.

⁷ *per* Sedley J: *R v Islington LBC ex parte Rixon* (1998) 1 CCLR 119

⁸ The guidance DGM (97)88 was issued on 30 October and health authorities were required to submit their plans for the use of the monies to the Welsh Office within four weeks.

⁹ The full research report considered a Swansea hospital-at-home scheme as an example of winter pressures money funding a joint initiative.

One local authority respondent expressed the view that (in the absence of a change to the legal rules relating to budget sharing) small ‘one-off’ shared grant initiatives would be valuable purely in terms of fostering trust between the two organisations¹⁰: In general, however, most other authorities felt that budget-sharing initiatives required a change in primary legislation because their value lay in long-term relationships involving core funds.

Whilst the study interviews were conducted prior to the publication of the government’s consultation document on budget sharing (DoH 1998a), the need for pooled budgets and integrated provision were recurrent concerns for many of the survey respondents. Notwithstanding government advice to the contrary (WHC (95)52; DoH 1998a), no survey respondent considered that the present legislative arrangements for budget-sharing under s28A NHS Act 1977 allowed for imaginative inter-agency initiatives in the field of continuing care of the elderly; this view was endorsed by WIHSC (1997).

III.3 The Welsh Office ~ mixed messages

‘We don’t need more Welsh Office guidance; what we need is more commitment to prioritise continuing care. We would like to adopt and run with the Audit Commission proposals in *The Coming of Age* but in spite of central rhetoric about continuing care, the priorities still reveal a political imperative which is prioritising patient throughput, waiting lists, patients’ charters, etc. It is concerned with measurable things and continuing care is not easy in this respect.’

Health authority

Four local authorities and four health authorities expressed the view that the Welsh Office was sending out contradictory messages both to the public and to them. The view of these eight authorities was essentially that the rhetoric of the importance attached to the provision of continuing care services is not matched by the Welsh Office’s action, particularly in respect of the annual purchasing priorities issued to health authorities¹¹. Most of the views expressed by local and health authorities on this issue referred to the fact that, notwithstanding the government’s frequently expressed enthusiasm for primary care, in Wales there appeared to be an accelerating reduction in such services:¹²

‘The Welsh Office is part of the problem. If you look at its purchasing intentions for the last few years they are cancer, emergency services, paediatrics, plus patient waiting times. They are basically concerned with hospital care and waiting times. These documents are highly influential; what is required is for the Welsh Office to bang on about community nursing/ primary care for older people.’

‘The Welsh Office needs to spell out that continuing care is a priority; all too often the published priorities contradict that rhetoric.’

No local authority or health authority respondent appeared aware that the Welsh Office, in conformity with the Department of Health¹³, had included continuing care as a purchasing priority for 1997-98 (DGM (96)143); a matter of some concern, given the perceived importance of such guidance¹⁴.

¹⁰ Thistlethwaite (1996) noted considerable support for such initiatives, commenting that they could ‘build trust and communication’ which might ‘lead in time to more ambitious approaches and minimise the risk of early demoralising failure’.

¹¹ That the rhetoric on joint working is not matched by practical realities has been noted on many occasions. Webb (1991) for instance commented that ‘exhortations to organisations, professionals, and other producer interests to work together more closely and effectively litter the policy landscape, yet the reality is all too often a jumble of services fractionalised by professional culture and organisational boundaries and by tiers of governance.’; *see also* Means and Smith 1994; Woodhouse et al. 1997

¹² *See also* page 37 below

¹³ *See* DoH (1995c) and (1995d)

¹⁴ Since the research survey was completed, the government has issued national priorities guidance for the next three years (DoH 1998b). The guidance expresses ‘ministers’ determination to force closer co-operation between health

The belief that mixed messages of this nature are being given, hampers inter-agency collaboration by raising the expectations of certain sections or indeed whole authorities and thereby creating unhelpful tensions. Whilst officers in both local and health authorities may be able to rise above the political rhetoric, they have to respond at the local level to the contradictory demands such messages engender.

III.3.1 Welsh Office ~ further guidance

‘We need national guidelines on the continuing health care criteria. It is absurd that there are none. And yet we are criticised by the Welsh Office and others when they find significant regional variations! National criteria and nationally applied rulings [on what certain principles mean] would make life so much easier.’

Local authority

In February 1995 the Welsh Office issued guidance (WHC (95)7/ WOC 16/95) obliging health authorities to prepare and publish local policies and eligibility criteria for continuing health care. The inter-agency benefits and difficulties which are perceived to have flowed from this initiative are considered at page 28 below. Continuing care statements have, however, provided a mechanism that has enabled the various NHS bodies and social services departments to engage in discussion over their respective responsibilities for people who have continuing care needs.

Thirteen local authorities highlighted the need for further guidance from the Welsh Office on various general issues, as did four health authorities. However, there was a marked divergence of opinion between health and local authorities over the need for the Welsh Office to issue further continuing care guidance. All thirteen local authorities expressed a need for such follow-up guidance, of which seven specifically mentioned the need for the Welsh Office to issue All-Wales criteria. In contrast, only two health authorities indicated that they felt the need for further guidance in this area.

The need for such national criteria was expressed by one local authority thus:

‘We need a national bench-mark for continuing care criteria: we use three different hospitals in three different local authorities and two different health authority areas! Some basic standards would avoid idiosyncratic local interpretations.’

In addition to those seven local authorities which specifically expressed a preference for national continuing care criteria, a further six referred to the need for follow-up guidance on continuing care criteria, particularly (to quote one authority) “in the ‘grey areas’ of the [health/social services] interface, i.e. terminal care, community rehabilitation, and so on”.

Almost 70% of respondent local authorities consider that there is a need for follow-up guidance on the continuing care criteria, of which more than half considered that this should be in the form of All-Wales continuing care criteria. In contrast only two health authorities considered national criteria would be of benefit.

The reason for the difference in response between local authorities and health authorities is probably explained by the overall findings of the research study. Overall health authorities were significantly more satisfied than local authorities with the way inter-agency collaboration on continuing care was functioning. Local authorities generally perceived a need for greater input by health authorities and therefore the need for further guidance to achieve this end.

There does appear to be an imbalance between the amount of follow-up advice given by the Welsh Office concerning the requirements of its Continuing Care Guidance (WHC(95)7/ WOC 16/96) and that given by the Department of Health concerning the

and social services’ (Healy 1998) and includes specific emphasis on inter-agency working, with particular reference to the promotion of independence in older people.

equivalent guidance in England¹⁵. The difference in response between health authority and local authority survey respondents may also be explicable in terms of an imbalance of Welsh Office advice. Health authorities were given advice on the contents of their continuing care statements (*see* DGM (96)38 paragraph 2) whereas no equivalent assistance appears to have been provided to local authorities. Therefore there appear to be strong grounds for concluding that Welsh Office advice in this area has proved helpful, and that further guidance would be valued by local authorities and could be a positive force in improving relationships in this area of uncertainty.

The majority of local authorities and health authorities (respectively 69% and 80% of the survey respondents) indicated that further Welsh Office guidance would be welcome in other specific areas, including on:

- 'elderly care issues'
- 'social care planing objectives - on what social services departments should be doing/ how they should be revamping themselves'
- 'equipment provision and responsibilities'
- 'reinforcing the importance of *The Coming of Age* report and the importance attached to it by the Welsh Office as defining the coming agenda'
- 'commissioning in the independent sector for domiciliary care'
- 'partnerships between local authorities and health authorities'
- '[hospital] discharge criteria and model protocols for this'
- '[hospital] information leaflets etc for patients'
- 'joint mapping of information'

III.3.2 Dissemination of information

'The Welsh Office asks for a lot of information and there are sanctions when it is not provided - but it is not a two-way process. It has a lot of information of use to us and yet we don't even have reliable access to circulars we may have missed.'

Local authority

Eight local authorities indicated that they looked to the Welsh Office to act as a 'disseminator of information'. This role, although linked to the issuing of guidance, is distinct in that it indicates a desire for partnership (and for the Welsh Office to co-ordinate a networking relationship with other local authorities). Given the relatively large number of relatively small local authorities in Wales, the need for the Welsh Office to fulfil this role is perhaps of greater importance than was the situation prior to local government reorganisation. Examples of the type of information sought included:

- 'models of joint planning.'
- 'a resource package describing existing joint projects (including the relevant guidance and law).'
- bench-marks on what (in a given population) one would expect in terms of residential/ nursing care home placements; what respite/ rehabilitation provision should be provided by health authority, and so on.'
- 'joint protocols with the trusts on each area of interface - so that the key workers on each side of the divide were aware of their responsibilities.'

No health authority expressed a need for any additional resources from the Welsh Office in relation to its information distribution/ networking role. This may well be because they have already established an effective information network which meets regularly, the creation of which was probably relatively straightforward, given that there are only five relatively large health authorities (i.e. the reverse of the local authority situation).

A major message from the research study is the negative impact that local government and health authority reorganisation has had upon inter-agency collaboration and strategic planning in particular. The overwhelming view of survey respondents centred

¹⁵ DoH 1995a; *see also* DoH 1995d, 1996a, 1996b, and 1997a; Henwood 1996

around the need to minimise any further reorganisation, and this important message is emphasised in the White Paper (Welsh Office 1998a at paragraph 1.21). As relationships mature and joint planning develops, the Welsh Office's 'information dissemination and network promotion' role may well become paramount.¹⁶

III.3.3 Summary

'The Welsh Office seems to be obsessed with child care to the exclusion of all else.'

The strong demand from local authorities for further guidance and information in various fields was frequently expressed in terms of Welsh Office neglect or lack of commitment to continuing care issues. By way of contrast, a number of local authority respondents identified an example of a former galvanising role played by the Welsh Office in promoting the All Wales Strategy (Welsh Office 1983)

The demand expressed is for 'practical' guidance to enable common approaches to be taken to common problems. There is a clear appreciation that (as one local authority commented) 'no guidance can make people get on'. Nevertheless, the responses constitute a significant message for the Welsh Office: that local authority officers involved in continuing care issues perceive the Welsh Office as isolated and having a 'hands off' approach. Whilst such an approach may be appropriate (or in the present political climate, unavoidable) there is a need for improved communication. The local authority demands of the Welsh Office that emerge from the research study appear to be relatively modest. If human resources within the Welsh Office permit, then the servicing of these demands is likely to lead to tangible improvement in inter-agency collaboration.

¹⁶ The local authority/ health authority respondents' view on the potential networking role of the Welsh Office is also considered at pages 0000 below.

Part IV Organisational Issues

‘I believe it is a very mixed picture throughout Wales. The reason why relations differ concerns the attitude of the institutions to “services”. If you start from the point of view that you can’t deliver them without collaboration and that collaboration is about long-term relationships, then this will improve matters. It will lead to frequent meetings and the development of shared goals.’

Local authority

All authorities were asked a series of questions that sought their views as to the impediments to good inter-agency relationships, and how such difficulties could be overcome. The main categories of response are listed in Table 1 and considered separately below, as well as issues mentioned as being of general concern, namely (i) information exchange; (ii) continuing care statements; and (iii) inter-agency networks.

	LAs specifically referring to the issue below (total respondents: 19)	HAs specifically referring to the issue below (total respondents: 5)
Personal relationships	13	5
Local government and health reorganisation	12	4
Organisational size differences	3	5
Cultural differences	7	1
HA locality presence	6	0
History	4	1

TABLE 1

IV.1 Personal Relationships

‘Personalities’ was the single most common response to our questions that sought to identify the main impediments to good inter-agency relationships. Thirteen local authorities and all the health authorities emphasised that good working relationships between the key players in both agencies were crucial; typical comments being:

‘The personalities changed from the previous good working relationship within [named council area] and it has taken time to establish new relationships.’

‘Personal relationships are key; I have known my opposite number for many years.’

‘Relationships are crucial; it is only on the basis of past experience that people learn to trust you.’

Such a result is in line with other research studies. In Davidson and Hunter (1994) Hunter observed that ‘whereas much concern about joint planning has centred upon structures, on creating coterminosity, and on achieving the planned organisation of service boundaries so as to minimise multiple overlaps, in reality, where mutual trust has existed between senior officers from health and local authorities, the relationship has appeared to be far more important than joint planning machinery.’ In similar vein, Challis et al. (1995) noted that personality clashes dominated as an issue in the co-ordination of inter-agency practice. The Social Services Inspectorate for Wales has also emphasised the importance of positive working relationships as a means of breaking down formal structural impediments to joint working (Welsh Office 1996e).

All survey respondents were additionally asked an ‘open question’: namely, how they would describe their relationship with their respective health or social services

authorities: nine local authority respondents ranked personal relationships as 'good'; seven 'average'; and three 'poor'. In contrast, three health authorities ranked their inter-agency relationship to be 'good'; one as 'average' and one as 'poor'.

Survey respondents were asked if their general inter-agency relationships had improved or deteriorated since April 1996. None considered that they had deteriorated. All the health authorities considered the relationship was improving/ maturing and seventeen local authorities considered that it was either improving or in one case 'had always been good and remained so'. Two local authorities considered that their relationship was neither improving nor deteriorating, but at negative 'stalemate'¹⁷.

The optimism of local and health authorities concerning the prospects of future collaboration is marked; comments included:

'There is a determination from all agencies to prevent barriers being built and to resolve areas of concern as they occur; the relationship is maturing.'

'Good and improving because we are both getting to know each other better in the aftermath of the restructuring.'

'The relationship has improved immeasurably since local government reorganisation; it's a positive relationship, largely because we have each got to know each other.'

Survey respondents were asked if they considered that the inter-agency relationship differed at different points of the hierarchy. Although the overall view was that relationships were generally good¹⁸ at the ground floor and became more difficult as one ascended the hierarchy, the finding is methodologically inconclusive given the sample size and the fact that only senior officers were surveyed in the present study. One health authority however graphically expressed the potential dangers of hierarchical differences in relationships between health and social services:

'There is, however, a danger of 'frogism'. This is the leap-frog factor. We try and foster locality commissioning/ locality decision-making but then, for instance, the Director of Finance happens to meet the Director of Social Services and the two of them make a decision, leaping over the heads of locality commissioners.'

IV.2 Local Government Reorganisation/ Health Authority Reform

'It is almost impossible to overstate the problems that local government reorganisation has caused, particularly in relation to joint planning.'

Local authority

The importance of organisational stability has been emphasised by many studies¹⁹, not as a virtue in its own right but because of the detrimental effects of reorganisations upon a key determinant, 'interpersonal relationships or trust' (Webb 1991), which has been described as 'the lubricant for smooth running of mechanisms for collaboration and co-ordination' (Challis 1995).

Twelve local authorities and four health authorities stressed the negative effect that the 1996 health and local government reorganisation had wrought upon their inter-agency relationships. One health authority survey respondent expressed the general view succinctly:

'Local government reorganisation set back joint initiatives and joint planning with the local authority a long way. If you move people, but structures remain, then this is OK; but if you move people *and* structures [as occurred in LGR] then it's disaster.'

¹⁷ Both these survey respondents are in the same health authority area.

¹⁸ Thistlethwaite (1996), considered the inter-agency relationships at a primary care level and noted, among other things, that the study provided 'a frequently depressing account of relationships at local level'

¹⁹ See, for instance, Webb and Wistow 1986; Hunter and Wistow 1987; Welsh Office 1998a

Local authority survey respondents spoke of the problems caused by ‘continual change’ and of the need for ‘some stability’, particularly in respect of the configuration of health services. This concern should be seen in the context of the other comments emphasising the importance of personal relationships in managing the interface between health and social services. In an area where it appears that personal relationships are crucial, local government reorganisation and health authority reform had the effect of shifting a number of key people. As a result, in the opinion of most survey respondents, this fractured joint planning and the development of the ‘seamless’ service between the two authorities. The evidence suggests that the organisational turbulence caused by the 1996 reforms damaged relations, not only those between social services departments and the NHS, but also their relationships with other partner organisations, such as those in the voluntary sector (Welsh Office 1996a). The problems of joint planning are considered separately below.

Local government reorganisation not only caused considerable ‘turbulence from the organisational upheaval’ it produced (Welsh Office 1998a), but in the immediate post-reform period it also created new political and administrative power bases. This resulted in an environment conducive to ‘political jockeying’ and ‘personal assertions of virility’ (in the words of one health authority). These comments need to be seen in the context of many Welsh local authorities being ‘member led’ (to quote several of the survey’s social services respondents). Schneider (1997) refers to the important role played by ‘political pressures and internal power struggles’ in determining the quality of the social services/ health services relationship; Hudson (1987) highlights such negative activity as evidence of a lack of a shared sense of purpose²⁰.

The 1996 reorganisations created a relatively large number of small local authorities and, in comparison, a relatively small number of large health authorities although paradoxically health authorities employ relatively few personnel in comparison with social services departments. In consequence, it appears that a few health authority officers play a crucial role in relation to the local authority/ health service relationship. A change of personnel (or administrative structures) by a health authority will therefore have a more significant effect upon inter-agency relations than any equivalent local authority change. Looking to the future, it will remain the situation that health authority organisational or personnel changes have the potential to be disproportionately disruptive to the inter-agency relationship.

The generally negative findings in relation to the effects of the 1996 reorganisation are discouraging, given that the research suggests that unitary authorities should offer better prospects for joint working and commissioning; not least because they bring housing and social services into the same authority (Audit Commission 1998).

IV.2.1 Trust reconfiguration

The research survey was carried out both before and after the publication of the White Paper. Not surprisingly, the White Paper’s emphasis on the avoidance of further health or social services reorganisation was welcomed by all respondents surveyed post-publication.

Those authority respondents interviewed who considered local government reorganisation and health authority reform to have been an impediment to inter-agency collaboration were asked whether they considered that the reconfiguration of trusts in Wales would prove similarly disruptive.

Seven local authorities viewed their relationship with local NHS trusts as more important (on a strategic and personal relationship basis) than with their health

²⁰ See also in this context Hudson 1995

authority. Whilst trust reconfiguration could be viewed as a potentially disruptive episode for all authorities, in theory it would appear to pose a particular problem for such local authorities with a close working link to local trusts. However, this concern was explicitly expressed by only one survey respondent:

‘We are concerned that all our important personal relationships are with the trusts; given the lack of a health authority presence in the localities; we are not unnaturally concerned therefore as to what will happen on trust reconfiguration.’

However, the six other local authorities that commented upon the issue indicated that they considered reconfiguration was necessary (although they differed in the form they considered that it should take). Their general view was that even where their key inter-agency relationships were primarily with trust employees rather than the health authority, any reconfiguration was unlikely to remove these individuals but would merely change the employing trust. A typical comment being:

‘Although our authority has forged its relationship with the trusts rather than the health authority, nevertheless we believe that reconfiguration is desirable – provided it is done in such a way that existing relationships are maintained.’

In contrast to the majority of local authorities, all those health authorities that commented upon trust reconfiguration viewed it as potentially harmful to inter-agency collaboration (while also stressing the need for such a reconfiguration). Of the four health authorities that specifically mentioned the negative effects of the 1996 reforms on inter-agency collaboration, two respondents anticipated that trust reconfiguration would initially have the potential to lead to disagreements with the local authorities involved concerning the form the reconfiguration would take, especially if it led to trusts straddling local authority boundaries. A third health authority respondent stressed the disruption the process was causing, stating:

‘Trust reconfiguration is becoming an all-consuming issue; our staff are constantly being distracted by this work. We have so few staff that it makes other work impossible.’

IV.3 Size Mismatches

‘What many local authorities and voluntary organisations don’t appreciate is that we have only 140 employees from chief executive to cleaner. We are constantly being asked to provide representatives at lots of forums; we just don’t have sufficient staff to service this dialogue.’

Health authority

Although health authorities and social services departments both command substantial budgets, their employee numbers are markedly different, as are their political and professional constraints. A failure to appreciate these differences can result in misunderstandings detrimental to inter-agency collaboration. These misunderstandings are nurtured by the separateness of the two organisations and the relatively little ‘shoulder-rubbing’ that appears to occur between their employees (both of which issues are considered below).

Local authority awareness of the small scale (in human resource terms) of health authorities does appear to be a problem. A similar misconception is also probably responsible for some of the negative comments made by local authorities concerning the role of the Welsh Office (quoted above). Local authorities do not appear to realise that the Welsh Office section responsible for social services is itself relatively small.

Survey respondents from all five health authorities made particular reference to the low number of staff they employed in comparison with their constituent social services departments. They considered that this lack of human resources created a number of impediments to effective inter-agency collaboration particularly in relation to

consultation and inter-authority liaison. For example, if they failed to send representatives to meetings and events related to the health/ social services divide, then social services departments or the voluntary sector may interpret this as their lack of commitment to the principles of joint working. In reality, however, the health authority may have only one officer with lead responsibility for liaison with several constituent local authorities and perhaps as many trusts.

The size mismatch of both types of organisation can cause other problems. In human resource terms, the fact that the relationship is vested in a relatively few key health authority officers means that:

- (i) one such officer who is perceived by the constituent local authorities to be 'difficult' can cause disproportionate problems within the system;
- (ii) a health authority's decision as to how it chooses to invest its resources in personnel may have crucial implications for the relationship;
- (iii) where such a key officer has built up a good working relationship with the constituent local authorities, it is important that she or he not be transferred to another function by the health authority without proper consultation and transitional arrangements being agreed to minimise the disruption caused. This problem was raised by one local authority:

'We had built up an excellent relationship with the health authority's locality manager; without any discussion or consultation, it moved him to another post. This change put the inter-agency relationship back by a year or so.'

In response to this problem one social services respondent raised the possibility of the joint appointment of those officers with key responsibility for inter-agency collaboration (for instance the locality commissioning managers). Such a device has been advocated by a number of studies (*see, for instance*, Kreuger 1990). Davidson and Hunter (1994) note that 'single joint service managers, case or care managers of key workers have all been important devices to overcome boundary problems of one sort or another'. The Social Services Inspectorate (DoH 1990b) considered that joint teams or preferably the appointment of project managers was 'one of the most critical and positive factors in ensuring that transition from hospital to new community facilities caused least trauma for patients'.

The mere appreciation of the size mismatch does not necessarily resolve the problem. Two local authorities considered that health authorities were too small (in human resource terms) to discharge their functions effectively:

'There is a lack of any real "strategic planning" by the health authority; its personnel resources are so stretched that in reality it does little more than fund trusts.'

'We are concerned about the future ... we feel the health authority is over-stretched [in staffing terms]; there is too much power with the trusts; the health authority doesn't stand up to them - nor is it in consequence properly developing its commissioning role.'

Two local authorities made particular mention of their human resource difficulties: namely, that as small authorities (in population terms) they themselves lacked sufficient staff to maximise the benefits of inter-agency planning.

The disparity between employee numbers is not, of course, the only size mismatch between local and health authorities in Wales. Geography is also a key factor, with two out of five health authorities covering almost three-quarters of Wales. This was perceived to be a problem by local authority survey respondents, particularly in relation to the health authority that had not established commissioning arrangements based upon local authority areas. This geographical isolation reinforced the local authority respondents' view that the health authority was also 'distant' in its cultural and professional attitude towards inter-agency collaboration:

'The old local and health authorities disappeared in 1996. It was the new health authority's change of philosophy [ceasing to have a locality commissioning presence]

that damaged the previously positive relationship. The health authority became “distant” - both figuratively and geographically; that’s what harmed the relationship.’

IV.4 Cultural Differences

The ‘cultural differences’ between health and social services authorities have not been the subject of significant research studies, although they do find mention in the literature, most commonly in the context of ‘a culture of misunderstanding’ (*see for instance* CHSR 1996) where they refer to discharge nurses conforming to a ‘culture of misunderstanding of the roles of social workers’ (in relation to the time such social workers take to carry out community care assessments).

Whilst six local authorities considered that cultural differences between the two organisations were an impediment to effective joint working only one health authority mentioned this as a relevant issue.

Local authorities and health authorities are markedly different organisations with differing goals. Their senior employees are professionals who have in many cases had significantly different training and work experiences. Local authorities are run by democratically elected members who may have little or no expertise in management, whereas health authorities are not subject to the same democratic control and are generally managed by personnel from a business/ managerial background.

These differences, which give each type of organisation particular strengths, can be misconstrued as cultural differences to a degree that impedes joint working. Two particular examples of this type of problem were illustrated by health authority survey respondents.

‘Local authorities are quite different to us; they come from a different direction. They are frequently nervous in their practice because of their political masters and unhappy or unable to make decisions.’

Health authority

This comment illustrates the first perceived problem. The requirement that major local authority decisions be mandated by the members means that in many cases health authorities can often make faster policy decisions than their constituent local authorities. In some cases this was interpreted by the health authority survey respondents as either (or both) (i) a lack of commitment and/ or (ii) a lack of leadership qualities (or ‘nervousness’).

The second example arises out of the resource difficulties experienced by health and social services personnel. There was common recognition among survey respondents that both types of organisation had financial difficulties and that although the problems of health authorities were probably less severe, their practical/ political room for manoeuvre was equally limited.

It is also the case that nursing home accommodation is a major item of expenditure for local authorities, whereas it tends to be a minor ‘one-off’ item of expenditure for most health authorities²¹. As a result, local authority cost ceilings for nursing home accommodation tend to be strictly controlled and extremely ‘tight’, whereas health authorities may have rather more latitude in fixing weekly charges. One health authority survey respondent commented critically about the level of payments made by one of its constituent local authorities, suggesting that the level was so low that the resulting service offered by the homes to such residents was minimal, if not unacceptable. This

²¹ In 1994 only 5% of all nursing home placements were funded by the NHS compared with the 71% funded by social services or from social security; *see* Harding et al. 1996.

may be the case, given the budgetary difficulties faced by some local authorities. Not surprisingly, this can cause divisive attitudes in itself, at its most basic manifested as a view from the health authority that it is more concerned about patient welfare than its constituent social services departments. It can serve to reinforce professional cultural stereotypes: that health is the caring profession and social services personnel do not care as much.

Of the six local authorities that raised the issue of cultural differences acting as an impediment, three did so primarily with reference to the perceived democratic deficit in health authority decision-making and two commented as follows:

‘Medical privilege/ arrogance is a problem. Only one consultant turned up to a joint assessment training day, and consultants believe they can discharge from hospital despite what the guidance says.’

‘Cultural differences are major problems; there is a failure by the health authority to appreciate the way we function: team managers have budgets, not individual social workers.’

All survey respondents were asked whether they considered that there were any ethnic minority, gender, or language²² issues which affected the outcome of their negotiations with their respective health/ local authorities over access to continuing care. Whilst research by Rawaf and Bahl (1998) identifies the ‘language barrier’ as the ‘single most important impediment to users (whose first language is not English) interacting with health and social care professionals, this was not considered by the survey respondents to be a significant problem. The *Welsh Health Survey 1995* (Welsh Office 1996) notes a similar finding, in that the survey ‘disclosed very little dissatisfaction with accessing material in the Welsh language’. In only one case did a respondent authority consider this to be a matter for concern:

‘We considered that there was a problem in that the health authority did not recognise the importance of the cultural linguistic background of the area in the staff they employed. There were, for instance, very few Welsh-speaking community psychiatric nurses, and the area contains a high number of EMI patients who are Welsh-speaking. We insisted on a Welsh-speaking appointment when a joint appointment arose.’

IV.5 The Locality Presence

‘Things have improved dramatically since the locality commissioning manager was appointed. I don’t need any convincing now that this is the way forward.’

Local authority

As noted above, a health authority’s failure to develop a locally-based commissioning presence may cause inter-agency relationship problems. It may lead to the authority being viewed as both geographically and ideologically ‘distant’ and result in the local authority forging stronger strategic relationships with trusts than with health authorities. This may prove to be problematic during trust reconfiguration, and may in any event be undesirable in relation to the discharge of the strategic functions of health authorities and local authorities (functions which are not shared by trusts)²³.

Six local authorities considered the lack of a locality presence by a health authority was an impediment to joint working. Significantly five²⁴ of these authorities were in the one health authority area which had not at that time developed such a presence.

²² We specifically asked about Welsh and minority language issues.

²³ In support of the principle of a health authority locality presence, the Audit Commission has stressed the importance of aligning the organisational structures of health and social services (Audit Commission 1986). Notwithstanding this advice, the view has been expressed that the infrastructure costs of establishing health authority-sponsored locality commissioning schemes is disproportionate (WLG 1997).

²⁴ The sixth authority lay within a health authority that had only recently appointed a locality manager for its area.

Whilst research has questioned the intrinsic value of ‘coterminosity’ as an aid to collaborative joint working (Davidson and Hunter 1994), a number of local authority survey respondents commented positively²⁵ upon how locality commissioning had improved their relationship with the health authority, for instance:

‘The establishing of the locality structure meant our involvement with the health authority increased dramatically and for the benefit of all.’

Only one health authority mentioned this issue, in the context of the importance of locality commissioning and the benefits it had borne, commenting:

‘We have developed commissioning teams coterminous with the local authority areas - each with a team director; this has worked very well and leads to good relationships.’

IV.6 History

‘The previous relations between [our predecessor authority and the former health authority] was diabolical; the old director of social services was not on speaking terms with the health authority director. We are gradually learning to talk to each other.’

Local authority

Historical relationships were mentioned by a number of local authority and health authority survey respondents as explanations for why specific problems or opportunities had arisen (most obviously in relation to the 1996 reforms). However, four local authorities and one health authority considered that history itself was an impediment today to inter-agency working: at its crudest, the settling of old scores or the remnants of distrust. Comments in this mould included the quotation above and:

‘There is also the hostility of councillors to the health authority; a resentment about the removal of councillors from health authorities - by Thatcher.’

‘History has been a problem; we worked with a lot of classic negatives about health.’

The loss of a previously good relationship was also seen as a problem, with the present imperfect being contrasted with the past perfect. The only health authority which mentioned history as an impediment did so on the basis of the inheritance of previous difficulties, namely “‘There was no history of working together”.

IV.7 Information Sharing

‘In order to succeed, joint planning needs to be conducted at officer and board level. The key essentials to a good relationship are: (i) get the foot soldiers working together (via the consortia); (ii) get uniform planning assessment tools; (iii) get joint commissioning going.’

Health authority

The Audit Commission has stressed the importance of the open sharing of information between health authorities and social services departments in order to improve inter-agency collaboration (Audit Commission 1997). Survey respondents were therefore asked about the extent to which they had been able to develop joint strategic planning and joint commissioning with their respective health authority/ social services departments. In addition they were asked how they obtained information on new initiatives in health/ social collaboration in Wales.

It was particularly striking that local authority survey respondents appeared to have very little expectation of any information sharing/ openness with their health authorities. In one interview the local authority officer referred to a report commissioned by the health authority on the future of community hospitals within its area. The local authority was particularly concerned about the possible implications of

²⁵ No local authority commented adversely on the development by health authorities of a locality presence.

the report which, we were told, had apparently ‘been sitting on [a named health authority officer’s] desk for several months’. Extracts from the report had apparently been quoted in inter-agency negotiations, but no copy had been disclosed to the local authority. Indeed, the local authority survey respondent was surprised when we observed that we found it remarkable that such an important document should not have automatically been copied to constituent local authorities.

An expectation of openness between the two authorities underlies much of the relevant guidance (*see, for instance*, Welsh Office 1991), although in practice this is clearly not occurring. Robinson, in her 1994 review of multidisciplinary working under the Welsh Office Elderly Initiative, highlights the importance of information sharing as a key element in successful interagency collaborations, and noted that this was a problem in a number of the projects she reviewed²⁶. Williams (1995) noted that the problems of information sharing across boundaries at the primary care level in Wales largely resulted from incompatible recording methods, stating ‘[j]oint working does not necessarily cut out duplication of data ... because each carries its own information system’.

In one respect, however, there was clear evidence that local authorities and health authorities had not only shared information, but also appreciated the benefits of such openness - the open disclosure to the other party of their financial situation:

‘The reason why there has been a significant improvement in our relationship with the health authority is that they now know the budget problems we have and we recognise that they have their own resource problems and limited room for manoeuvre.’

IV.7.1 Joint strategic planning and commissioning

Concern about the processes and practices of health and social services joint working is not new, (Audit Commission 1986), not a uniquely Welsh problem (Webb and Wistow 1986), nor indeed one confined to the British Isles (Hokenstad and Ritvo 1982). However, in no area of the NHS/ social services interface is the contrast between the amount of guidance and the signs of success, more stark:

- (i) The specific guidance on joint working (WOC 51/95 - WHC (95)43) stressed that joint working is essential to ensure effective and efficient delivery of complementary health and social services to the individuals that need them; and that at the strategic level this necessitated joint working in planning.
- (ii) WOC 79/94 stressed the importance of joint planning; that ‘joint planning is essential to ensure complementary health and social care services’ and that ‘local authorities and health authorities should work together at all stages of the planning process’ (para 2.2).
- (iii) WOC 6/92 - WHC (92)4 stressed the importance of health and social services authorities working closely together to produce joint plans for social and community care and in the development of local strategies for health in order to ensure effective collaboration at all levels. WOC 79/94 required local authorities (in preparing their community care plans) to involve providers throughout their planning process, including NHS trusts and GPs as well independent-sector providers of nursing, residential, and domiciliary care.
- (iv) In relation to the preparation of local community care charters in Wales, WOC 9/96 - WHC (96)12 emphasised that a key aim was that they should ‘allow local and health authorities to establish together criteria against which to monitor the quality of their services’.

The crippling effects of the 1996 local government reorganisation and health authority reform is most evident in relation to their assessments of the development of their joint

²⁶ *See also in this context* Rowntree 1992. The widespread public and professional ignorance of the Code of Practice on Openness in the NHS has been noted by the House of Commons Select Committee on the Parliamentary Commissioners for Administration (1997).

planning and commissioning functions. Fifteen local authorities considered that as a result of the reforms joint strategic planning was still in its infancy. Of these, nine authorities considered that it was 'too early' as yet for joint planning and commissioning to be described as anything other than a future objective.

The responses of health authorities did not even match this level of optimism; four considered it essentially 'too early' for comment due to the 1996 reforms. One respondent indicated that the major impediment was its human resource shortages (in part attributed to the administrative dislocation caused by the resources required to devote to trust reconfiguration).

Guidance and research on joint working can only stimulate good practice where a modicum of organisational stability exists. The clear lesson from this study is that strategic planning is one of the major casualties of any organisational reform and that the effects of reorganisation are long lasting. The effect of such reform has not merely been to put joint planning into abeyance, but to shift such matters 'back to square one'. The 1996 reforms have, therefore, invalidated many of the imaginative earlier joint working proposals that were being developed prior to 1996.

IV.7.2 Joint mapping

'Health authorities, trusts and social services departments must map needs and the services available to meet them. They should share this information with each other as the basis for joint planning and commissioning.'

*Audit Commission, The Coming of Age*²⁷

The Welsh Office has for a number of years encouraged collaboration between health and social services in the development of their plans (*see for instance* Welsh Office 1989 and 1990). WOC 19/69 emphasised that 'close collaboration' between agencies is an underlying theme as well as improving communication by addressing key issues on the use and disclosure of information. In its publication *Local Monitoring of Continuing Care* (WHC (96)49) the Welsh Office reiterated this advice, emphasising (i) the importance of procedures for joint mapping exercises in hospital discharge and community settings; (ii) the need for joint protocols for information exchange between agencies to enable joint counting; and (iii) the need for such systems to be flexible and robust.

The Audit Commission has also advised on the need for authorities to develop more sophisticated ways of gathering, using, and sharing information (Audit Commission 1994) and placed special emphasis on this issue in its report *The Coming of Age* (1997). The findings and implications for good practice of this report have been substantially endorsed and promoted by the Welsh Office (*see, for instance*, DGM (98)42). The Audit Commission warned that a failure to develop such inter-agency systems could lead to the persistence of rigid and unresponsive patterns of service (Audit Commission 1994).

Local authority and health authority survey respondents frequently referred to the importance of joint mapping of their communities' needs and disclosed an appreciation of the problems they faced in implementing such an exercise:

'The major problem with strategic planning is the lack of an information base (or a "common" information base).'

One health authority survey respondent, referring to the lack of uniformity in the way data is collected by trusts, GPs, and health authorities, commented that 'a problem is that the NHS is not sure what it knows', thus emphasising the difficulties of inter-

²⁷ (1997) Recommendation 1 page 77

agency mapping in Wales when those agencies are unable internally to develop common data languages²⁸.

No local or health authority survey respondent in the research study indicated that a procedure had been developed for joint mapping to facilitate joint planning and commissioning of services. The clear impression given was that this was something they would like to develop but given their current priorities they had insufficient human resources to engage in this task. Given these difficulties there may be a role for a Welsh Office-supported pilot project to (i) establish a set of common procedures, and (ii) produce a blueprint on how such collaborative joint mapping can be initiated.

IV.7.3 Information exchange arrangements within Wales

All survey respondents were asked how they gained access to information on collaborative initiatives on health and social service provision elsewhere in Wales. Social services respondents highlighted a significant problem in this area; in contrast no health authority expressed concern. The marked difference in response is attributable to the existence of a well-developed health authority information network and the absence of such an arrangement for social services. The issue of health/ social services information networks is considered separately below.

Fourteen local authorities answered the question: 'If there was an interesting/ successful example of innovative/ collaborative work being pioneered by another local authorities and/ or health authorities in Wales, how would you get to hear about it?' The most positive response to this question was that the process was haphazard or 'via the grapevine' to use the respondent's phrase. Typical responses included:

'There is a real lack of a network. There is a need for specific grade officers to meet their counterparts, for instance an All-Wales meeting of planning officers and so on. We need up-to-date news and information on research and innovation. We see a role for WORD²⁹ to be proactive in information exchange/ dissemination. WORD should have a strong role in not only facilitating research but also disseminating material. There is a need for a proactive agency in this area rather than a reactive one.'

'We see this as a real weakness of social services departments as compared with health authorities which have a national network. As social services departments have become smaller the lack of any network has become an even more serious problem. Before local government reorganisation there were exchange meetings of senior officers usually chaired by a director of social services. The grapevine is now very weak.'

Thus 92% of the local authorities that responded to this question (68% of all survey respondents) expressed significant dissatisfaction with the information exchange arrangements within Wales. This is an area where input of Welsh Office resources could pay disproportionate dividends.

Whilst no health authority expressed concern about their access to information, it is possible that the effectiveness of the health network in relation to continuing care matters may not extend far beyond the exchange of information about the drafting of continuing care statements and the sharing of experiences in relation to disputes. For instance, it appeared during interviews that health authority respondents were relatively poorly informed on a number of relevant matters that are considered elsewhere in this report. We cite three examples below:

- (i) One health authority indicated that it would help greatly if the Welsh Office issued a model 'hospital discharge' protocol, because the authority's healthcare trusts adopted different procedures throughout its area. However, the other health

²⁸ Glennerster et al. (1996) made this point in relation to primary care interfaces when they noted the 'natural imbalance in the information available to medical providers' (that is, the problems of information sharing are not just between authorities but also between purchasers and providers within authorities).

²⁹ Wales Office of Research and Development for Health and Social Care

authorities indicated that they each had an agreed protocol and that (in each case) it had been developed from a model circulated by the Welsh Office.

- (ii) One authority indicated that it had had insufficient time/ human resources to develop hospital discharge information leaflets for patients, whereas another health authority drew our attention to such a leaflet which it had produced in conjunction with personnel from other health authorities.
- (iv) Only one authority appeared to have knowledge of the existence in Wales of an innovative health/ social services EPICS-type scheme³⁰ designed to ensure safe discharge into the community of vulnerable elderly persons and reduce unnecessary admissions.

IV.8 Inter–Authority Networks

‘We have met [with the other local authorities within our health authority area] and adopted a joint statement outlining our concerns about the continuing care statement. We collaborated because of our lack of trust with the health authority, although this is ceasing to be relevant.’

Local authority

Survey respondents were asked with which other authorities they had collaborated in managing the difficult overlapping area of health and social care provision. In addition, we asked questions to ascertain the extent to which other collaborative initiatives had been explored, such as inter-agency training events and the sharing of office space. A clear pattern of inter-agency collaboration exists. Social services departments collaborate with the other social services departments within their health authority area, and the five health authorities have a networking meeting every two months.

Sixteen of the local authorities described their inter-agency collaboration in terms of significant networking with the other constituent local authorities within their health authority area. The remaining three local authorities indicated that similar co-operation had occurred but only of a strictly limited (and somewhat defensive/ reactive) nature. In general the local authority responses indicated that they found this type of co-operation extremely helpful in developing a collective approach to relations with their health authority.

Five local authority survey respondents who considered that collaboration had been helpful expressed the view that the usefulness of such co-operative networks was however beginning to wane.

In all cases the social services departments had co-operated with the other authorities within the health authority area but hardly any others. The greater the difficulties they experienced with their health authority the greater they appeared to value the collaboration.

It is interesting to note that survey respondents’ inter-local authority collaboration was very much targeted upon (and limited to) negotiations over the health authority continuing care statements. None of the local authority respondents indicated that they had collaborated about the overlap of health/ social services provision with other Welsh local authorities that were not also within the same health authority area. In only two cases had local authorities collaborated with other local authorities outside their own health authority area; and in both cases collaboration was with local authorities across the border in England.

In marked contrast, health authorities have a well-defined All-Wales networking group that meets regularly and discusses a range of issues, including questions of policy arising out of continuing care statements. It appears that this group also has Welsh

³⁰ Elderly Persons Integrated Care System (see page 31 below)

Office representation. Four health authority respondents considered the networking group very useful whilst the fifth considered that its usefulness was now limited.

The positive aspect of such local authority and health authority collaboration is the peer support it provides. The health authorities' collaboration also facilitates exchange of information (and benefits in this respect from a Welsh Office presence). The negative aspect is that the collaboration is exclusive and perpetuates the social services/ health service divide. In both cases collaboration seems to have been driven predominantly by the need to sustain bargaining positions in the continuing care statement negotiations. The responses to the research study suggest, however, that some of the participants are now questioning the value of such networking meetings, in the sense that they feel that they are perhaps concentrating on 'yesterday's problem' rather than fostering inter-authority information exchange and collaboration. Again, it appears that there may be a positive role for the Welsh Office to play in stimulating such an inter-agency network.

IV.8.1 Common needs initiatives

'Health trusts and social services staff should review assessment arrangements, clarifying responsibilities for different members of staff, standardising procedures and documentation, and monitoring the completion of documentation.'

*Audit Commission, The Coming of Age*³¹

The survey has highlighted the importance of the 'personality factor' in improving collaboration between local authority and health service staff. Initiatives that increase the frequency with which key players come into contact with each other would appear to be intrinsically beneficial. A number of possible opportunities for achieving this goal exist, including joint training arrangements and office sharing. Health service bodies and social services departments frequently have common training and office accommodation needs.

IV.8.2 Joint training

The importance of inter-professional training has been long recognised (*for instance* Younghusband 1959). Its value has, however, been analysed by a number of commentators and the obvious dangers pointed out, not least that it can lead to an unhelpful preoccupation with inter-professional boundaries and relationships (Biggs 1993)³². However, the issue of most relevance in the present context appears to be the need for the professionals at all levels working at the boundaries in health and social services to get to know each other, better understand the constraints under which their colleagues in the other authority operate, and gain an appreciation of others' perspectives (Bruce 1983; Hoeflinger et al. 1990). As noted above, many of the joint training activities would concern issues of common relevance (such as manual handling and joint-assessments), which are not so much 'boundary issues' as common problems.

Many of the survey respondents emphasised the importance of agreeing joint assessment criteria, or if possible having joint assessment teams. Survey respondents reported that in several situations differences between social services and the NHS over an assessment procedure (or its timing) had resulted in a continuing care dispute (*see page 28*). It would therefore appear desirable that assessment training should be a joint exercise with professionals from all authorities attending and sharing their experiences, rather than each authority arranging separate events³³.

³¹ (1997) page 26

³² Weinstein (1994) helpfully reviews many of the current issues and commentaries on joint training.

³³ The Audit Commission has referred to the lack of joint training of social workers and nurses as a factor which contributing towards poor hospital discharge performance (Audit Commission 1995), a point reiterated by the Social Services Inspectorate which considered that 'continuing multidisciplinary training is essential if social services medical and nursing staff are to work effectively together and provide good quality assessment and discharge practice' (DoH 1995b).

Even where the issue is unlikely to cause inter-agency conflict, shared training events would appear to be an obvious way of building confidence between the different agencies. For instance, both health ancillaries and social services home care assistants need training on manual handling regulations, while health and social services managers need training on the impact of the proposed Local Health Groups and/ or the proposed reform of the procedures for inter-agency budget pooling (DoH 1998). Joint training initiatives may, however, include a wider range of staff than might superficially be considered relevant; by way of example, Neill and Williams (1992) suggest that social services 'home helps' in fact do a considerable amount of community care assessments themselves, and accordingly would have a place in such joint training sessions along with care managers and discharge nurses.

All survey respondents were asked if they had considered the possibility of holding joint training events (or combining their training functions). Local and health authority respondents', although generally positive about the idea, indicated that in most cases such training initiatives had not occurred; a typical comment being:

'Unfortunately in our area this is not currently in vogue but it is essential to ensure we understand where the other person is "coming from". We see great scope for it but believe that there is a "cultural problem" stopping it.'

IV.8.3 Office sharing

The benefits of health and social services officers sharing office space have been highlighted in a number of reports which have noted that discharge planning works best when social workers and trust staff share the same building (CHSR 1996), while Robinson in her 1994 review of multidisciplinary working under the Welsh Office Elderly Initiative recommended that 'shared office space might allow informal discussions between members thus facilitating the formal decision making process'. Office sharing has also been promoted for purely financial reasons (i.e. that health authority locality commissioning schemes are only sustainable in 'resource use terms' if they 'utilise existing infrastructure at local level, i.e. local authority accommodation' (WPGA 1997).

Survey respondents gave very few examples of health authority and social services staff sharing office space; the most common response being that this was something considered to be a good idea in theory but that there was little practical evidence to suggest that it would be of enormous benefit in practice.

IV.9 Continuing Care Statements

'The preparation of continuing care statements was an edict from the Welsh Office, so we had to "suck it and see". It has thrown up some gaps, such as people who met the criteria but for whom we had no provision, and so we have purchased new services, such as nursing home places. That said, however, in my opinion admission to community hospitals, for instance, is still determined on the basis of historic practice rather than by virtue of the continuing care criteria. As a result we've prepared a report highlighting this and the need to ensure that patients meet the continuing care criteria.'

Health authority

WOC 16/95 - WHC (96)7 obliged health authorities to produce annual continuing health care statements and, in their production, to consult with local authorities. Welsh Office advice was given to health authorities on their initial draft statements (DGM (96)38). The problems caused by the social services/ health authority negotiations over the continuing care health statements appear to be 'Wales-wide'. This point was noted by the Social Services Inspectorate for Wales after the final statements were first issued, when it commented 'that in no area were [they] finalised to everyone's satisfaction' (Welsh Office 1996c; *see also* Saper and Laing 1995).

As noted above, health authority continuing care statements have provided a mechanism which has enabled the various health bodies and social services departments to engage in discussion over their respective responsibilities for people who have continuing care needs. Most local authority survey respondents indicated that negotiations over continuing care statements had been a generally negative activity, although one referred to the statement as 'acting as a catalyst which had improved' its relationship with the health authority.

This engagement has been both positive and negative, but in either case the benefits or problems have not necessarily been caused by the continuing care statements, which have often merely highlighted existing problems. Their introduction has not necessarily changed the way in which decisions are made, but merely the means by which decisions are justified. A number of survey respondents suggested that historic practice/ resource constraints (such as bed availability) were still the dominant determinants in the allocation of resources, rather than what outcome might objectively be dictated by a neutral reading of the continuing care criteria.

In similar vein, our research suggests that the more detailed the continuing care statement, the greater appeared to be the problems experienced by the constituent parties. The size of the document appeared to be a reflection of the difficulties experienced rather than offering a particularly useful tool in resolving the problems³⁴.

IV.9.1 Continuing care disputes

All five Welsh health authorities have similar procedures for resolving disputes between social services and health over which agency has responsibility for the continuing care of a particular patient³⁵. The first stage of the procedure is that the matter be resolved locally between the immediate professionals involved. The second stage involves arbitration between a senior officer of the trust and the social services department. If this fails the third stage requires a resolution to be reached between the health authority's director of patient care and the director of the relevant social services department.

Survey respondents were asked how many continuing care disputes had reached the second and third stages, and whether these disputes could be characterised in any particular way. The majority of local authorities reported no disputes that had progressed to the third stage, and no local authority indicated that more than three complaints had progressed to that stage. Two local authorities characterised the disputes that had occurred as basically coming down to 'distrust' or simple 'personality clashes':

'Many of the disputes have been small or marginal and unnecessary; they have been more symptomatic about a distrust than anything else.'

Three local authorities characterised their disputes as structural in nature, three as procedural, and one as a mixture of both. By the term 'structural' respondents appeared to mean that the dispute touched on a fundamental disagreement between the health and social services authorities as to which of them was responsible for service provision. In contrast, 'procedural' disputes generally concerned flawed assessment procedures; the

³⁴ The increasing detail of these statements (*see* Henwood 1996) does not appear to have improved inter-agency joint-working and may indeed be detrimental to long-term relationships. The organisational pitfalls of excessive detail have been noted, and it has been suggested that this is an interface where only through the means of such values as 'ambiguity' can 'complex organisations function in complex settings rather than seize up' (Hunter 1998).

³⁵ The continuing care statements reviewed were as follows: Bro Taf HA (April 1996), Dyfed Powys HA (April 1996), Gwent HA (November 1997), Iechyd Morgannwg HA (early 1998), North Wales HA (September 1997).

problem here was not which authority was responsible for a particular need, but whether it could be agreed that the person in question had that need³⁶.

Divergent assessments are not only a characteristic of a health / social services divide: even within trusts assessments are 'sometimes carried out more or less in isolation from ongoing rehabilitation by occupational therapists and physiotherapists. In one location occupational therapists ruefully referred to the fact that medical and orthopaedic consultants seemed to perceive them as 'discharge technicians' (CHSR 1996; *see also* Kendrick and Hindmarsh 1989).

An example of a procedural difference was given in the following terms::

'Problems occur where GPs or hospital staff fail to understand the need for co-ordinated [in time and procedure] multi-disciplinary assessments.'

A corresponding structural difference was described thus:

'There have been several disputes and they are generally structural in nature: basic differences over what a person's prognosis/ life expectancy is, whether they need palliative care, and so on.'

³⁶ One social services survey respondent commented that these disputes may (paradoxically) have been exacerbated by the adoption in the continuing care statements of ostensibly objective nursing dependency measures, which produce different results depending upon whether the assessor is a health or social services officer. Such dependency measures are controversial and not in themselves substitutes for the inter-agency community care assessments (Wellwood et al. 1995). They can lead to multiple assessments (each agency insisting on separate evaluation) and there is evidence that this can result in hospital staff delaying the referral of patients to social services for assessment (*see* CHSR 1996).

Part V Key Local Interfaces

V.1 Introduction

Table 2 provides an overview of survey respondents' respective ratings for discrete areas of service provision at key local interfaces.

	LA view of service arrangements		HA view of service arrangements	
	% good	% poor	% good	% poor
Hospital discharge procedures	58%	35%	60%	20%
Respite care	22%	72%	100%	0%
Rehabilitation	27%	52%	100%	0%
Continuing inpatient care	23%	64%	60%	20%
Primary/ community care for residential/ nursing homes	13%	46%	0%	80%
Primary/ community care to domestic homes	42%	35%	40%	20%
Special equipment to domestic homes	43%	31%	40%	20%
GP involvement	41%	52%	20%	60%
Palliative care	36%	36%	60%	0%

TABLE 2

The interface between the NHS hospital and social services departments' community care responsibilities extends well beyond the hospital discharge process. There is increasing evidence that improved inter-agency collaboration (especially in the form of multi-disciplinary primary care teams) can reduce unnecessary admissions to hospital (*see, for instance*, Audit Commission 1995 and 1997). Multi-disciplinary teamwork of this nature can also facilitate earlier discharge from hospital and prevent unnecessary re-admissions. It can also engage in the complex assessment process to ascertain whether, for instance, a person's continuing care needs require NHS, social services department, or joint-funded continuing care support.

The importance of health authority involvement in the assessment and care management process has been emphasised in WOC 20/91 [WHC (91)31], particularly their role in assisting the local authority to identify, secure, and manage individually-tailored care packages to meet the needs of service users. Set against this research and guidance is evidence that social services authorities have 'little expectation that community care services will be provided by the NHS; and that they appear to be acting as the provider of last resort' (AMA 1995). This was a view endorsed by the majority of the social services survey respondents, who repeatedly referred to the disparities between the resources they applied to community care and those applied by the NHS to primary care for the elderly.

Several survey respondents expressed great interest in the possibility of developing multi-agency primary care/ community teams. Both health and social services respondents frequently identified as one of the crucial roles for such units the implementation of common assessment procedures.

Our findings indicate that the inter-agency arrangements for facilitating hospital discharge are well-developed compared with those preventative collaborations aimed at reducing unnecessary hospital admissions. Marks (1994) has noted in this regard that such an outcome is in part an inevitable result of the implementation of the NHS & Community Care Act 1990 in that it 'focused both social services departments and trusts on the issue of the funding of continuing care and the rights of access to post-discharge care' (as opposed to more imaginative inter-agency initiatives). This is unsurprising in view of the frequently-identified perverse incentives which act against such collaboration: a social services department investing in such a service reduces (in

the short term) NHS expenditure rather than its own. In any event, hospital admission is frequently GP-instigated, and the incentives operating on GPs may be at considerable variance with those experienced by social services or health authorities. A hospital admission may reduce the pressure on GPs and will frequently be an expression of the GP's confidence in the ability of the social services department to maintain the patient safely in the community³⁷.

A number of reports have described imaginative inter-agency initiatives that have reduced unnecessary hospital admissions or improved the community rehabilitation of elderly people. In 1992 the Audit Commission drew attention to 'early supported discharge' schemes (Audit Commission 1992); in its 1996 report the House of Commons Health Committee noted with approval the development of social rehabilitation schemes that enabled people to return home after a short spell in a residential care home (HCHC 1996); the Department of Health had promoted such initiatives in a report earlier that year (DoH 1996c). Alternative schemes aimed at maintaining the independent living skills of elderly people have been described by Walker and Warren (1996) as consisting of flexible user- and carer-responsive community support services from intensive short-term to tailor-made low-input schemes. In 1997 the Audit Commission drew attention to the cost/ outcome benefits of such schemes, noting that 'health authorities must start to decide what changes are needed and what gaps must be bridged. Many have already started introducing imaginative initiatives. Some are trying to reduce admissions to hospital by providing care in different ways through focused, community-based schemes. The [EPICS scheme³⁸] offers an alternative system of integrated care in the community for people aged 65 and over, who ... might otherwise be admitted to hospital' (Audit Commission 1997).

Survey respondents were accordingly asked whether their authority had any plans to develop an EPICS-type schemes in their locality. Both local and health authorities expressed considerable interest in such schemes, but explained that the problems of joint planning and resource constraints meant that few had been developed. Additionally, although there does appear to be at least one established example of an 'EPICS-type' scheme in operation in Wales, it was noticeable how few survey respondents were aware of it.

This again is an area where there may be a role for a Welsh Office-supported pilot project which could establish a set of common procedures and produce a blueprint as to how such multi-agency primary care/ community care teams can be developed, managed, and funded.

V.2 Hospital discharge procedures

'Although we have agreed procedures with the health authority, unfortunately these are not agreed by trusts or consultants. The problem is that consultants never attend training or understand the health authority/ local authority agreements; a consultant's idea of a blocked bed is twenty minutes after his decision that he needs the bed: this amounts to a delayed discharge.'

Local authority

Prior to the implementation of the community care reforms, the Audit Commission and others (*see* Marks 1991; Neill and Williams 1992) referred with concern to the generally poor relationships between hospital managers and social services departments and to the resultant problems of hospital discharge planning (Audit Commission 1992). The

³⁷ The essential role played by GPs as gatekeepers for hospital services has been noted by a number of studies (*for example* Evers 1982; Penney 1988; Marks 1991; Neill and Williams 1992). However, research also shows the importance of effective communication at the primary care level: for instance, at the extremes there is a 'twenty-fold variation in the rate at which GPs refer patients to hospital, and a four-fold variation in referral rates is not uncommon; although the reasons for the variation are not clear' (DoH 1989b).

³⁸ A scheme described by the Audit Commission known as an Elderly Persons Integrated Care System.

situation in Glamorgan was described by Farag and Tinkler (1986) where they found that approximately 25% of patients experienced delayed discharge from hospital for non-medical (predominantly social) reasons.

This generally poor situation in relation to joint working on hospital discharge was not evident from our research findings, and it is clear that the highly focused attention given to this area by the Welsh Office and other national agencies since 1992 has yielded considerable dividends. Welsh Office initiatives have included the dissemination of the *Hospital Discharge Workbook* (WHC (95)18) and robust follow-up scrutiny of trusts' discharge policies (*see* DGM (97)22 and DGM (97)60).

Most local authority survey respondents reported that they had working agreements or formal discharge protocols with their health authority, and the majority of local and health authority respondents considered that the procedures were working well and improving. The problems that did arise were largely attributed to:

- (i) consultants' ignorance of the social services role and an ignorance of 'advice given by the health departments...' (House of Commons Select Committee on the Parliamentary Commissioner for Administration 1997);
- (ii) consultants or trusts which were not adhering to the agreed protocols, particularly when the system was under pressure (Neill and Williams 1992);
- (iii) procedures that varied from authority to authority, from trust to trust, causing particular problems where a social services hospital team was assessing for a number of other local authorities (i.e. where the trust received patients from a number of local authorities); this is described elsewhere as the 'idiosyncratic' interpretation of discharge agreements by trusts (CHSR 1996);
- (iv) agreements that might result in an efficient discharge from hospital but might not necessarily be in the best interest of patients: they might, for instance, be discharged before they had achieved maximum recovery.

In contrast, the Audit Commission identified the main impediments as being: (i) poor referral practices (*see also* Penney 1988 and Kendrick and Hindmarsh 1989); (ii) failures of communication; (iii) poor service organisation; (iv) inadequate staffing levels; and (v) problems in organising aids and appliances.

Ten local authorities considered that their inter-agency arrangements for hospital discharge worked well, although it was commented that an effective discharge system may merely shift the patients' problem to another setting: 'we are concerned that people may be leaving who require more rehabilitation or continuing care'. Woodhouse (1997) refers to this issue: 'the preoccupation with bed numbers or occupied bed days was frustrating for those staff who provide rehabilitation and community services.... In all health authorities there was no indication when outcomes might form a routine part of the contract currency'.

Six local authorities considered hospital discharge arrangements to be a problematical area (albeit in five areas problems arose only occasionally). Comments included:

'In the two large district general hospitals they have to deal with different procedures for two or three different local authorities, so it is not surprising things get mixed up.'

Three health authorities considered that their inter-agency arrangements for hospital discharge work well. Comments included:

'We have made major efforts to improve this by ensuring that the social services departments always have a named person to act as point of contact. There are, however, no authority-wide agreed discharge protocols, and the lack of Welsh Office help here is a matter of regret. The human/ time resources that have gone into trying to sort this problem out is ridiculous.'

One health authority considered that it was not in general a problem, and one considered that it was, stating:

‘We see problems on both sides. We are unhappy about the lack of attention to this by trusts - especially on the acute side. We have also had problems with local authorities. For instance, the [named local authority] took a unilateral decision to establish a panel to agree discharges into residential or nursing care; this caused delay - when we asked them to spell out their difficulties they were reluctant to do this.’

Our research study accordingly supported the findings of the Welsh Office review on hospital discharge arrangements (WHC (95)18) that inter-agency collaboration on discharge planning had improved and was working ‘in the main’. The review itself echoed the reservations of the CHSR report (1996) concerning the essential importance of the ‘timing of discharge assessments’ (finding evidence of duplication of assessments in almost half of the places visited). The Welsh Office review (in common with Audit Commission 1995 and DoH 1995b) emphasised the need for joint training and the particular problem of persuading health care professionals (notably GPs and hospital consultants) to participate in training activities and seminars.

V.3 Respite care services

‘They work reasonably well; in [named region] we have sufficient community hospital beds, whereas in [another named region] we have funded nursing home places. We are currently carrying out an assessment of the need for further investment in this area.’

Health authority

Welsh Office Circular 16/95 - WHC (95)7 confirmed the obligation upon health authorities to arrange and fund an adequate level of respite health care for the needs of its population as well as the need for health authorities to agree with local authorities their respective responsibilities.

As noted above, notwithstanding the circular guidance, the present funding arrangements produce little incentive for either the NHS or social services to invest in respite services (Audit Commission 1997). In this respect, NHS-funded respite care is to a degree the flipside of social services-funded EPICS schemes (*see page 31*).

Given the publicly-expressed ‘priority’ that the government attaches to respite and rehabilitation services, the responses to our research study suggest that there is a reasonable availability of respite care provided by health authorities in Wales in those areas where community hospitals exist. This is borne out by two significant observations by respondents:

- (i) The availability of NHS-provided respite care in Wales is directly proportionate to the number of community hospitals in a given area.
- (ii) Individuals who accessed respite care did so in spite of, rather than because of, the continuing care criteria. And social services survey respondents expressed a concomitant fear that if health authorities did seek to clarify the continuing care criteria for accessing respite care services, this action would lead to a reduction in availability.

Survey respondents were asked an open question as to whether they considered the arrangements for respite health care in their area were working well or causing difficulties. Four local authorities from three different health authority areas considered that respite health care arrangements were working reasonably well (although one of these entered the caveat that this was from a ‘low base’).

However, thirteen local authorities considered that in the context of inter-agency joint working, respite health care provided cause for concern, albeit that five of these indicated that the problems experienced were only intermittent, and one indicated that the problem existed in only one part of its local authority area (an area where it considered there to be a shortage of community hospital beds). In this regard, *see* DGM (96)161 and Audit Commission (1996a) which expressed concern that ‘people who qualify in one authority may not qualify in another’; indeed our research findings

suggest that this may be the case within individual authorities, depending upon whether the patient lives near or far from a community hospital³⁹.

Where community hospital beds were absent or in short supply, the problem of accessing NHS-funded respite care was seen as severe. In these areas the health authority and local authority respondents made imaginative suggestions as to how the difficulty could be overcome. There was general acceptance by local authorities that if health authorities were to invest in new community hospitals they would inevitably have to disinvest elsewhere. Several local authority and health authority survey respondents indicated that they considered the most viable option to be the use of specialist independent nursing homes in combination with a multi-disciplinary community assessment team. However, no respondent was actually able to provide an example of steps being taken to realise the proposed type of provision. Again, this is an area where a Welsh Office assisted pilot project could act as a useful blueprint for local authorities and health authorities as to how to commission such a service.

Local authority respondents who indicated that they were satisfied with the level of respite care provision arranged by their health authority almost invariably explained this in terms of the availability of community hospital beds, for instance:

‘Respite care works well in areas with community hospitals such as [town x and town y] but poorly elsewhere, for instance in [town z] and in [named region].’

Local authority survey respondents who expressed concern about the level of respite care provision arranged by their health authority commented:

‘Trusts do not see it as their role; we need a clearer Welsh Office lead on this.’

‘Provision is *ad hoc*; there are no clear criteria within the health authority - it depends where you live.’

More general comments concerning the service often indicated that a factor of almost equal importance to the availability of community hospital beds was the attitude of consultants:

‘For respite services to work well it is essential to have the full involvement of trusts and consultants; where things go well it is often due to a committed consultant – we are fortunate to have one such who calls this “doing an MOT” on older people.’

In marked contrast to the local authority respondents’ concern about the quality of respite services, all health authorities considered that respite health care services were generally working well in the context of inter-agency joint working. One health authority respondent tempered by stressing that service availability was patchy and depended upon the historic distribution of community hospitals:

‘There is a big [region a/ region b] divide; [region a] has an abundance of respite care services because of community hospitals and lot of morbidity; this has created a high historic expectation. We accept that the closure of two [named] hospitals in [named] region has added to the problem because the capacity from these has not been replaced.’

³⁹ The potential role of community hospitals in Wales for innovative and continuing health care developments has been the subject of a Welsh Office initiative (DGM (96)161); (*and in this context, see also Black 1998 and Royal College of Physicians 1994*).

V.4 Rehabilitation services

‘Rehabilitation - like respite services - is not considered by the health authority to be a health authority obligation. We assume it is probably being provided in the various cottage hospitals, but in spite of - rather than because of - the continuing care criteria. The health authority really is making no provision on paper.’

Local authority

WOC 16/95 – WHC (95)7 emphasised the particular importance attached by the Welsh Office to rehabilitation services commissioned by health authorities for older people⁴⁰. Whilst rehabilitation is an NHS responsibility, the setting may be hospital- or community-based⁴¹. There has been further emphasis of the crucial importance that the government attaches to these services (DoH 1996a and 1995a). In addition, concern has been expressed that some continuing care statements have been unduly restrictive by limiting health authority responsibility for rehabilitation to post-acute care without taking account of their responsibilities to contribute to longer-term rehabilitative care (DoH 1996b; Henwood 1996). However, none of the five Welsh continuing care statements considered appear to be so restrictive.

Local authority survey respondents disclosed very little appreciation of the health authority resources being applied to this area. No survey respondents reported that they had attempted to access the health authority assessment of public health need or purchasing arrangements.⁴²

Five of the local authorities considered that the inter-agency arrangements for the provision of rehabilitation and convalescent services worked well, although two added the caveat ‘generally’. As with respite care services, their evaluations were affected by the availability of local community hospital beds and/ or a committed consultant. Three local authorities considered it to be ‘not a problem area in general’ whilst ten viewed it as a problem area, although four of these respondents indicated that the problems were only occasional. One commented:

‘It is a particular problem now that hospital stays are significantly shorter. There is a great need to adopt the Audit Commission’s approach and look at what can be done with inter-agency OT liaison networking etc. This must be done on a multi-agency basis; the health authority does not see this as a priority; there is no overview as to whether rehabilitation can be better delivered via nursing homes or in a community setting.’

As with the question of respite care, all five health authorities considered that rehabilitation services worked well although one qualified this by stating:

‘Given the health authority’s capital position, the only way of improving the situation would be to use the independent sector to provide rehab. We recognise that at present nursing homes are not set up to provide rehab; it could only succeed if there were clear contracts and a community team of specialist peripatetic multidisciplinary staff. These would have medics specialising in rehab plus physios, OTs and speech therapists who would be able to carry out assessments and provide services to people in their own homes - and also co-ordinate EPICS schemes to stop unnecessary admissions. However, this could only take off if there was central support from the Welsh Office.’

⁴⁰ Annexe A paragraph C

⁴¹ See for instance the conclusions of Rudd et al. (1997) that ‘early discharge with specialist community rehabilitation of stroke patients is as clinically effective as conventional care, and acceptable to patients’.

⁴² i.e. the assessments that the health authorities are required to do consequent on WHC (95)7

V.5 Continuing inpatient care

‘The agenda set by the 1995 circular has never been properly addressed. The Welsh Office has not followed it up with any force or “helpful” guidance as to what is or is not meant by a particular term; as to what is or is not acceptable; as to the detail of what should or should not be provided.’

Local authority

Whilst WHC (95)7 required health authorities to arrange and fund an adequate level of continuing care provision, it allowed for this to be provided (at health authority expense) in nursing homes as well as in hospitals. The circular also anticipated that the existence of high-quality rehabilitation services and well-developed community health services and social support might lessen, although not eliminate, the need for continuing inpatient care. The survey responses suggest that local authority respondents are more concerned to see the imaginative development of high-quality rehabilitation services and well-developed community health services provided by health authorities than to argue for a wholesale expansion of health authority continuing care provision.

A clear majority of local authority respondents expressed the view that (with the exception of continuing care services for people likely to die in the near future)⁴³ there was no continuing care provision in their area apart from *ad hoc* services in community hospitals. These concerns are borne out by a consideration of the five Welsh continuing care statements, all of which appear to be most restrictive in relation to continuing care responsibilities as opposed to the specific areas of (for instance) rehabilitation, respite care, and palliative health care services⁴⁴.

Four local authorities considered that continuing inpatient care services work well whilst eleven considered it to be problematical, comments included:

‘No such beds exist; none are designated. If people occupy such beds it is because they have drifted into them. There are no criteria.’

Three health authorities considered that these services were working well; one that it was not a problem and the remaining authority commented as follows:

‘This has considerable potential to cause problems as the health authority recognises that many people in nursing homes are receiving continuing nursing care. We have classified some beds in [named region] as long-stay beds whereas in [another named region] there is only rehabilitation/ respite care, although clearly some of these are in fact probably used for long stay by default rather than by design.’

V.6 Specialist support in nursing/ residential homes

Survey respondents were asked their opinions as to how well inter-agency collaboration was working in relation to specialist support for older people in residential and nursing homes. The responses were of general significance for two reasons:

- (i) Local authority and health authority concerns had a markedly different focus. In general the social services view was that health authorities were not putting sufficient services or equipment into residential or nursing homes (*see* Impallomeni and Starr 1995). On the other hand health authorities expressed particular concern about the inappropriate placement in residential accommodation of vulnerable people who needed substantial nursing care.
- (ii) This area was one of the few in which health authority survey respondents expressed greater overall concerns than their local authority counterparts.

⁴³ And then frequently only if the patient had palliative health care needs.

⁴⁴ This is also a problem that has been identified with many English health authorities’ continuing care statements- which have placed an ‘over reliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing inpatient care’ (DoH 1996a).

Specialist equipment was frequently mentioned by local authority respondents as an area of friction - largely because of the difficulty of implementing joint equipment stores. This issue is considered in more detail at *pages 38* below.

Two local authorities considered that inter-agency arrangements to support people in residential or nursing homes were working reasonably well and seven considered specialist support in nursing homes to be a problematical area; one commented:

‘Specialist NHS physiotherapy or OT services to residential and nursing homes are very limited. There is also anecdotal evidence that when [a neighbouring local authority] had financial difficulties patients had to stay longer in hospital, and there was a marked improvement in their recovery. This indicates that the trust had previously been discharging people prematurely.’

Whilst no local authority considered that specialist support in nursing homes ‘worked well’, six indicated that it was not a problem area. In contrast four health authorities viewed it as a problem. In particular, they expressed considerable disquiet about the inappropriate placement in residential care homes by social services of frail elderly people, whom they considered in need of nursing home care. Their view was that this represented a form of cost-shunting by social services, in that the health authority was subsidising the residents’ care by the input of free community nurse services and incontinence supplies. These health authority respondents also expressed concern that in consequence, residents who needed 24-hour nursing and specialist incontinence advice were not receiving it and suffered accordingly (*see* Denham 1997). This level of concern contrasts with the research findings that have tended to question inappropriate nursing home placements (*see* Bennet et al. 1995). Whilst the issue of incontinence services and inter-authority responsibilities has been the subject of research (*see* Swaffield 1994 *and* Welsh Office guidance (WOC 27/93 - WHC (93)23), the level of health authority concern disclosed by our research study suggests that this is an issue that warrants further evaluation:

‘We have done a snapshot survey which suggests that district nurses make three times as many visits to older people in residential care than to incontinent people living in their own homes. We would like to see Welsh Office research into why this should be; we believe it may be because of pressure sore complications, etc.’

‘We are seriously concerned over the inappropriate placement by social services departments of people in residential care when they should be in nursing home care. We fund incontinence services in residential care but not in nursing home accommodation. It is thus in local authorities’ interest to place in residential care as a hidden health authority subsidy. We believe that many residential homes use incontinence pads as a first resort - it’s cheaper to pad up old people than to manage alternatives - and in terms of staff time it may well not be in the home’s interest to encourage continence. We are very concerned about the high dependency of patients in residential care. It costs £50 a visit for a nurse to go into a home, so if visiting daily it could cost us £350 per week merely to save the local authority £100 [the weekly difference between residential and nursing home costs].’

One health authority indicated that such was its concern about inappropriate placements of ill people in residential homes that the authority was contemplating the prosecution of the proprietors under the Residential Homes Act 1984.⁴⁵ The respondent referred to a recent survey conducted by the health authority, which had apparently found 27 inappropriate placements in a large residential home.

⁴⁵ s23 (1)

V.7 Primary health services to people's own homes

'Problems have been caused by the reduction in the tasks that community nurses will carry out and this has therefore increased the pressure on home care provision.'

Local authority

In general, where survey respondents indicated that matters were working well they gave little or no explanation; and where a problem was reported there was a generalised reference to a shortage of community nurses. Three local authorities considered that there were insufficient community nurses and that (notwithstanding the rhetoric of an expanded role for primary health care) the trend was not only towards fewer such nurses but also for their functions to be increasingly restricted.

These findings suggest that this is possibly an area of service provision about which neither local nor health authorities have detailed knowledge. It is likely that many people in need of domiciliary and primary care health services are not receiving them because of the severity of eligibility criteria, such that their unmet needs would not be manifest as an organisational/ administrative problem between health and social services. If this is the case, the extent of the problem would most probably be revealed only by interviewing carers and GPs.

No local authority or health authority referred to service disputes about which agency was responsible for a particular function (i.e. the classic dilemma as to whether the need for a bath is medical or social). Our finding contrasts with research conducted by the Social Services Inspectorate for Wales which referred to a social services office that described its continuing disputes with the NHS as 'the battle of the baths' (Welsh Office 1996d). In measure there appeared little expectation from social services respondents that such services would be provided by primary health care teams. Local authority respondents did, however, express concern about the different ways that they and their health colleagues interpreted the Manual Handling Operations Regulations 1992. As noted above at *page 26*, there appears to be considerable scope (i) for adopting unified local / health authority manual handling assessments and interpretations and (ii) for all staff involved in such work (be they ancillary health workers or social services home care assistants) to undergo joint training.

Six local authorities stated that inter-agency arrangements for domiciliary/ primary care services were working well, although they gave very little explanation as to why this was felt to be the case. Likewise, the five local authorities that considered this to be a problematical area were laconic in their comments. Apart from equipment problems (see below) most respondents referred to a shortage of community nurses and differences of interpretation over the manual handling regulations.

Two health authorities considered that primary health services in people's own homes were working well, without explaining in detail why. The one health authority survey respondent who considered that it was a problem made the following comment:

'This depends upon the trust/ local authority concerned and is highly variable; there are problems - for instance in [named town] which are largely due to personality clashes and often to an overly-rigid attitude to what district nurses do.'

V.8 Specialist equipment in the domiciliary setting

'We do toileting and they do walking: there is no logic to it, but it works reasonably well. We have plans for a joint equipment store but it has not yet happened.'

Local authority

The Audit Commission (1995) has identified as one of the five key impediments to inter-agency working the problems involved in organising aids and appliances.

Most health and local authority survey respondents reported that they had attempted to create joint equipment stores based in one building (often an NHS trust) for which the equipment was funded separately by each authority but which could be accessed by either authority.

Almost all survey respondents considered joint equipment stores to be essential because the community care needs of people living in their own homes frequently required a multi-disciplinary response with the provision of aids spanning the health and social care spectrum. In theory such stores should be simple to operate but in practice they generally appeared to cause problems. The principal difficulty appeared to be the legal issue of pooling budgets (*see 9 above*). In consequence, most authorities opted for the pooling of equipment rather than the funds to buy that equipment. This in turn resulted in problems when either health or social services funding was in short supply, as well as disputes over whether or not a particular item was required to meet a health care or social care need.

Often respondents expressed the view that, in the absence of budget pooling, their arrangements were at best *ad hoc*, pragmatic, uncertain, and in normal practice were probably unsatisfactory for patients. There does therefore appear to be a need for the Welsh Office to promote a model protocol explaining how joint equipment stores should best be arranged and funded. Whilst in overall budgetary terms such stores are a minor matter, their management does appear to cause disproportionate administrative time, with inter-agency friction frequently leading to delayed hospital discharges and other inappropriate service responses.

Seven local authorities considered that inter-agency arrangements to provide specialist equipment in peoples' homes worked well, however five local authorities considered this to be a problematical area. They made a number of points, including:

'Although theoretically there is an agreement on these items, it causes problems. For instance, recently the trust has suggested that we should buy hospital beds for people at home - as they were required to ease lifting by the carers not the patient!'

'We tend to provide long-term equipment and the health authority short-term. We have had problems with the local trust which runs the store, in that equipment is not always properly cleaned or in best condition; this is an increasing problem as the transaction levels have grown.'

One health authority considered that provision of specialist equipment in the domiciliary setting was working well without explaining why. Two however considered that it was a problem and referred to the difficulties (unnecessary in their opinion) of arranging joint equipment stores. In part they considered this a legal problem and looked to the Welsh Office to offer a unified protocol for All-Wales.

V.9 GP involvement in inter-agency working

'This is a significant problem area; they are generally unaware what we are obliged to do and *not* do; they make misleading statements to patients and give poor advice on options available. They arrange for social admissions to hospital when these could be avoided if they spoke to us. They refuse to become involved in care planning unless paid £90 per session - this is outrageous! They do not visit patients out-of-hours, which makes people call our lifeline service or, indeed, an ambulance. They are not providing support to people in residential care.'

Local authority

WOC 51/95 - WHC (95)43 emphasised (at paragraph 8) that 'GPs need to be involved, with other members of the primary health care team, in the multi-disciplinary assessments of people with social care and health care needs *and* that health and local authorities need also to ensure that there is genuine collaboration with GPs and others in primary care to develop and implement realistic overall plans and policy frameworks.' Likewise, DoH guidance has stressed that '[i]t is essential that social

services departments and [health authorities] work closely to ensure that the contribution GPs can make to community care is fully realised' (especially in relation to contributing to joint assessment and reviews) (DoH 1990a; *see also* Penney 1988 and Kendrick and Hindmarsh 1989).

Our research survey did not include contact with GPs (except when discussing specific collaborative schemes⁴⁶). Health and local authority survey respondents were asked whether they considered that the involvement and co-operation with GPs and other primary care workers in planning and delivering community-based services worked well or caused problems.

Survey respondents generally restricted their comments to the role of GPs, and made scant reference to the role of community nurses or practice managers. However, in those parts of Wales where there is a high level of contact between social services and GP surgeries it does appear from our interviews that the crucial relationships are frequently between practice managers/ community nurses and the social workers.

The range of responses to this question from both health and local authority respondents varied enormously - probably more than to any other single question. In some areas the relationship was described as generally excellent and in others as generally very poor. In some situations the quality of relationships varied greatly in neighbouring local authorities (and in one case, between unitary authorities that until local government reorganisation in 1996 had been part of the same local authority). The reason for this significant variation is probably, therefore, attributable to historic health authority and Family Health Service Authority policy matters. Indeed, one of the local authorities that rated the social services/ GP relationship as 'good' gave just such an explanation.

Those local authority survey respondents with total fundholding projects within their boundaries considered that the GP practices involved had not appreciated their responsibilities for continuing care, and invariably viewed patients with such needs as being the responsibility of social services departments⁴⁷. Health authority survey respondents generally also agreed that GPs did not appreciate their role in this area.

Seven local authorities considered that GPs' collaboration in inter-agency joint working worked well commenting:

'Generally it's very good; we have regular two-weekly meetings with practices, although problems remain in fully integrating primary care teams, and it is an area in which further development is needed. We have divided our social work teams into sectors that correspond with the key surgeries in the area.'

'This has been poor, but the development of a locality commissioning scheme has opened up a good channel of communication, such that the relationship has changed out of all recognition in the last twelve months. We now feel that there is a good group of GPs out there. The benefits of this improved planning are felt more at the macro level than at the individual level.'

Two local authorities considered that working relationships with GPs had not been a problem, although they also emphasised the variable nature of GPs' commitment to this area of inter-agency collaboration, nine however considered the GPs' role in inter-agency joint working to be a problematical; a not untypical comment being:

'At best, GP involvement is non-existent - with one honourable exception. At worst they are aggressive; there are a number of maverick GPs who fall into this category. They do not know what their responsibilities are and have no idea about ours.'

⁴⁶ *See* note 1 above.

⁴⁷ The areas of high GP/ social worker contact are characterised by a relatively low take-up in GP fundholding. The limited extent to which fundholding embraced social services joint working has also been noted by the Audit Commission (Audit Commission 1996b).

One health authority considered that the inter-agency joint working of GPs was generally good, whilst three considered that this was a problem area. Their many comments included:

‘It’s very difficult to get them involved - particularly fundholders. They still assume that social services departments will provide everything. A significant problem concerns cases where we require from them a clinical assessment of need; they often have no idea what this means.’

‘Continuing care is seen by GPs as marginal to the locality commissioning scheme. We see continuing care as central to GPs’ new role and something they should be dealing with directly with the relevant social services department - whereas whenever it arises, it is referred straight back to us by the GPs.’

The frequency with which survey respondents illustrated problems they had experienced in attempting to liaise with GPs suggests that further consideration needs to be given as to the most appropriate educational/ training programmes to encourage GPs to participate fully in inter-agency developments.

V.10 Palliative healthcare services

This area appeared to cause least problems when there was a specific hospice, dedicated unit, or nursing homes capable of taking such patients (and in all cases accompanied by the presence of a respected consultant). When survey respondents viewed palliative care as a problem area, they often considered this to be an organisational difficulty rather than a major financial issue (although individual packages might be expensive they were thankfully few and sadly short-term, given the life expectancy of the patients).

Seven local authorities considered that palliative care provision worked well, four consider palliative care services were not a problem but had some reservations (for instance arguments with the health authority over a patient’s life expectancy) and seven considered it to be a problematical area. Their comments included:

‘We have problems with GPs insisting on admitting dying people to nursing homes funded by social services.’

‘This is a significant problem area; we are consistently in dispute about life expectancy - in my mind unnecessarily.’

One health authority respondent considered that palliative care services were not a problem (whilst ‘not working well’), whereas three authorities considered that services were working well, although one expressed concern about the provision of services to people with non-acute needs.

Appendix 1: Bibliography

- Association of Metropolitan Authorities and Association of County Councils (1995) *Who Gets Community Care?* London: AMA
- Audit Commission (1986) *Making a Reality of Community Care* London: HMSO
- Audit Commission (1992) *Lying in Wait* London: HMSO
- Audit Commission (1994) *Taking Stock: progress with community care* London: HMSO
- Audit Commission (1995) *United They Stand* London: HMSO
- Audit Commission (1996a) *Balancing the Care Equation* London: HMSO
- Audit Commission (1996b) *What the Doctor Ordered: a study of GP fundholding in England and Wales* London: HMSO
- Audit Commission (1997) *The Coming of Age* London: HMSO
- Audit Commission (1998) *Home Alone* London: HMSO
- Bennet M, Smith E, and Millard P (1995) *The Right Person? The Right Place? an audit of the appropriateness of nursing home placements post-Community Care Act* Department of Geriatric Medicine, St George's Hospital Medical School
- Benzeval M, Judge K, and Whitehead M (eds) (1995) *Tackling Inequalities in Health: an agenda for action* London: Kings Fund
- Bernstein, R (ed) (1993) *Assessment and Care management – The Welsh experience* Social Information Systems
- Biggs, S (1993) 'User participation and interprofessional collaboration in community care' 7 (2) *Journal of Interprofessional Care* p151
- Black, D (1998) 'Remains of the Day' *Health Services Journal* 19 February
- British Medical Association (1992) *Priorities for Community Care* London: BMA
- Bruce, N (1983) *Social Work and Education Research Highlights No 7 Collaboration and Conflict with Others*, Department of Social Work, University of Aberdeen
- Burgner, T (1996) *The Regulation and Inspection of Social Services* DoH and Welsh Office
- Carey, S (1993) *Older People and Community Care* London: OPCS
- Centre for Health Services Research (CHSR) (1996) *Pathways Through Care: the processes and outcomes of hospital care for elderly people* University of Newcastle upon Tyne
- Challis D, Darton R, Johnson L, Stone M, and Traske K (1995) *Care Management and Health Care of Older People* PSSRU University of Kent, Ashgate Publishing Ltd
- Clements, L (1996) 'Legislating for a change' *Community Care* 12 September p24
- Clements, L (1997a) 'Community Care: towards a workable statute' XIX (2) *Liverpool Law Review*
- Clements, L (1997b) *Community Care and the Law* London: Legal Action Group
- Colgan, E and Rose, J (1997) 'The long and winding road' *Health Services Journal* 20 November
- Davidson, R and Hunter, S (eds) (1994) *Community Care in Practice* Batsford
- Denham, M J (ed) 1997 *Continuing Care for Older People* London: Stanley Thomas
- Department of Health (1989) *Caring for People* London: HMSO (Cm 849)
- Department of Health (1989b) *General Practice in the NHS – The 1990 Contract: the government's programme for changes to GPs' terms of service and remuneration system* London: HMSO
- Department of Health (1990a) *Community Care in the Next Decade and Beyond – Policy Guidance* London: HMSO
- Department of Health (1990b) *All Change - From Hospital to Community Care* London: SSI Report
- Department of Health (1994a) *NHS Hospital Activity Statistics: 1983 – 94* London: DoH Statistical Bulletin
- Department of Health (1994b) 'Developing NHS purchasing and GP fundholding' (Executive Letter (94) 79) London: DoH
- Department of Health (1995a) 'NHS responsibilities for meeting continuing health care needs' (HSG (95) 8 / LAC (95)5) London: DoH
- Department of Health (1995b) *Moving On: a further year* London: DoH SSI Report
- Department of Health (1995c) *Priorities and Planning Guidance for the NHS 1996/97* London: DoH
- Department of Health (1995d) 'NHS responsibilities for meeting continuing health care needs' (NHS/SSI Monitoring, EL(95)88/CI(95)37) London: DoH
- Department of Health (1996a) 'NHS responsibilities for meeting continuing health care needs – current progress and future priorities' (Executive Letter (96)8) London: DoH
- Department of Health (1996b) 'Progress in practice: initial valuation of the impact of the continuing care guidance' (Executive letter (96)89) London: DoH
- Department of Health (1996c) *The Key to Independence: social rehabilitation for older people* London: DoH SSI February 1996
- Department of Health (1997a) 'Better services for vulnerable people (EL(97)62) London: DoH
- Department of Health (1997b) *Residential Accommodation, Detailed Statistics on Residential Care Homes and Local Authority Supported Residents* London: DoH
- Department of Health (1998a) *Partnership in Action* London: DoH
- Department of Health (1998b) *Modernising Health and Social Services: national priorities guidance 1999/00-2001/02* (HSC 1998/159) London: DoH
- Department of Health and Social Security (1986) *Neighbourhood Nursing – A Focus for Care* London: DHSS

- Department of Health and Social Security Welsh Office (1990) *Caring for People* London: HMSO (Cm 849)
- Evers, H (1982) 'Professional practice and patient care: multidisciplinary teamwork in geriatric wards' *2 Ageing and Society* p57
- Farag, F R and Tinkle, G M (1985) 'Delays in discharge of patients from an acute geriatric unit' *17 Health Trends* p14
- Glennerster, H, Cohen, A and Bovell, V (1996) *Alternatives to Fundholding* Discussion Paper WSP/123 London School of Economics
- Glennerster, H, Matsacanis, M and Owen, P (1994) *Implementing GP Fundholding: wild card or winning hand?* Open University Press
- Gregson, B A, Cartledge, A, and Bond, J (1991) 'Inter-professional collaboration in primary health care organisations' Occasional Paper No 52 London: *Journal of the Royal College of General Practitioners*
- Harding, T, Meredith, B and Wistow, G (1996) *Options for Long Term Care* London: HMSO
- Health Service Commissioner (1994) *Failure to Provide Long-Term NHS Care for a Brain-Damaged Patient* Second Report for Session 1993-94 London: HMSO (HC197)
- Healy, P (1998) 'Guidance will force pace on joint working' *Health Services Journal*, 8 October
- Henwood, M (1992) *Through a Glass Darkly - Community Care and Elderly People* London: Kings Fund
- Henwood, M (1996) *Continuing Care: analysis of a sample of final documents* Nuffield Institute
- Henwood, M (1998) *Ignored and Invisible?* London: Carers National Association
- Hoeflinger, T, Taft, S and Pelikan, J (1990) 'Clinical management teams: integrators of professional service and environmental change' *15 (2) Health Care Review* p67
- Hokenstad, M. C and Ritvo, R (eds) (1982) *Linking Health Care and Social Services: international perspectives* California: Sage
- House of Commons Health Committee (1995) *Long Term Care: NHS responsibilities for meeting continuing health care needs* First Report, Session 1995 – 1996 London: HMSO (HC 19-1)
- House of Commons Health Committee (1996) *Long Term Care: future provision and funding* Third Report, Session 1995 – 1996 London: HMSO (HC 59-1)
- House of Commons Select Committee on the Parliamentary Commissioner for Administration (1997) *Report on Health Service Ombudsman for 1995-96* London: Stationery Office (First Report)
- Hudson, B (1987) 'Collaboration in social welfare: a framework for analysis' *15 Policy & Politics*
- Hudson, B (1995) 'Joint commissioning: organisational revolution or misplaced enthusiasm?' *23 Policy & Politics* p233
- Hunter, D J, McKeganey, N P and MacPherson, I A (1988) *Care of the Elderly Aberdeen*: Aberdeen University Press
- Hunter, D (1998) 'Review' *Health Services Journal* 8 January, p37
- Huxley, P and Oliver, J (1993) 'Mental health policy in practice: lessons from the All Wales Strategy for mental illness' *International Journal of Psychiatry* Autumn p177
- Impallomeni, M and Starr, J (1995) 'The changing face of community and institutional care for the elderly' *Journal of Public Health Medicine* March, p171
- Kreuger, M A (1990) 'Promoting Professional Teamwork' *13 Child and Youth Services* p123
- Kendrick, A R and Hindmarsh, D J (1989) 'Which type of hospital discharge report reaches general practitioners most quickly?' *298 British Medical Journal* p362
- Laing & Buisson (1997) *Care of Elderly People Market Survey* Buisson Publications Ltd
- Leese, B and Bosanquet, N (1996) 'Changes in general practice organisation: survey of general practitioners' views on the 1990 contract and fundholding' *46 British Journal of General Practice* p95
- Marks, L (1991) *Home and Hospital Care: redrawing the boundaries* London: Kings Fund Research Report 9
- Marks, L (1994) *Seamless Care of Patchwork Quilt: discharging patients from acute hospital care* London: Kings Fund Research Report 17
- Means, R. and Smith, R (1994) *Community Care* London: Macmillan
- Monaghan, S (1998) *An Atlas of Health Inequalities between Welsh Local Authorities* Cardiff: Welsh Local Government Association
- Neill, J and Williams, J (1992) *Leaving Hospital: elderly people and their discharge to community care* London: HMSO
- O'Donnell and Propper (1991) 'Equity and the distribution of UK National Health Service resources' *10 Journal of Health Economics* p17
- Nuffield Institute (1993) *All Change, No Change? Community care six months on*
- Parsloe, P (1993) 'Making a bid for fair play' *Community Care* 5 August
- Penney, T M (1988) 'Delayed communication between hospitals and general practitioners: where does the problem lie?' *297 British Medical Journal* p28
- Rawaf, S and Bahl, V (1998) *Assessing Health Needs of People from Minority Ethnic Groups* London: Royal College of Physicians
- Robinson, C (1994) *Multidisciplinary Working Under the Welsh Office Elderly Initiative* Centre for Policy Research and Development
- Rowntree, J (1992) *Good Intentions* York: Joseph Rowntree Foundation

- Royal College of Physicians (1994) *Geriatric Day Hospitals: their role and guidelines to good practice* London: Royal College of Physicians
- Rudd, A G, Wolfe, C D A, Tilling, K and Beech, R (1997) 'Randomised controlled trial to evaluate early discharge scheme for patients with stroke' *British Medical Journal* p1039
- Saper, R and Laing, W (1995) 'Age of Uncertainty' *Health Service Journal* 26 October
- Schneider, J (1997) 'Joint commissioning of services for elderly people' Discussion Paper 1216, Personal Social Services Research Unit, University of Kent
- Shukla, R B (1994) *Care of the Elderly* London: HMSO
- Singer, R (ed) (1997) *GP Commissioning: an inevitable evolution* Radcliffe Medical Press
- Smith, R, Butler, F and Powell, M (1996) *Total Purchasing: a model for locality commissioning* Radcliffe Medical Press
- Swaffield, J (1994) 'The management and development of continence services within the framework of the NHS & Community Care Act' *Journal of Clinical Nursing* (March) p119
- Thistlethwaite, P (ed) (1996) *Finding Common Cause* Association of County Councils
- Townsend, P and Davidson, N (eds) (1982) *Inequalities in Health: the Black report*. Penguin
- Vetter, N (1995) *The Hospital: from centre of excellence to community support* London: Chapman & Hall
- Walker, A and Warren, L (1996) *Changing Services for Older People: the Neighbourhood Support Units Innovation* London: Open University Press
- Webb, A (1991) 'Co-ordination: a problem in public sector management' 19 (4) *Policy and Politics*
- Webb, A and Wistow, G (1986) *Planning, Need and Scarcity: essays on the personal social services* London: Allen & Unwin
- Weinstein, J (1994) *Sewing the Seams for a Seamless Service* CCETSW
- Wellwood, I, Dennis, M S and Warlow, M P (1995) 'A comparison of the Barthel Index and the OPCS disability instrument used to measure outcome after extreme stroke' 24 (1) *Age and Ageing* January p54
- Welsh Institute for Health and Social Care (1997) *Commentary - Better Health, Better Wales* Pontypridd: WIHSC
- Welsh Local Government Association (1997) *Local Government and Health – An Overview* Cardiff: WLGA
- Welsh Local Government Association (1998) *Working Together for a Healthy Wales: the local government role* Cardiff: WLGA
- Welsh Office (1983) *All Wales Strategy for the Development of Services for Mentally Handicapped People* Cardiff: Welsh Office
- Welsh Office (1989) *Caring for People: community care in the next decade and beyond - the proposals for Wales* Cardiff: Welsh Office
- Welsh Office (1990) *Guidance on Care Plans* Cardiff: Welsh Office
- Welsh Office (1991) *Managing Care: guidance on assessment and the provision of social and community care* Cardiff: Welsh Office
- Welsh Office (1996a) *Welsh Health Survey 1995* London: HMSO
- Welsh Office (1996b) *Partnerships in Care* Cardiff: Welsh Office
- Welsh Office (1996c) *Local Government Reorganisation Personal Social Services Monitoring Exercise Overview Report* Cardiff: Social Services Inspectorate for Wales
- Welsh Office (1996d) *The Management of Community Care in Gwynedd* Cardiff: Social Services Inspectorate for Wales
- Welsh Office (1996e) *Management Arrangements in Personal Social Services – Overview Report of Inspections in Blaenau Gwent, Monmouthshire and Wrexham Local Authorities 1997* Cardiff: Social Services Inspectorate for Wales
- Welsh Office (1996f) *Health Statistics Wales 1996* Cardiff: Welsh Office
- Welsh Office (1997a) *Wales in Figures* Cardiff: Statistical Directorate
- Welsh Office (1997b) *Welsh Health – Annual Report of the Chief Medical Officer 1996* Cardiff.
- Welsh Office (1998a) *NHS Wales: putting patients first* London: Stationery Office (Cm 3841)
- Welsh Office (1998b) *Better Health: Better Wales* London: Stationery Office (Cm 3922)
- Williams, L (1995) *A Review of the Flexible Community Care Grant 1991 – 1994* Cardiff: Social Services Inspectorate for Wales
- Wistow, G and Hardy, B (1991) 'Joint management in community care' 5 (4) *Journal of Management in Medicine* p40
- Wistow, G (1995) 'Aspirations and realities: community care at the crossroads' 3 (4) *Health and Social Care in the Community* p227
- Woodhouse, K, Williams, R and MacMahon, D (eds) (1997) *Services for People who are Elderly* London: Stationery Office
- Younghusband, E (1959) *Report of the Working Party on Social Workers in the Local Authority, Health and Welfare Services* London: HMSO

Appendix 2: Annotated Summary Of Welsh Office Circulars

1991

WOC 20/91
WHC (91)31

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**Caring for people: community care into the next decade and beyond**  
*Managing care: guidance on assessment and the provision of social and community care*

Primary guidance (i.e. guidance under s7(1) Local Authority Social Services Act 1970) on the implementation of s47 NHS & Community Care Act 1990, including the development of (i) the purchaser/ provider split for the commissioning of community care services and (ii) the care management and assessment process. The primary material was enclosed as attachments to the circular.

### 1992

WOC 6/92  
WHC (92)4

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NHS and local authority collaboration: provision of NHS services to local authorities and of health-related social work services to the NHS

Guidance reminding local and health authorities that the implementation of the NHS & Community Care Act 1990 did not affect the obligations. As clarified in WHRC (74)14 to collaborate and in particular that neither authority is empowered to charge the other for any services which they provide to it.

1993

WOC 25/93
WHC (93)21

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**Local authorities' powers to make arrangements for people who are in independent-sector residential care and nursing homes on 31/3/93**

Guidance on the effect of s26A National Assistance Act 1948 and preserved entitlement to higher rate income support funding.

WOC 27/93  
WHC (93)23

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Continuing care: boundaries between health and social services

Early and important guidance to local authorities and health authorities concerning their continuing care responsibilities in key areas including:

- local authority contracts for residential/ nursing home care;
- health authority consent to people entering nursing homes with local authority financial support;
- supply of incontinence aids.

1994

WOC 29/94

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**Guidance notes: social care plans (independent non-residential care sector) direction 1994**

WOC 79/94

**Guidance on the framework for social care planning**

Provides guidance on the preparation of social care plans and the construction of a framework for planning and commissioning social care services to meet local requirements.

WOC (94)17

**Responsibility for prescribing between hospital and GPs**

This circular to be read in conjunction with previous guidance WHC (91)94.



1995

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- WOC 16/95**  
WHC (95)7      **NHS responsibilities for meeting continuing health care needs**  
Primary guidance on the formulation of health authority's continuing care statements and their obligation to fund a range of services to meet the needs of people who require continuing physical or mental health care.
- WOC 18/95**  
*Support for adults, older people, and children with physical or sensory disabilities*  
The circular announces a specific grant package for support (payable under s28B NHS Act 1977) for projects which support rehabilitation, social integration, and personal development.
- WOC 47/95**  
WHC (95) 38      **NHS responsibilities for meeting continuing health care needs: arrangements for reviewing decisions on eligibility for NHS continuing inpatient care**
- WOC 51/95**  
WHC (95) 43      *Joint working in health and social services: checklist for health and local authorities*  
The guidance identifies the responsibilities of each authority to develop 'close' joint working relationships and provides a checklist to identify 'what needs to be done, by when and by whom'. It also provides (as Annexe A) a list of relevant Welsh Office guidance on joint working.
- WHC (95)18**      **Policy and guidance practice on hospital discharge**  
Circulated with the guidance were two publications:
- *The Hospital Discharge Workbook* (3<sup>rd</sup> edition - Dec 1994; Hospital Discharge Working Group) – a manual of good practice concerning hospital discharge procedures.
  - *Hospital Discharge Arrangements: A review of Transfer of Care for Older People in Wales* (Welsh Office) - a review of hospital discharge practice in Wales, based on a sample of twelve hospitals.
- WHC (95)52**      *Arrangements between health authorities and NHS trusts and private and voluntary sector organisations for the provision of community care services*  
The circular clarifies the legal framework under which health service bodies may enter into arrangements for the provision of community care services, including the provision of residential or nursing care. The guidance clarifies the arrangements health service bodies may enter into with independent-sector organisations for these services. It supersedes and cancels WHC (91)66, and clarifies (i) the effect of the judgment in *Secretary of State for Social Services v Percival White* and (ii) certain issues concerning 'preserved rights'.
- DGM (95)74**      **Code of practice on openness in the NHS**
- DGM (95)109**      **Planning and priorities guidance for 1996/97**  
(see also DGM (95)138)
- FHSL(W) 13/95**      **Purchasing high-tech health care for patients at home**

**1996**

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- WOC 9/96**  
WHC (96)12      **Framework for local community care charters in Wales**  
The final guidance on the production of community care charters, following on from the consultation circular WOC 48/95 – WHC (95)39.
- WOC 19/96**      **Guidance on the care in the community of people with a mental illness**
- WOC 52/96**  
WHC (96)55      *The Regulation and Inspection of Social Services* – report by Tom Burgner  
*The Obligations of Care* – a consultation paper on the setting of conduct and practice standards for social services staff.
- WOC 62/96**  
WHC (96)60      **Joint consultative committees (GACC) voluntary-sector members**  
Guidelines on the eligibility and election of voluntary-sector representatives to JCCs.
- WHC (96)40**      *Registration and inspection of nursing homes and independent hospitals*  
The circular encourages joint working between local authorities and health authorities in their registration and inspection functions, not only in relation to homes with dual registration (*see Welsh Office Circulars 40/84 and 53/92*) but also re the need for health authority involvement in local authority nursing home placements (*see also WHC (93) 23*).
- WHC (96)49**      *Local monitoring of continuing care: developing a framework for health and social care - circulated with the guidance was a copy of: Local Monitoring of Continuing Care*  
A work book produced by the Community Care branch of the NHS Executive which suggests an approach to joint monitoring (between health, social services, and GPs) to ensure that:
- individuals with community care needs are correctly identified;
  - continuing care services are appropriately co-ordinated;
  - continuing care services are planned and commissioned to meet the nature and extent of likely demand.
- DGM (96)38**      The guidance circulated to health authorities a training pack produced by Trent Regional HA on implementing the panel review procedures (for hospital discharge/ eligibility for NHS continuing care).
- DGM (96)70**      The guidance compliments WHC (95)38 (*see above*). It provides informal guidance to health authorities on such matters as the procedures for taking separate clinical advice and remuneration.
- DGM (96)143**      **Planning and priorities guidance for 1997/98**
- DGM (96) 161**      **Community hospitals – the future**  
A working group prepared a multi-disciplinary report on community hospitals with a view to providing advice regarding their potential for innovative and continuing health care uses.

## 1997

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WOC 22/97

### **Regulation of residential care homes**

WOC 53/95, which was due to cease to have effect on 1 April 1997, was as a result of this circular retained as of continuing validity.

WOC 59/97  
WHC (97) 43

Advice to health and local authorities on the implications of the House of Lords judgment in *R v Gloucestershire County Council ex parte Barry* and the Court of Appeal judgment in *R v Sefton Borough Council ex parte Help the Aged*.

DGM (97)22

### **Welsh Office response to its review of the Welsh NHS trust hospitals' discharge policies**

The circular expressed concern that some documentation was very disappointing i.e. several trusts mentioned WHC (90)1 which was superseded by WHC (97)7 in February 1995.

DGM (97)60

### *Further Welsh Office guidance pursuant to its ongoing review of the Welsh NHS trust hospitals' discharge policies*

The circular refers to the Welsh Office letter of 7 February 1997 seeking copies of all Welsh hospital trusts' discharge policies and the resultant DGM (97)22. It reasserts that a key priority of the NHS is the implementation of the guidance on NHS responsibilities for continuing care [WOC 7/95/ WHC (95)1] and for effective hospital discharge policies. The guidance states that the Welsh Office intends to keep the issue under review and required trusts to forward copies of the current discharge policies and patient information leaflets by 9 August 1997.

DGM (97)64

### **Locality commissioning pilots**

The announcement of the Welsh Office's intention to launch (in August 1997) a number of locality commissioning pilots.

DGM (97)88

### **Additional £9.5 million for patient care in 1997-98**

The 'winter pressures' grant payment (30 October 1997).

## 1998

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DGM (98)42

### **Audit Commission Report *The Coming of Age***

An announcement of a series of review meetings to take place at the Welsh Office between senior health authority and social services representatives to consider among other things:

- assessment of current practices against the report's recommendations;
- progress in implementing the short-term actions at Appendix 1 of the report;
- planning to tackle the medium-term issues at Appendix 1 of the report.

This DGM followed on from a Welsh Office letter of 7 November 1997 headed 'Better services for vulnerable people'.