PO-CH/NL/0398

PART A

Part A.

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Begins: 15/2/88.
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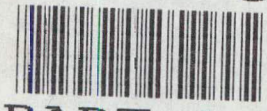


PART A

Chancellor's (Lawson) Papers:

THE GRIFFITHS REPORT ON COMMUNITY CARE

DD's: 25 Years

13/12/95.

PO -CH /NL/0398 PART A

002/3293 CONFIDENTIAL

FROM: CHIEF SECRETARY
DATE: 15 February 1988

CHANCELLOR

GRIFFITHS REPORT

Over the week-end I read a pirate copy of the summary Chapter of the Griffiths Report. The full report should be available to us today.

2 The recommendations in Sir Roy's report are (a) uncosted and (b) potentially very expensive. Nor, at first glance, is there any mention of the interface with NHS hospital care.

In particular the Report proposes:-

(i) central Government "standards" of service;

(ii) a transfer of resources from central to local government despite the fact that no diminution in central Government costs appears to be proposed (apart from joint finance and part of the social fund);

(iii) no reference whatsoever to private sector provision of homes for the elderly, and how the difficulties for them caused by politically hostile local authorities are to be overcome (instead, an implication that local authorities should provide all community care housing);

(iv) the proposed creation of a new army of "community carers" with training.

3 There are other proposals on the financial responsibility of local authorities for health care (which are ambiguous from the summary table) and on the continuation of income support as an unrestrained element of finance that will bear further study when we have the full report.

4 All this - particularly (i) and (iv) above - is likely to create unavoidable pressure for expenditure increases. If our first instincts about the report are right then it will need very careful handling.

5 Since I mentioned this at prayers this morning John Moore has telephoned me. He shares my preliminary view of the Griffiths Report and described it as 'horrifying'. He will be writing to you and the Prime Minister today to say so and to make recommendations on handling. In the circumstances I will not write to John as suggested this morning until after we receive his letter.

6 I did verbally outline my concerns to him and he shared them.

Jim Ruth

pp JOHN MAJOR

(Drafted by the Chief Secretary and signed in his absence).

COMMUNITY CARE:

AGENDA FOR ACTION

A REPORT TO THE SECRETARY OF STATE FOR SOCIAL SERVICES

BY

SIR ROY GRIFFITHS

Dear Secretary of State,

1. In December 1986 your predecessor, Mr Norman Fowler, asked me to undertake an overview of community care policy. The emphasis was specifically that the review should be brief and geared towards advice on action as was the review of management in the Health Service in 1983.

2. The precise terms of reference were - "To review the way in which public funds are used to support community care policy and to advise me on the options for action that would improve the use of these funds as a contribution to more effective community care".

3. The review is accordingly brief as requested. The recommendations are summarised immediately following this introduction and the main text explains the proposals in more detail. I regard them as essentially the first stages in a flow chart. If they are acceptable in principle, then there is considerable further work to be done by way of analysis of responsibilities, funding mechanisms, etc. If they are unacceptable, then the brevity will have been even more appropriate.

4. It was particularly emphasised that the inquiry should not be a Royal Commission type investigation taking formal evidence. Indeed the Audit Commission report (December 1986) 'Making a Reality of Community Care' and the report of The House of Commons

Social Services Committee on "Community Care with special reference to adult mentally ill and mentally handicapped people" (HC 13 1984 -5) to a great extent made this unnecessary. These two reports contain the essential facts on which this review is based.

5. Nevertheless whilst not asking for formal evidence I have received a large number of submissions and have supplemented these by extensive discussions and visits. There is in addition a formidably voluminous body of other literature. Many submissions have been received on a whole range of detailed points. Where they are relevant to the main thrust of the Review they have been reflected in the general conclusions. In all other cases they have been noted separately for consideration.

6. Some of the submissions recommended changes in the content of policy. I have not regarded this as within my brief except in one or two rare instances; my work is essentially geared to ensuring that the machinery and resources exist to implement such policies as are determined.

7. Many of the submissions have drawn attention to inadequacies of funding. Again my remit is not to deal with the level of funding but rather to suggest how resources, whatever the level, may better be directed. The Audit Commission on the one hand were satisfied that better value could be obtained from existing resources. On the other hand many social services departments and voluntary groups grappling with the problems at local level

certainly felt that the Israelites faced with the requirement to make bricks without straw had a comparatively routine and possible task.

8. Equally the review is not about cost reduction. Cost improvement, by which I mean the more efficient use of resources, is at the heart of any management process and should be characteristic of the use of whatever money is available. But emphatically I have not been asked to provide recommendations aimed at reducing the total levels of expenditure, whether in the Health Service, the social services departments or elsewhere.

9. There is a temptation against the background of the Audit Commission's work to tackle at the outset the matters highlighted, of funding on the one hand and, on the other, the complex network of relationships and responsibilities at the local level between the various authorities, voluntary groups, etc. I chose first to view the position at the two extremes, of policy at the centre and consumer satisfaction in the field. At the centre, community care has been talked of for thirty years and in few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great. To talk of policy in matters of care except in the context of available resources and timescales for action owes more to theology than to the purposeful delivery of a caring service. This is not an argument in itself for more resources: the imperative is that policy and

resources should come into reasonable relationship, so that we are clear about what community care services are trying to achieve and so that leadership and direction to those providing service can be given. The problem is compounded by the responsibility for inputs to community care at the centre being divided between the two arms of the DHSS, the Social Security and the Health and Personal Social Services sides, and the Department of the Environment - a feeling that community care is a poor relation; everybody's distant relative but nobody's baby.

10. At the other extreme one is immediately struck by differences between the arrangements for provision of medical and non-medical care. If a person is in need of medical care he knows that he has to contact his GP, who will then arrange for appropriate medical care to be given. It would be too elaborate and indeed inappropriate for a similar system to be set up for non-medical care. What is surprising however is that such a system involving the assignment of a person in need of support to an individual carer, so as to become his responsibility, is rarely made, even where it would be highly applicable, e.g. in the case of patients discharged from long stay hospitals.

11. If we are clear what we are trying to do by way of Government policy and if we can build up what is required at local level from knowledge and assessment of individual need, then we can move on to look at the machinery and structure to deliver this - or rather to allow it to be delivered. The aim must be to provide structure and resources to support the

initiatives, the innovation and the commitment at local level and to allow them to flourish; to encourage the success stories in one area to become the commonplace of achievement everywhere else To prescribe from the centre will be to shrivel the varied pattern of local activity.

12. The first approach on structure must be to see why at present care is not being delivered effectively. Major restructuring can be disruptive and time - consuming and before it is contemplated it has to be shown that the existing authorities are incapable of delivering; in short, we have to be satisfied that it is not the roadblocks to achievement which are the major problems, but the vehicles themselves.

13. We are equally left with the problem that no matter how much we restructure we simply move the interface between responsible authorities. Collaboration is vital, whether in planning, financing or implementation. The history of joint planning or financing is far from reassuring, but again can it be made to work in default of major restructuring, possibly by incentives and sanctions?

14. I have referred to roadblocks. The system for the distribution of rate support grant makes it extremely difficult for local authorities to commit themselves confidently to collaboration with the health authorities. This has been recognised by Government with the introduction of direct measures

such as joint finance for the direct transfer of funds, but the problems highlighted by the Audit Commission remain, along with the related problems of the inadequacy of bridging finance.

15. The Audit Commission highlighted the policy conflicts and perverse incentives which exist in the impact of supplementary benefit payments for residential care on community care policies. This particular benefit is at the interface between the social security open - ended financial commitment based on entitlement and a budgeted provision against priority of need, which is the social services approach. Prima facie the two approaches are diametrically opposed.

16. The present provision of social security for residential care is not wholly bad; the unintentional consequence of Government action has been to provide accommodation for large numbers of people, many of whom would have needed it and by international comparisons we do not as yet have excessive numbers of people in residential accommodation. The arguments against it are that the ready availability of social security makes it easy to provide residential accommodation for an individual regardless of whether it is in his best interest. Secondly if overall resources are limited residential accommodation may take an undue proportion of available money to the exclusion of more satisfactory alternatives of keeping people in their own homes. To use an increasingly expensive social security provision as a safety valve to keep the lid on the pot of community provision would be inconsisitent with governmental and managerial

responsibility.

17. If a solution is found to this question one is left with the further anomaly exposed that it is a matter of chance whether a person needing long stay care finds himself in a geriatric ward, or in a nursing home or a residential home, with different costs and charging. Certainly a common approach is needed.

18. Dominant in discussions and visits was the question of the closure of the large mental hospitals. Representations ranged inevitably around the desirability of the policy and problems of implementation. The policy and its implementation are matters of major national importance and need to be recognised and handled as such. Each closure needs approval, monitoring and control at the highest level. No person should be discharged without a clear package of care devised and without being the responsibility of a named care worker. This is not simply an administrative or financial process: it is intended to be a thorough process of review to guarantee that there are carefully prepared plans to ensure an optimal quality of life for the individuals leaving hospital - plans which are above all realistic in the light of the particular community and of the staffing and facilities likely to be available.

19. Overall the submissions ranged from minor departures from the status quo to an exhortation to seek radical solutions. As to the status quo the Audit Commission warned that the one option

that is not tenable is to do nothing; the history of piecemeal changes compounding the confusion in community care suggests that I am thus debarred from what might otherwise have been the safest option.

20. At the other extreme the urging to be radical has generally implied that I should tear up the present organisational structures and start afresh. I have decided to be even more radical. Nothing could be more radical in the public sector than to spell out responsibilities, insist on performance and accountability and to evidence that action is being taken; and even more radical, to match policy with appropriate resources and agreed timescales. I emphasise responsibilities; collaboration, joint planning, joint finance are admirable provided that in the first place responsibilities are clear and, in the absence of collaboration, authorities can be held accountable. Of course this would be helped by restructuring at the local level with health authorities, social services authorities and family practitioner committees enjoying co-terminosity, or even being brought within a common structure. To make restructuring mandatory would be enormously disruptive and would create turmoil under a semblance of action. I believe that there is a diversity of response at local level which is appropriate and would be forthcoming in the planning system proposed. Some clarification has inevitably, however difficult the task, to be sought between the role of Health Authorities and Social Services Authorities.

21. The recommendations are detailed at the end of this

introduction. There are a number of keystones.

22. At the centre a new focus for community care should be provided with a Minister clearly and publicly identified as responsible for community care. Funding of Social Services Authorities should be by way of specific grant amounting to say 50% of the costs of an approved programme (with an upper limit on the grant but not necessarily on total expenditure). Alternatively the grant might be slightly lower (say 40% - 45%) to indicate that the primary responsibility for community care should correctly lie with the Local Authority. The composition of the fund is detailed in the report. Approval of the social services authority's programme is simply designed to ensure that plans are well thought through; that they represent value for money at local level and meet the needs of the locality; that adequate provision is being made for support of the voluntary groups and that they are participating in the preparation and implementation of the plan; that the role of the informal carer is appropriately supported; and finally and importantly that the commitment and contribution of the appropriate housing and health Authorities have been secured as part of the plan.

23. In short there must be a clear framework within which local and health authorities are working out their own process of co-ordination. The programme should be matched by parallel approval of those parts of the health service plans allocated and ring-fenced for community care. Approval of the health service allocation should normally, of course, be part of the health

service review process. As far as possible however it is desirable that the plans of the health service and social services, with support of the local voluntary groups, should together be submitted and should evidence the appropriate collaborative framework. The only exception to this general approval would be for certain major programmes of national importance e.g. closure of long-stay hospitals where resources would be targeted to ensure implementation against much more detailed plans.

24. At local level the role of social services authorities should be reorientated towards ensuring that the needs of individuals within the specified groups are identified, packages of care are devised and services co-ordinated; and where appropriate a specific care manager is assigned. The type of services to be provided would be derived from analysis of the individual care needs: the responsibility of the social services authorities is to ensure that these services are provided within the appropriate budgets by the public or private sector according to where they can be provided most economically and efficiently.The onus in all cases should be on the social services authorities to show that the private sector is being fully stimulated and encouraged and that competitive tenders or other means of testing the market, are being taken.

25. This is a key statement. The role of the public sector is essentially to ensure that care is provided. How it is provided is an important, but secondary consideration and local

authorities must show that they are getting and providing real value.

26. As to residential accommodation social services authorities would be responsible for assessing whether a move to such accommodation was in the best interests of the individual and what the local authority would be prepared to pay for. This would be achieved by the social security benefit for residential accommodation being limited to a fixed maximum sum, substantially lower than at present, payable on the present basis with the rest being paid by the social services authority against an assessment of need for care. The alternative is to leave the entitlement as it is, payable in total by social security, but to make it payable only against an assessment by the social services authorities and to have part of the social security allowance recharged to the social services authority, either immediately or by way of subtraction from the central specific grant. As part of the decision making process the social services authority should take account of the total resources available for the provision of care. The aim would be first, to preserve entitlements whilst putting the social services authority in a position of financial neutrality in deciding what form of care would be in the best interests of the individual and secondly to ensure that individuals are not placed in residential accommodation, when it is not in their best interests.

27. I believe that the above will provide an acceptable framework. It substitutes for the discredited refuge of

imploring collaboration and exhorting action a new requirement that collaboration and action are present normally as a condition for grant. It places responsibility for care clearly within the local community, which - subject to minimum provisions for all sections of the disadvantaged groups - can best determine where money should be spent. It will bolster experiment and innovation at local level by not being prescriptive about organisation. The recommendations as to the changed role for social services authorities were foreshadowed by the Barclay Report in 1983. The essence of the present proposals is that there is machinery to ensure that it happens.

28. But any recommendations are made with a full appreciation that implementation will bring problems. There is no neat perfect solution waiting to be discovered - no Rubik Cube which will be perfectly solved if one can get the various components appropriately related. The reality is that one is faced, whether in making recommendations or in their implementation, with a choice between unsatisfactory alternatives. In many areas, in addition to responsibilities needing to be defined more precisely and management structures to be effectively established, there is a particular need to collect data in order to permit decisions as to the cost - effective use of resources. The present lack of refined information systems and management accounting within any of the authorities to whom one might look centrally or locally to be responsible for community care would plunge most organisations in the private sector into a quick and merciful liquidation. This has in any case to be remedied in the interests

of an effective service and I am confident that the social services authorities will meet this particular challenge.

29. The proposals face up to what may be regarded as a danger by some local authorities that there will be more central control of community care. The control is actually intended to be a minimum consistent with there being any national policy in this area and is designed simply to ensure and evidence at local level that the matter is being taken seriously and that the framework of collaborative care is established and working; in exceptional cases, such as the closure of major mental hospitals, a much more detailed plan would be required. Any less control is inconsistent with the claim that there is a national policy.

30. At the same time the proposals are designed to ensure that the real responsibility for seeing that appropriate care is provided is at local level with the social services authorities and the health authorities. If community care means anything it is that responsibility is placed as near to the individual and his carers as possible. I also believe that where the priorities between different groups may differ widely according to local needs, the right and indeed obligation to determine that should be as local as possible and with the locally elected authority. It cannot be managed in detail from Whitehall, but it has to be managed.

31. The move to specific grant is important. It should be seen as liberating to local authorities to have more certainty. It

will provide an instrument of central control but it should not be seen as an instrument of constraint.

32. Because of the importance of the Audit Commission report, many of the submissions which I received fastened on the Commission's recommendations for consideration of a lead authority for the mentally ill, and the elderly and the mentally and physically handicapped respectively. I have side-stepped these recommendations, largely because I believe that the starting point has to be to identify and respond reasonably and appropriately to the needs of individuals in their particular circumstances. How these needs are to be met will call for particular responses, one of which in a given locality may be to provide special facilities for the elderly or the handicapped and to organise accordingly. The emphasis, however, is that the structures have to be responsive to the local situation and there is room for infinite experiment.

33. The recommendations do not preclude the establishment of lead authorities by agreement at local level, submitted for approval to the centre as part of the local plan. This could extend to the lead Authority being given the funds and being the paymaster by buying back services from wherever necessary. To make this concept of lead Authority mandatory however would, I believe, be premature and over-prescriptive at this stage.

34. I also received submissions on staffing and training and unresolved issues on terms and conditions for staff. An

overriding impression on training is the insularity of training for each professional group. It may be over ambitious to talk about common training in skills for everyone working in the community, but an understanding by each profession about the role of the other professions in the community could easily be achieved. Again this type of collaboration at local level in training matters should form part of the basic plan.

35. There may in fact be a tendency to over - elaborate, both as to the professional input and the training required. Many of the needs of the elderly and disabled are for help of a practical nature (getting dressed, shopping, cleaning). There is need for a new multi-purpose auxiliary force to be given limited training and to give help of a practical nature in the field of community care. There is little likelihood that the professions will be available in the numbers required to cover all aspects of community care, but more importantly it is a waste of resources to be leaving this type of practical work to them. Certainly major experiments should be initiated and should involve not only mature adults, but particularly school leavers, YTS etc. To some extent this is already being tried with an extension of the role of home helps in certain authorities.

36. On terms and conditions for staff transferred between authorities as a result of the move to community care, a variety of solutions are possible. What is inexcusable is the inordinate delay in setting out these solutions for the transfer of staff.

The alternatives are mentioned in the report and a clear decision should be given.

37. The main body of the report deals with the transitional provisions at local level; the aim would be to minimise disruption and essentially to provide a framework which will encourage and facilitate achievements which are present in many areas today despite the system.

38. The general banner under which many submissions were made carried the legend "care in the community is not a cheap option". It is worth reiterating that I was not asked to consider the level of resources appropriate. I have however insisted that we should be quite open as to what we are seeking to achieve and be realistic as to what policies can be pursued with the likely available money. What cannot be acceptable is to allow ambitious policies to be embarked on without the appropriate funds. On many counts poorly implemented programmes for change are very often worse than the status quo. Even with the improved machinery of handling and funding which are recommended, if we try to pursue unrealistic policies the resources will be spread transparently thin.

39. I believe that the recommendations contained in this review should answer most of the points made by the Audit Commission but I have the occasional sinking feeling that there is nothing so outdated as to provide today's solution to today's problem. It is however a necessary preliminary to thinking ahead and a

precaution to ensuring that nothing is recommended which is inconsistent with tomorrow's scene. There is a need to experiment with a whole variety of initiatives - social/health maintenance organisations, insurance/tax incentives, not simply for the individual, but for the individual in a family context. Tomorrow's thinking in corporate Personnel Departments on provision and assurance for community care requirements may be the equivalent of the corporate pension thinking of thirty years ago, with the same opportunities for care to be provided as a result of employer/employee contributions into a corporate scheme. More immediately there is no reason why, on a controlled basis, social services authorities should not experiment with vouchers or credits for particular levels of community care, allowing individuals to spend them on particular forms of domiciliary care and to choose between particular suppliers as they wish.

40. I have made suggestions as to the next stages of work and implementation. I believe the recommendations contain the best blend of purpose, practicality and minimum disruption and provide an appropriate base for a much improved delivery of community care.

41. May I finally thank first my support team from the Department - Martin Woolley, Nicholas Bromley, Chris Kenny, Linda Barnard and Frances Graham - for their unremitting efforts over the past twelve months, and the team of outside Advisers who have guided me throughout and contributed extensively to the

thinking behind the Report. Whilst the recommendations are my own, I am grateful to the Advisers for indicating that they are supportive both of the style and content of the report.

Feb. 12th 1988.

CONTENTS

CHAPTER 1

SUMMARY OF PROPOSALS FOR ACTION

1.1 I recommend that the following steps be taken to create better opportunities for the successful and efficient delivery of community care policies for adults who are mentally ill, mentally handicapped, elderly or physically disabled and similar groups.

1.2 Central Government should ensure that there is a Minister of State in DHSS, seen by the public as being clearly responsible for community care. His role should be strengthened and clarified in the light of the other recommendations. His responsibilities would include:

1.2.1 preparing and publishing a clear, short, statement of its community care objectives and priorities;

1.2.2 deciding on those areas in which it wishes to lay down standards of service delivery;

1.2.3 making arrangements for reviewing local social services authority plans, against national objectives, and for linking that process with the allocation of resources;

1.2.4 setting up adequate machinery for identifying the results of local social services authority activity;

1.2.5 making arrangements for the distribution of the specific grant recommended below, and ensure the necessary matching between policy objectives and the resources provided to meet them;

1.2.6 ensuring through the NHS planning and review machinery that community care objectives are adequately reflected in health authority plans and the allocation of resources to health authorities.

1.3 Local social services authorities should, within the resources available:

1.3.1 assess the community care needs of their locality, set local priorities and service objectives, and develop local plans in consultation with health authorities in particular (but also others including housing authorities, voluntary bodies, and private providers of care) for delivering those objectives;

1.3.2 identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible;

1.3.3 arrange the delivery of packages of care to individuals, building first on the available contribution of informal carers and neighbourhood support, then the provision of domiciliary and day services or, if appropriate, residential care;

1.3.4 act for these purposes as the designers, organisers and purchasers of non-health care services, and not primarily as direct providers, making the maximum possible use of voluntary and private sector bodies to widen consumer choice, stimulate innovation and encourage efficiency.

1.4 To enable this to happen, local social services authorities must be put into a position to take a more comprehensive view of care needs and services. Therefore they should be made responsible for:

1.4.1 assessing the need for residential care and, if they judge it appropriate, meeting the costs of caring for people who cannot pay for themselves, in residential (including nursing) homes above a basic level of support. (This basic support should continue to be available as a social security entitlement, at a level broadly in line with that available to people in the community.)

1.4.2 funding the community care projects currently supported through the NHS resources described as "Joint Finance".

1.4.3 spending the money currently allocated to the community care grant elements of the Social Fund, with discretion to decide on what goods and services should be provided;

These changes will release local social service authorities from pressures, which can distort the delivery of publicly supported services.

1.5 Equally to enable action to be taken, local social services authorities will need confidence that their resources can match their responsibilities. Therefore

1.5.1 central government should arrange for the necessary transfer of resources between central and local government, to match the defined responsibilities;

1.5.2 in order to provide the necessary basis for planning, create the desired relationship between central and local government in the delivery of policies, and ensure that resources are used for their intended purposes, social services authorities should be supported by general and targeted specific grants providing a significant proportion of the total cost of the programme;

1.5.3 payment of specific grant should be conditional on central government being satisfied that local social services authorities have adequate management systems,including planning machinery in place; and that local objectives are sufficiently in line with Government policy.

1.6 It is further recommended that:

1.6.1 health authorities should continue to be responsible for medically required community health services, including making any necessary input into assessing needs and delivering packages of care;

1.6.2 general medical practitioners should be responsible for ensuring that local social services authorities are aware of their patients' needs for non-health care;

1.6.3 public housing authorities should be responsible for providing and financing only the "bricks and mortar" of housing for community care;

1.6.4 authorities should have the power to act jointly, or as agents for each other;

1.6.5 distribution of specific grant should take account of the extent to which consumers in a local authority area are able to meet the full economic cost of services.

1.6.6 the functions of a "community carer" should be developed into a new occupation, with appropriate training, so that one person can , as far as possible, provide whatever personal and practical assistance an individual requires.

1.7 To manage implementation, I recommend that:

1.7.1 the Minister be responsible for developing the necessary action plans, including those that will require legislation, and supervising their implementation;

1.7.2 the Minister be supported by an implementation team.

1.7.3 the training implications of my recommendations be assessed.

CHAPTER 2

BACKGROUND AND GENERAL APPROACH

2.1 I was asked by the then Secretary of State for Social Services, Mr Norman Fowler, to undertake an overview of community care policy on 16 December 1986. The formal terms of reference were:-

> "To review the way in which public funds are used to support community care policy and to advise me on options which would improve the use of these funds as a contribution to more effective community care."

I was asked to gear my recommendations towards advice on action, and have done so in chapter 1.

2.2 This chapter describes my general approach to the task, and method of working.

Interpretation of Terms of Reference

2.3 The review has concentrated on adults who require more than the usual care and support from others because they are elderly, mentally ill, mentally handicapped, or physically disabled. I have taken community care to be care and support for these and similar groups.

2.4 I was not asked to consider child care issues A similar approach to that which is recommended may however be relevant in that context.

2.5 The review encompasses the roles of families and friends (the so - called informal carers); volunteers and the organised voluntary sector; private profit-making services; and public services in the provision of community care. The report concentrates on the action needed in the fields of personal social services, health services and social security. I have not felt precluded from considering the contribution of other public services such as housing, education and transport, but have not found it necessary to make extensive recommendations in those areas.

2.6 I have reviewed the full range of services which make up community care: those provided to people in their own homes, group homes, residential care homes, hostels and nursing homes. I have not therefore considered hospital in-patients, who require both medical supervision and twenty - four hour availability of nursing support.

2.7 The recommendations for health and personal social services are directed to the position in England. Social security is administered on a common basis throughout Great Britain and on a fully parallel basis in Northern Ireland. The recommendations

about social security in particular have implications for services in Scotland, Wales and Northern Ireland which will need further consideration.

Method of Approach

2.8 The Audit Commission Report "Making a Reality of Community Care" (published in December 1986) provided a valuable description and analysis of current problems. Other publications have since made helpful contributions to the debate including "Public Support for Residential Care" (the Report of the Joint Central and Local Government Working Party), "Community Care Developments" by the National Audit Office, and an Audit Commission Occasional Paper "Community Care: Developing Services for People with a Mental Handicap". I have had helpful contact with the Independent Review of Residential Care, chaired by Lady Wagner, which has been working throughout the period in which I have been conducting my review.

2.9 I have not seen my primary task as one of fact finding. The facts have already been well documented in the publications I have described, and the issues have been well identified. My job has been to produce proposals for action, and the report sets out not to add to the volume of information about community care, but to explain the proposals.

2.10 By visits, extensive discussions and through the written material sent to me, I have learned the views of consumers and front line providers of community care, as well as those of managers and policy makers. I am grateful to all those who have shared their knowledge and views with me.

2.11 I have been greatly helped by a panel of Advisers, who throughout have given me unstintingly the benefit of their knowledge and experience as I developed my proposals. They are:

Dorothy Blenkinsop, Regional Nursing Officer, Northern Regional Health Authority;

Dr Peter Horrocks, formerly Director of the Health Advisory Service and currently Consultant Physician (Priority Services Development) Yorkshire Regional Health Authority;

Geoffrey Hulme, Director of the Public Expenditure Policy Unit;

Ken Judge, Director of the King's Fund Institute;

John Kay, Director of Centre for Business Strategy and Professor in Industrial Policy, London Business School;

Herbert Laming, Director of Social Services, Hertfordshire;

Jill Pitkeathley, Director of National Council for Carers and their Elderly Dependants; and

Sir James Swaffield, former Director General of the Greater London Council.

I am grateful for all the help I have been given, although the recommendations are entirely my own responsibility.

CHAPTER 3

COMMUNITY CARE

What is Community Care?

3.1 This chapter sets out the approach to the value and purpose of community care and the role of the State in its provision.

The Role of the State

3.2 Publicly provided services constitute only a small part of the total care provided to people in need. Families, friends, neighbours and other local people provide the majority of care in response to needs which they are uniquely well placed to identify and respond to. This will continue to be the primary means by which people are enabled to live normal lives in community settings. The proposals take as their starting point that this is as it should be, and that the first task of publicly provided services is to support and where possible strengthen these networks of carers. Public services can help by identifying such actual and potential carers, consulting them about their needs and those of the people they are caring for, and tailoring the provision of extra services (if required) accordingly.

3.3 The second task of the publicly provided services is to identify where these caring networks have broken down, or cannot meet the needs, and decide what public services are desirable to fill the gap.

3.4 The primary function of the public services is to design and arrange the provision of care and support in line with people's needs. That care and support can be provided from a variety of sources. There is value in a multiplicity of provision, not least from the consumer's point of view, because of the widening of choice, flexibility, innovation and competition it should stimulate. The proposals are therefore aimed at stimulating the further development of the "mixed economy" of care. It is vital that social services authorities should see themselves as the arrangers and purchasers of care services - not as monopolistic providers.

3.5 The resources available for public services will always be finite. As well as assessing needs and arranging suitable services, managers of public services are therefore bound to apply priorities. A fundamental purpose of the proposals is to ensure that someone is in a position to apply priorities in a way that maximises the chances that those most in need will receive due care, and that eliminates the possibility of low priority need being met while higher priorities are neglected.

Value and Purpose of Community Care

3.6 Much of the comment I have received during the review urged me to make recommendations about specific services. It is first

important to identify the principles and objectives of community care which can then be used to guide the development of appropriate services. A reasonably complete official statement comes in the DHSS evidence to the House of Commons Committee on Social Services (HC13 1984-1985):

> "- to enable an individual to remain in his own home wherever possible, rather than being cared for in a hospital or residential home;
>
> - to give support and relief to informal carers (family, friends and neighbours) coping with the stress of caring for a dependent person;
>
> - to deliver appropriate help, by the means which cause the least possible disruption to ordinary living;
>
> - to relieve the stresses and strains contributing to or arising from physical or emotional disorder;
>
> - to provide the most cost-effective package of services to meet the needs and wishes of those being helped;
>
> - to integrate all the resources of a geographical area in order to support the individuals within it. The resources might include informal carers, NHS and personal social services and organised voluntary effort, but also sheltered housing, the local security office, the church, local clubs, and so on."

3.7 This is a valuable approach, but needs to be supplemented. It makes no explicit mention of the need for assessment of the individual in his or her own situation, taking account of all the resources that may be available and the gap which may exist between the assistance those resources provide and the individual's needs. Nor is the potential for the preventative and rehabilitative value of community care made explicit. The recommendations propose that a more comprehensive statement should be drawn up to remedy these deficiencies.

Care and Support for Individuals

3.8 To translate broad community care objectives into action for individual people, those arranging public services must:-

> i. Have systems which enable them to identify those who have need of care and support in the community;
>
> ii. Assess those needs within the context of the individual's own situation;
>
> iii. Taking account of the views and wishes of the person to be cared for, and any informal carers, decide what packages of care would be best suited to the needs, whether provided directly or indirectly;

iv. determine the priority to be given to the case, given the total resources available and the competing needs of others;

v. arrange delivery of the services decided upon;

vi. keep under review the delivery of that package of services, and the individual's needs and circumstances.

Where services are provided directly those providing them will also have the usual line management responsibilities.

3.9 The first duty of identifying the people in need deserves extended comment. Systems to achieve this are essential because, by definition, those in need of care and support may not be able to obtain the information they need, or to act upon it, in order to inform the agencies concerned. Unless those charged with responsibility for meeting needs are reasonably sure that they have a good knowledge of the major needs in their area, and of the individuals who have those needs, they can have no assurance that their policies and actions focus the resources they manage on the individuals in greatest need.

Chapter 4

RESPONSIBILITIES

4.1 This chapter deals with the question of responsibilities for community care.

4.2 I have found, along with most commentators on this subject, that there is at present insufficient clarity of responsibility for the arranging of publicly provided services in line with people's needs and service priorities. Where successes are achieved, they can as often as not be attributed to the flair and determination of individuals, in spite of the system rather than aided by it. It is unsafe to rely on this. It runs the risk that no-one is taking a sufficiently wide view of all the help that can be given, with the result that the most suitable forms of care are overlooked, priorities distorted and resources wasted. Also, present arrangements do not encourage systematic attempts to discover how helpful services are perceived to be by consumers, for example through market research techniques. The proposals are aimed at ensuring that, for community care, one authority is responsible for identifying and assessing needs, and organising suitable care.

Families and Informal Carers

4.3 The information provided to carers about service availability and how they might be helped with their onerous responsibilities is limited. A failure to give proper levels of support to informal carers not only reduces their own quality of life and that of the relative or friend they care for, but is also potentially inefficient as it can lead to less personally appropriate care being offered. Positive action is therefore needed to encourage the delivery of more flexible support, which take account of how best to support and maintain the role of the informal carer.

Voluntary Sector

4.4 The contribution of the voluntary sector could be developed further if the basis and management of funding were more appropriately applied. This is the subject of further comment in Chapter 8.

Private Sector

4.5 The contribution of the private sector is mainly in the field of residential care, but there has also been growth of private sheltered housing provision and, on a relatively small scale, organised domiciliary care services. The best examples show how services can respond very flexibly to meet the particular needs of individuals in a way that is acceptable to them and takes full account of their personal circumstances.

4.6 It is important that changes in the present systems for using public funds to support community care do not strengthen the potential monopoly power of the public sector and so restrict this contribution. There are similar dangers in the present system for regulation and inspection of residential and nursing homes, which can result in higher standards of provision being required from private (and voluntary) homes than similar homes in the public sector often provide. The proposals should encourage a proportionate increase in private and voluntary services, as distinct from directly provided public services. This process will aid consumer choice both by encouraging the development of a greater range of services and by increasing competition.

Social Service Authorities

4.7 Social services authorities* have the main local authority responsibility for community care. I have seen numerous examples of imaginative projects serving relatively small numbers of clients, and am aware of others, but have found in general that social services authority activities tend to be dominated by the direct management of services which take insufficient account of the varying needs of individuals.

4.8 There is only limited evidence of systematic planning to ensure that resources are targeted at the areas of greatest need. Without such planning, there is a danger that the concentration on child care duties and responsibilities (which are more explicitly stated in legislation and attract more political and public attention) may result in low priority being given to community care.

Housing Services

4.9 At present, housing authorities provide warden services in sheltered housing schemes and community alarm systems in addition to the "bricks and mortar" of the buildings themselves. Additionally, in shire districts the district authority is often responsible for the provision of a meals on wheels service. This dissipates responsibility for delivery of services and does not fit well with the changes in the overall role and function of housing authorities envisaged in the recent White Paper "Housing: the Government's Proposals" (Cmnd 214). In particular their role will change from one of concentrating on the direct provision of housing to concentrating on an enabling role. The recommendations go with the grain of these changes, and would confine housing authorities' responsibilities for community care to the provision of "bricks and mortar".

* " Social services authority" throughout this report is used to refer to the responsibilities of the elected members of the local authority social services committee exercised through the officers of the social services department.

Other Local Authority Services

4.10 Education services can have a significant impact on community care for particular groups of individuals, especially handicapped children and mentally handicapped young people and adults. In general, there is little confusion of roles and responsibilities in this sphere. For other local authority services, there is minimal or even no need for specialist provision for consumers of community care, although service providers in such fields as leisure and recreational services and library services need to ensure that satisfactory arrangements exist for equal access and treatment.

Health Authorities

4.11 An individual's need for long term care and support may stem from a medical condition that itself requires medical treatment, whether regularly or occasionally. In addition, an individual's handicap or disability may affect their normal acute health care e.g. a blind person may need some special arrangements for recognising different medicines which have been prescribed. The health care contribution to community care is to respond to both sets of need.

4.12 Acute hospital services and community care are complementary. There is, of course, interaction between them and in some cases there may be a need to improve planning and communications between different bodies, so that the appropriate range of services is readily available to patients when they are discharged from hospital. With this proviso, I believe that the assignment of responsibilities for acute health services is generally clear and the boundaries of responsibility are well defined.

4.13 It has been Government policy for many years that long stay hospitals for mentally ill, mentally handicapped and elderly people are not, in general, the right setting for people who do not need both medical supervision and nursing care to be available throughout twenty-four hours, although there will be a continuing need for some long stay hospital facilities. The recommendations are intended to enable that policy to be implemented more effectively.

4.14 Lack of clarity of responsibility has frustrated successful implementation to date. On the one hand, there is widespread concern that people have left long stay hospitals with inadequate care and support being provided in the community. On the other, we can see very full and elaborate support schemes being provided by health authorities, in preference to the less desirable conditions of long stay hospitals, although those schemes would not normally be thought of as health services. Equally, while there are successful joint community care projects linked to hospital closures there is concern about the care and support available in the community for those who have never entered a

long stay hospital, but who need a comparable level of care.

4.15 One particular problem, that of the transfer of employment for staff of former long stay hospitals, needs early resolution. The problem arises in cases where the support that staff used to provide in the hospital becomes the responsibility of the local authority, and in particular the social services department. Such issues must not be allowed to slow down the development of effective community care services, and I make recommendations about this in Chapter 7.

Family Practitioner Services

4.16 Primary health care services, including dental, ophthalmic and pharmaceutical services make an important contribution to community care both in preventing the need for such care by health promotion, care and treatment, and by contributing when health care is one component of an individual's total needs. The general medical service, or family doctor service, is unique in having near universal contact with the whole population. I do not believe that the full potential of this contact has yet been realised. The present contract for general practitioners gives them a responsibility for "advice to enable them (patients) to take advantage of the local authority social services". Many general practitioners interpret this responsibility widely, and make sure that the social services authority is aware of their patient' major unmet (non-health) community care needs , but this is not universal. There is scope for action therefore to ensure that this useful role is fulfilled.

Financial responsibilities

4.17 The ways in which money is spent on community care do not enable a comprehensive approach - to needs assessment, planning and delivery of services - to be achieved.

4.18 At the level of central government, large sums are provided through the health services, some of them earmarked for specific community care projects which may be linked to hospital closure programmes, and through social security, as supplementary benefit to eligible people in residential and nursing homes. None of central government's grant support for local authority expenditure is earmarked for community care.

4.19 At local government level, there may or may not be joint projects financed by health authorities; there will certainly be no responsibility for what is provided through social security.

4.20 The results are obvious and well documented. The system is almost designed to produce patchy performance: good where there happen to be earmarked funds and local goodwill and initiative; poor where, in spite of funds being available, the incentives to plan, prioritise, and organise across the whole field are negligible.

4.21 The separate funding of residential and nursing home care through social security, with no assessment of need, is a particularly pernicious split in responsibilities, and a fundamental obstacle to creation of a comprehensive local approach to community care.

4.22 The demographic trends that already affect the demand for community care and will continue to do so over the coming decades are well known. As an example, between 1986 and 1996 the number of people aged over 85, who are most dependent on support from others, will grow by nearly 50%. Thus the number of people of this age has risen from 459,000 in 1976 to 603,000 in 1986, and will rise to 894,000 by the year 1996. Also improvements in health and other care means that younger severely handicapped people are also surviving longer, with considerable care needs.

4.23 As well as demographic changes, future policy needs to be planned in the light of economic changes, in particular the significantly higher real incomes and greater wealth which today's middle-aged will have on reaching retirement. I discuss the opportunities for action in the light of this in chapter 6.

Conclusions

4.24 There will always be multiple responsibilities for providing care, since people's needs, and the skills needed to meet them, are infinitely varied. The purpose of the recommendations is to create a system, underpinned by financial accountability, in which local responsibility for delivery of community care objectives is clear beyond doubt.

5. STRATEGIC OPTIONS

5.1 This chapter explains my approach to organisational, management and financial issues.

Organisation

5.2 One approach, which some advocate, would be to dispense with the present organisation and design new structures. I have not favoured this, partly because of the disruption and turbulence that would result to no real benefit, but mainly because I firmly believe that the major responsibility for community care rests best where it now lies: with local government. Elected local authorities are best placed, in my judgement, to assess local needs, set local priorities, and monitor local performance. What is needed is a strengthening and buttressing of their capacity to do this, by clarifying and where necessary adjusting responsibilities; and to hold them accountable.

5.3 I have not, therefore, favoured restructuring, whether by the creation of new elected or non-elected authorities, or major transfers of responsibility between existing authorities.

5.4 Nor I have seen advantage in seeking to construct a prescriptive approach to local organisations, for example by insisting that local management be divided by client groups. I see significant advantage in allowing local diversity and initiative.

5.5 The proposals will diminish the responsibility of social security for supporting residential and nursing home care, but to the advantage of community care services as a whole. Our social security system is essentially designed to provide a standard range of benefits for large numbers of people against objective tests of entitlement. It is not an appropriate system for the direct provision of individually tailored packages of support, within a finite community care programme. The proper contribution of the social security system to community care is to provide for those who are eligible a reliable source of income to meet normal living expenses and to help with housing expenses

Management

5.6 I have no wish to be over-prescriptive about management. However, some things are fundamental, and in particular the creation of a budgetary approach, centrally and locally, which aligns responsibility for achieving objectives with control over the resources needed to achieve them, so that there is a built - in incentive and the facility to make the best use of the resources available. Such a system will facilitate effective planning and responsiveness to change. It is self-evident that resources must be consistent with the agreed responsibilities and objectives to be achieved within a given timescale. So, for example, if resources are not great enough to meet agreed objectives, a budgetary system will provide a firm information

base from which to make decisions about either reducing the scale of set objectives or identifying the precise resources needed to discharge them. Such a system will also provide a spur to managers to provide themselves with better information, and to search for the most effective and efficient ways of meeting needs.

5.7 A similar approach is needed both at local and national levels to ensure that the entire resources allocated are properly identified and accounted for. The absence of such processes at national level is inconsistent with any claim that there are serious national policy objectives to be achieved. Such a system should be an integral part of the central decision-making and management process. Its purpose should be to ensure that:-

i. national objectives and priorities are clearly established;

ii. the necessary resources (not just of money, but also people with the requisite skills and training) are available to enable the nationally set objectives and priorities to be translated into action;

iii. objectives and priorities for local action are established locally;

iv. central government has the necessary leverage to ensure that local objectives properly contribute to meeting national objectives;

v. results are monitored locally so that there is local accountability for meeting local objectives and central accountability for meeting national objectives.

The recommendations provide a framework for the development of such a system.

Finance

5.8 The system of local political and managerial responsibility must be under-pinned by a suitable financial system. This is a keystone in the structure.

5.9 Under the present system of local government finance, local government raises its revenue from:-

- grant from central government in the form of either general block grant or specific grants for particular services or activities;

- local taxation in the form of domestic and non-domestic rates;

- fees and charges for services.

The percentage of expenditure supported by government grant has declined in the 1980s and this, combined with the increasing proportion of grant which goes to support specific activities has reduced the block grant support for services such as community care.

5.10 The level of block grant which an authority gets is determined on an annual basis through the rate support grant settlement. Thus, unlike health authorities, local authorities do not have indicative figures for the grant that they can expect to receive in future years which would assist them to plan services for the years ahead. Moreover a complicated set of factors influence the amount of grant received by individual authorities and there can be considerable variation from year to year. Such uncertainty has been found to frustrate effective planning and is particularly serious where the plans of other statutory authorities (i.e.health authorities) are dependent upon steady progress being made. Social services authorities need security of funding if they are to plan to develop their community care services in a coherent way. Equally central government needs clear mechanisms to hold local authorities to account for centrally provided resources devoted to community care.

5.11 The new system of local government finance to be introduced in 1990 will

- replace domestic rates by the community charge

- replace non-domestic rates by a uniform business rate

- replace the block grant system by a new revenue support grant.

While the new system of central government grant is intended to be simpler than the existing system it will retain many of the features which have been found to impede the development of community care. The process of grant determination will still be an annual one and there is no proposal to issue indicative planning figures for future years.

5.12 For the purposes of this report, I have assumed that the new system of grant is unlikely to affect the delivery of community care objectives in any significant way. It follows that some additional change is needed to give central government the direct stake it should have in the delivery of its policies at local level. It needs to have that stake not just because of the intrinsic national importance of those policies, but also because of the considerable inter-relationships between what is done by local authorities, and what may or may not need to be done by others more directly accountable to central government, and in particular by health authorities.

5.13 On top of this, I am proposing switches of financial responsibility for community care to local authorities from both

social security and health authorities. It is essential that the transferred funds reach their intended destination, ie local social services authorities, and do not end up in the general grant pool.

5.14 For all these reasons i.e.

- to recognise the interdependence of local and central government programmes;

- to provide a degree of central government influence and control;

- to create a more stable basis for planning and delivery of services; and

- to ensure transferred funds reach their intended destination,

I have recommended a programme of specific grants that is spelt out in more detail in the next chapter. That chapter also covers the way in which income from fees and charges should be taken into account.

6. RECOMMENDATIONS

6.1 This chapter sets out the detailed recommendations for action.

RESPONSIBILITIES

Local Authority Social Services Authorities

6.2 Local social services authorities should be responsible for identifying people with community care needs in their area.

6.3 Where a social services authority has identified someone with community care needs, and that person has other needs e.g. for health care or housing, the authority should be responsible for ensuring that the other relevant public authorities consider whether, and if so what, they should do to contribute to the person's care and support.

6.4 Social services authorities should themselves be responsible for arranging for the needs of an individual for social, domestic and personal care and support to be assessed (and regularly re-assessed) in full consultation with the person concerned and any informal carers, so that these assessments take account of the individual's wider circumstances.

6.5 The social services authority must decide then what action to take itself. At the lowest level, support for informal care may be all that is needed. At the other extreme, multiple services may have to be arranged. It is recommended that social services authorities should develop and manage packages of care tailored to meet most effectively, within their budget and priorities, the needs of individuals.

6.6 In cases where a significant level of resources are involved a "care manager" should be nominated from within the social services authority's staff to oversee the assessment and re-assessment function and manage the resulting action. Where care is already being effectively managed, this proposal will amount to little more than making existing roles explicit.

6.7 Even when the situation is fairly stable, it is important that the individual and everyone else involved, including any informal carer, knows to whom to turn for immediate support. This might sensibly be the person with whom the individual has the most day-to-day contact. That person, regardless of their parent organisation, could be given responsibility for providing information to the social services authority about changes in the individual's circumstances that may affect the need for care and support.

6.8 Social services authorities should have sufficiently wide powers to enable them to provide goods and services to maintain or establish people in their own homes who might otherwise need to have institutional care. To that end, I propose that the

community care element of the Social Fund should be withdrawn from the social security system and the funds earmarked for that purpose transferred to social service authorities. I do not recommend any extension of social service authorities' limited powers to make cash payments to individuals.

6.9 Social services authorities should:

i. ensure that information is readily available about community care and where and how to seek services that will contribute to that care. This should cover services provided by public authorities, the voluntary sector, and private businesses.

ii. develop and sustain informal and voluntary community care resources by supporting informal carers, volunteers, and voluntary organisations;

iii. maximise choice and competition by encouraging the further development of private services.

I deal below with control over standards.

Local Authority Housing Authorities, Housing Corporation.

6.10 The responsibility of public housing authorities (local authority housing authorities, Housing Corporation etc.) should be limited to arranging and sometimes financing and managing the "bricks and mortar" of housing needed for community care purposes. Social services authorities should be responsible for arranging the provision of social, personal and domestic services in sheltered housing, and the finance for those services should be provided through social services, not housing budgets.

6.11 I do not intend this to prevent arrangements being agreed between housing authorities and social services departments, for example for the provision of wardens who carry out both property management and personal care responsibilities. Similar considerations in principle apply to alarm systems: the decision whether an alarm system would be an efficient means of meeting an individual's needs should be for the social services authority, which should also be responsible for financing those parts of a system that are not the landlord's fixtures and fittings.

Regional and District Health Authorities

6.12 The responsibilities of regional and district health authorities should in general continue to be the provision of health care. In broad terms this involves investigation, diagnosis, treatment and rehabilitation undertaken by a doctor or by other professional staff to whom a doctor (sometimes a general practitioner) has referred the patient. In addition, health authorities have important responsibilities for health promotion and the prevention of ill health. Health authorities

should not provide services which fall outside this definition.

6.13 The community nursing services provided by the health authority are an important part of the health care contribution to community care. My recommendations on responsibilities may affect but should in no way diminish the contribution that community nursing makes to community care. Since my intention is to pinpoint responsibility for arranging the provision of services in the community, there is a great deal of room for flexibility over who does precisely what for whom, while - I hope - increasing the opportunities for making the best possible fit between needs and services provided and avoiding unnecessary duplication. In this way, the special skills of community nurses should be used to best effect.

Family Practitioner Services

6.14 The contract between the family practitioner committee and the general medical practitioner should be amended to specify that the GP, either directly or through his practice staff, should inform the social services authority of possible community care needs of any patients registered with him who seem to have such needs which are not being met and which appear to be unknown to the social services authority. The GP should also be able to satisfy himself that the social services authority has considered the case. The social services authority should therefore confirm that it has received the referral from the GP, and tell him what action it has decided to take.

Joint Planning and Action

6.15 The proposals mean that joint local planning and action will continue to be essential, but that responsibilities and accountability for the plans and action will be clearer than they are now. The framework for joint action should be determined locally. The existing joint consultative committees may provide a useful model, but the emphasis should be on the total management of community care services, not the delivery of a few special projects. Special attention should be given to services at the point of delivery, with the aim of putting into practice at that crucial point the proposals on the identification and assessment of need, consultation with carers and those being cared for, design of care packages, setting of priorities, and monitoring.

6.16 Social services authorities and health authorities should review each others' plans when they significantly affect community care. Where they interact, agreement on the action proposed on both sides is essential. In some cases the best way of achieving this will be through the preparation of a joint plan. Other agencies, and in particular the voluntary sector, will need to be involved, depending on the nature and scale of their contribution.

6.17 Authorities should have powers to enable them to undertake joint action, or to act as agents for each other. For example, a community nurse might check, on behalf of the social services authority, on the general well-being of one of her patients whose family are having difficulties supporting them at home. On a larger scale, the management of some existing facilities might be handled on an agency basis.

6.18 Such arrangements for joint planning and action do not in any way lessen the responsibility of individual agencies for their own functions and actions. But it must be emphasised that effective co-operation at the local level will be essential, both to the success of individual projects and, more broadly, if the whole range of community care services is to be delivered effectively. The adequacy of arrangements for joint planning will therefore be a central area for scrutiny as part of the conditions of grant, which I discuss below.

Central Government

6.19 I recommend that there should be a Minister of State in DHSS, who is clearly identified as being responsible for community care. He should be supported by a designated group of senior officials including those with responsibilities for community care finance, community care policy, the operational distribution and monitoring of central government funds for community care, and the national inspection of standards of service provision. Experience of community care management, and familiarity with management of health services, should also be represented.

6.20 The Minister should promulgate a definition of community care values and objectives to guide its development. He should arrange for the distribution of central government funds to social services authorities, subject to the conditions I describe below.

6.21 The Minister would be responsible for ensuring that national policy objectives were consistent with the resources available to public authorities charged with meeting them and for monitoring progress towards their achievement.

FUNDING

Central Government

6.22 I recommend that community care needs, including the implications for revenue and capital, should be considered separately in the public expenditure planning process.

6.23 In order to provide the necessary basis for planning and implementation of the proposals, I recommend that central

government should provide directly to social service authorities, by specific grant, a substantial proportion of the total public funds it estimates are needed to meet national objectives. This might be 50%, or might be slightly lower (say 40% - 45%) to indicate that the primary responsibiltiy for community care should lie with local government.

6.24 The main component of the specific grant would be that part of the current rate support grant which is provided in respect of social services authority community care responsibilities. Additionally, provision would be transferred from the Social Fund to take account of the transfer of responsibilities recommended in paragraph 6.8.

6.25 The grant should be fixed as a proportion of the estimated total expenditure required.It should be distributed according to the best possible indicators of need, applied on an individual authority basis. Social services authorities would have discretion to "top up" from their other sources of funds.

6.26 A great deal of work will need to be done to develop satisfactory indicators of need. At the same time it is important that the formula should not be so complicated that it is difficult for either local authorities or people in general to understand its objectives. The mechanism for distributing grant should therefore as clearly and simply as possible reflect national policy objectives.

6.27 The basis of any formula should be the number of elderly, mentally handicapped, mentally ill and physically disabled people living within a local authority's boundaries. The number of people within other groups who need care are smaller, and the needs of the main four priority groups may be taken as a sufficient proxy for them. However the distribution formula should be kept under review to ensure that this is the case.

6.28 It is likely that a usable formula will depend on establishing "synthetic indicators" of need: correlations between such factors as age, and health, and the level of people's dependency on assistance.

6.29 These indicators would be the foundation of any distribution formula. Consideration should also be given, however, to the place of:

i) economic factors, such as levels of income and unemployment. The dependency indicators should reflect people's need for <u>publicly financed</u> care and support;in more wealthy areas more people will be able to buy care from both the private sector and social services authorities.

ii) the amount of private, voluntary and informal care in the area. This is also relevant to developing a picture of needs which the social services authority may have to arrange to meet.

iii) geographical disparities in the revenue and capital costs of arranging care, for example staffing costs in London.

6.30 In order to create the maximum possible assurance about future levels of funding, and facilitate sensible planning, changes in the relative proportion and distribution of grant should be kept to a minimum.

6.31 Within the overall specific grant structure, there should be provision for central government to make targeted specific grants available to social services authorities to facilitate transfers of responsibility. Such grants will be necessary in cases where projects are on a fairly large scale and have a high national priority, for example as part of a plan to develop community services and close a long- stay hospital. I discuss this particular case below.

6.32 In principle, funds intended for community care projects of the sort now funded through joint finance (ie money provided initially to health authorities) should in future go to local social service authorities.

6.33 Social service authorities already make charges for services directly provided, although practice varies widely. It seems right that those able to pay the full economic cost of community care services should be expected to do so. I therefore recommend that account should be taken in the distribution mechanism for general specific grant of the extent to which the local population are able to pay economic charges for services ie the actual care and support provided - not the assessment and other processes through which it is arranged.

Regional and District Health Authorities

6.34 I recommend that the contribution of regional and district health authorities to the delivery of community care objectives should be separately identified in their plans and budgets and ring-fenced. I do not believe that new funding mechanisms are needed.

PLANNING AND MANAGEMENT

6.35 As a condition for the payment of specific grant I recommend that social services authorities should prepare plans with costed objectives and timetables for implementation which demonstrate their approach to the delivery of community care in their areas, and the adequacy of their management systems. The plans should show that local activity has been well thought through in relation to local needs and that what is planned represents value for money. They should also give evidence of the support given to voluntary groups and their involvement in the preparation of the plan, as well as showing how informal carers are being supported. Importantly the plans should also

demonstrate that systems for joint planning and action exist and that the other relevant agencies, particularly the health and housing authorities, are content with the proposals for action. Progress against past objectives should also be reported.

6.36 Responsibility for the detailed content of these plans will rest with local authorities, but central government should seek to establish, amongst other things, whether plans requiring joint action have been agreed with all concerned; and whether the role of social services authorities is being developed along the lines proposed. The Social Services Inspectorate will have a major part to play in this process.

SUPPORTING PEOPLE IN THE COMMUNITY INSTEAD OF IN LONG STAY HOSPITALS

6.37 The recommendations I have made above should provide a much better structure for the care and support of people who in the past would have been cared for in long stay hospitals, and for those who have already been discharged from such hospitals. I have in particular, recommended that a targeted specific grant should be available to social services authorities to enable them to build up services so that people can be discharged from long stay hospitals. Those services must include the nomination of a care manager for each long stay patient discharged. In parallel with this, specific plans should be made by regional health authorities for the reduction in long stay hospital beds and any necessary increase in the contribution of community health services to community care. Plans from the two agencies should be closely integrated and preferably be a single document.The need for the preparation of tightly drawn plans by both authorities should help to ensure that action is put in hand, without the need for fundamental restructuring at local level.

6.38 Central government should address the consequences of my proposals for capital expenditure by health and social services authorities. Closure of long stay hospitals will release capital assets. Providing necessary consequent services in the community will require some capital expenditure by local authorities.

PUBLIC FINANCE FOR RESIDENTIAL AND NURSING HOME CARE

6.39 I recommend that public finance for people who require either residential home care or non - acute nursing home care, whether that care is provided by the public sector or by private or voluntary organisations, should be provided in the same way. Public finance should only be provided following separate assessments of the financial means of the applicant (using a means test consistent with that for income support) and of the need for care. These assessments should be managed through social services authorities as follows.

6.40 The social services authority should establish a system, including arrangements for consultation when necessary with others, for enabling it to decide whether residential care (including what is now the care provided in non-acute nursing homes) is the most appropriate way of meeting care needs, in the light of the other options available. Depending on the individual's circumstances, consultation might include private or voluntary carers including informal carers, and health carers, as well, of course, as the person directly affected. The social services authority would take the final decision. In doing so, it would take into account all the information available from its own sources, and assessments of the individual's health care needs provided through the health authority and the relevant GP.

6.41 In some urgent cases decisions to provide residential care may have to be taken and implemented without full consultation. In those circumstances consultation should be arranged as soon as possible thereafter.

6.42 As part of the assessment process, the social security system should contribute an assessment of the financial means of the applicant, leading to a decision about whether there is an entitlement to an income related social security benefit (described hereafter as "residential allowance"). The rate of residential allowance should be set in the light of the average total of income support and housing benefit to which someone living other than in residential care would be entitled.It would be for the social services authority to pay the balance of the costs, if it concluded that residential care was the most appropriate way of meeting the individual's care needs.

6.43 When the financial assessment showed that there was no entitlement to the income related residential allowance, the information collected should enable the social services authority to decide how much of the total cost of the residential care should be charged to the individual.

6.44 Some people may seek residential care even though the social services authority cannot agree that their care needs justify such care.In those circumstances there should continue to be entitlement to the residential allowance, but no financial support should be given by social services authorities.

6.45 A decision is required about which social services authority should be responsible for financing care for an individual who moves between one authority's area and another's. I recommend that financial responsibility should be based on the individual's "ordinary residence". This is consistent with current social services legislation.

6.46 If the recommendations are accepted, transfer of resources between social security and specific grant for social services authorities will be needed to take account of the changed responsibilities . Equally a transfer in the opposite direction

will be necessary to take account of the fact that residents of local authority provided residential care (commonly known as Part III) will be supported on the same basis as those in private and voluntary homes. The net effect will depend on the rate at which the social security residential allowance is set and will call for detailed assessment. "Public Support for Residential Care" (the report of a Joint Central and Local Government Working Party) provided useful illustrative calculations.

6.47 The pace of this transfer will depend on decisions about continuing support for existing residents both of private and voluntary homes and of Part III accommodation . It is important that the implementation of the changes proposed and the transfer of resources between agencies does not adversely affect the delivery of care to such individuals. Two approaches are possible : preservation of existing financial entitlements from the current funding agencies or preservation of the right to the existing form of care, but with responsibility for its management located clearly with the social services authority. If the latter is chosen, then a targeted specific grant, of the kind I recommend in paragraph 6.31, would be necessary to smooth the transition of responsibilities between the social security system and social services authorities, because of the wide variation between areas in the number of such recipients .

6.48 "Public Support for Residential Care" (the report of a Joint Central and Local Government Working Party) includes discussion (in Chapter 4) of other issues where changes in the current system might require decisions. These issues include respite care, day care, full time work, unregistered homes and personal expenses. I endorse the recommendations made on these issues.

THE PRIVATE CONTRIBUTION TO CARE

6.49 Social services authorities should not be allowed to become monopolistic suppliers of residential and non - acute nursing home care. Central monitoring of local plans and the distribution of grant should be used to prevent this, if necessary. Central government should not fund a general expansion of local authority run homes. The objective should be to encourage further development of the private and voluntary sectors.

6.50 The reorientation of social services authorities towards an enabling role will be particularly relevant here. They should seek to negotiate the best possible prices for individual places in residential and nursing home care, reflecting the particular care needs of the individuals concerned and local market conditions. They should look rigorously at the comparative costs of domiciliary services, where they may be judged sufficient and seek out the most efficient services there too,whether from the private, voluntary or statutory sectors.

6.51 The social services authority will have an important stake in the public financing of private and voluntary residential

care. It will therefore need to consider whether, for instance a significant input of domiciliary care, day care and help to use leisure time would be a better option, giving a better life for the individual, and making better use of public money. I stress that the outcome of assessment when residential care is being considered should not be a choice between residential care and very little else. Instead, residential care will be one means of providing care and support, with packages of other possibilities costing the social services authority nearly as much as residential care also being serious options. In time, this should transform the way in which community care is provided and viewed.

REGISTRATION AND INSPECTION

6.52 There is a continuing managerial responsibility for social service authorities in monitoring the standards of residential and domiciliary care services funded by them, whether provided directly or not. Formal arrangements for inspection and registration supplement, but do not replace,continuous management scrutiny and control.

6.53 I recommend that residential care and non -acute nursing home care should be subject to the same regime of regulation and inspection, which should be extended to cover small homes with less than four residents. Responsibility for regulation and inspection should rest with the social services authorities.

6.54 In discharging its responsibilities for the registration and inspection of residential homes and non - acute nursing homes, social services authorities should explicitly consider the arrangements for meeting the health care needs of residents, drawing on advice from the district health authority. These arrangements would be without prejudice to the responsibilities of health authorities and GPs for meeting the health care needs of their patients.

6.55 To help in the process of matching services with individuals' needs, each home should publish a statement of the services it provides. Different homes will seek to provide care to different types of residents, in some cases including the provision of respite care. It follows that a home should be registered in relation to its stated objectives for the residents it seeks to care for and what sort of care it seeks to provide.

6.56 The registration and inspection system should consider appropriate staffing of a home as at least as important as other aspects of a home. In particular, the person in charge needs to have the skills, knowledge, experience and personal qualities to be able to create the necessary environment both for residents and staff so that the home can achieve its objectives. This will often include the recognition that the needs of residents may change over time, and that the objectives of the home and its

staffing may need to change in order adequately to care for those residents who have made that home their own home.

6.57 Social services authorities should review the organisation and staffing of their registration and inspection units to ensure that they are suitable for carrying out these duties effectively.

6.58 I have already recommended that it should be a responsibility of central government to monitor the proper application by social services authorities of standards of registration and inspection, a task already being undertaken by the Social Services Inspectorate. Further decisions on statutory inspection will need to take account of the Report of the working party chaired by Lady Wagner.

LONG TERM OPPORTUNITIES

6.59 In framing the recommendations, I have been conscious of the need to look ahead at possible future patterns of service provision, as well as at today's challenges. This final section therefore sets out the opportunities for early action to facilitate innovative developments in the future.

6.60 The majority of those who need care and support are elderly. In looking at future options for the funding of community care,planning needs to take account of the possibilities of individuals' beginning to plan to meet their own care needs at an earlier stage in life. Recent changes in pension legislation have increased the opportunities available to employees to take more personal responsibility for planning their pension provision. Moves to make provision for anticipated community care needs is a logical extension of such an approach.

6.61 Many of the elderly have higher incomes and levels of savings in real terms than in the past. This trend will continue as the coverage of pension schemes grows. This growth in individually held resources could provide a contribution to meeting community care needs. Wider availability of information about the range of services would assist individuals in planning successfully for their own futures. This approach both encourages individual responsibility and assists consumer choice and may be a valuable way ahead. There are already a number of interesting schemes for encouraging owner occupiers to use their equity to provide income which can be used to pay for services in retirement and I believe that similar innovative schemes should be encouraged.

6.62 Encouraging those who can afford to plan ahead to do so should help to ensure that public resources are concentrated on those in greatest need.

6.63 I therefore recommend that central government should look in detail at a range of options for encouraging individuals to

take responsibility for planning their future needs. This examination should include evaluating the potential of innovative service models, such as social maintenance organisations along the lines of the health maintenance organisations, which currently exist in the USA, and the incentives available through taxation and insurance systems for encouraging individual and corporate planning in this area, perhaps through the extension of occupational pension schemes.

CHAPTER 7

IMPLEMENTATION

Introduction

7.1 This chapter deals with implementation and some transitional issues, should the recommended scheme be accepted.

Central Government

7.2 The process of change should start with the designation of a Minister within the DHSS to be responsible for community care, and implementation of the agreed changes. This appointment should be at Minister of State level because of the scale of expenditure, the importance of the subject and the multiplicity of interests in what is to be done. I foresee two primary tasks: first, securing the necessary climate for implementation of the general approach and second establishing and monitoring an implementation programme. These will be central to the work of the central implementation team, which should support the minister.

Legislation

7.3 New primary legislation will be required to implement several recommendations, in particular the transfer to local authorities of responsibility for providing public finance to support people in residential and non-acute nursing homes. Changes in and clarification of the responsibilities towards community care of social services authorities, health authorities, and general medical services are also likely to require primary legislation, as will the establishment of a specific grant system and the changes proposed to the responsibilities of the Social Fund and the existing joint planning and finance arrangements. Legislation should enable social services authorities to finance the provision of services by the private and voluntary sector, as well as directly providing services. It should also facilitate joint action, where this is agreed locally.

7.4 Developing the implementation plan will require detailed specification of further tasks, with timetables and identification of the critical path towards implementation by a due date. Successful implementation will require a measure of general willingness to make the recommended processes work. The precise resource implications will need to be worked out in detail.

Objectives, Values and Information.

7.5 There is a need for central government to make an early clear statement of the objectives and values underlying its community care policies, clarifying its view of the role of the

public sector. It should also make general information available about access to public agencies providing community care. Detailed information should be provided locally, as I have recommended.

7.6 Central Government has a responsibility for identifying and disseminating examples of good practice. This may be particularly important during the implementation period, as there is a danger of effort being wasted in the identification of identical solutions. This role should support rather than constrain the development of imaginative and entrepreneurial solutions at the local level.

Local Government

7.7 In shire counties, the local authorities with housing and social service responsibilities will not be identical. There will therefore need to be close co-operation if, for example, arrangements for the public finance and management of the warden services of sheltered housing are to work smoothly.

7.8 The recommendations, particularly the change in emphasis towards identifying suitable packages of care and the management disciplines associated with specific grant, will increase the demands upon social services authorities' capacity for planning, budgeting, monitoring and other skills. Developing this capacity will be a considerable task for their management and leadership.

7.9 Ministers will need to consider what implications recommendations have for child care services.

Health Authorities

7.10 The main effects on health authorities flow from the recommended clarification of their responsibilities. In particular, action will be needed to deal with the situation of some health authorities who have developed residential care and other non-acute services to meet functions which more appropriately will fall to be discharged by social services authorities. These services will need detailed scrutiny and action case by case. Various solutions are possible: for example, the health authority might agree to keep day-to-day management responsibility for a period after a formal transfer of financial responsibility and provision, but acting as an agent of the social services. A number of other models are possible. I emphasise the need for early action through the planning process in this area, rather than prescribing a model for every case.

Joint Planning and Action

7.11 I have emphasised the need for effective joint planning mechanisms at the local level. It is important that all authorities concerned review existing systems and make the necessary adjustments to them. In particular, new arrangements should concentrate on the whole spectrum of community care

provision, rather than focusing too narrowly only on the needs of those discharged from long-stay hospitals.

7.12 The Health Advisory Service, National Development Team for People with a Mental Handicap, and Social Services Inspectorate have provided assistance to authorities to develop realistic and workable joint plans and joint action. This sort of central activity will continue to make a valuable contribution locally.

Transfer of Staff from Health Authority to Local Authority Employment

7.13 It is important that the skills of staff formerly employed in long stay hospitals are not lost, as patients are discharged and responsibility for their care passes to another authority. Such staff are likely to have direct personal knowledge of individual former patients and their needs, as well as a wide range of skills which are equally valuable in a community care setting. There are legislative and other problems which inhibit the smooth transfer of staff between agencies at present,which can delay desirable changes.

7.14 There are a number of options for local action in regard to staff. They may be seconded to the local authority, which has the advantage of being a flexible approach. There can be locally arranged transfers to local authority employment with no redundancy compensation and with the retention of NHS superannuation scheme membership, which can be an important consideration for the staff concerned. Finally the health authority can make the staff redundant followed by engagement of the same staff by the local authority. Each of these options has its own advantages and disadvantages.

7.15 It is inexcusable for general progress to be halted because of this issue. I therefore recommend that Central Government make a clear decision on the action to be taken. If it is decided that the solution is not to involve legislation , this should be made clear to local management, who should also receive detailed guidance on which of the other options are acceptable. It should then be a local responsibility to identify and implement the most suitable option for the individual case, taking account of the views expressed locally.

8. OTHER ISSUES

Professional Roles

8.1 The proposals involve significant changes in role for a number of professional and occupational groups. In many cases their implementation will more sharply focus developments which are already taking place within professions. For example, many social services staff already have a managerial function, but my approach will give this added emphasis, for example in the development of the skills needed to buy in services. Other new skills, particularly in the design of successful management accounting systems and the effective use of the information produced by them, will be needed. The change in role of social services authorities might also allow them to make more productive use of the management abilities and experience of all their staff,including those who are not qualified social workers.

8.2 The recommendation in paragraph 6.14 implies a more systematic approach by all GPs to identifying the potential community care needs of their patients. The GP will have to consider all of his patients whose health status means they can be expected to have community care needs. The responsibility for arranging such systematic consideration will be the GP's, using the resources available to the practice in the most effective way.

8.3 The professional skills of community nurses and health visitors need to be effectively harnessed and their contribution in working with other professional groups fully recognised. In particular, the supportive skills and the ability to develop independence currently displayed by community psychiatric nurses and registered mental handicap nurses have an invaluable role to play in meeting the needs of both clients and informal carers.

8.4 The Audit Commission recommended the creation of a new occupation of "community carers" to undertake the front line personal and social support of dependent people. This might be a development of the roles of some home helps/home care assistants, community nursing assistants and residential care staff. There is scope for the development of multi-purpose domiciliary services along these lines by social services authorities, the voluntary sector and the private caring organisations. If this is acted upon, it will be vital to ensure that job descriptions enable individual workers to provide the assistance required without demarcation problems arising. The management of and support for such staff groups will need to be carefully planned.

Training

8.5 Ensuring that staff have the necessary skills to discharge their functions is a key task for any organisation, particularly one which is undergoing a significant degree of change. It will therefore be essential that the training implications of the recommendations are kept in mind throughout the implementation

period. I recommend, as a first step, that central government should make a full assessment of the training implications of the proposals for all groups concerned. This section highlights some particular areas for attention.

8.6 Recruitment and in-service training systems for professional social services staff at both the national and local level will need to give greater emphasis to management skills to reflect the proposed change in emphasis of social services authorities' role. The same is true of qualifying training for social workers. A further aspect of training of particular relevance to social services authorities is the transfer of skills from professional staff to informal carers. Staff need to be trained to regard such support and training as an essential part of their job, and have the knowledge and skills to undertake the work effectively.

8.7 The training needs of the "community carers" mentioned in paragraph. 8.4 also need to be defined. Action in this area should take account of the useful initiatives currently being pursued by the National Council for Vocational Qualifications involving the Central Council for Education and Training in Social Work, the United Kingdom Central Council, the Local Government Training Board and others.

8.8 Staff need training to fulfil their own roles, but also need to understand the contribution of other professions to community care. Insularity among individual professional groups can lead to failures of communication and inability to recognise both needs and options for meeting them. The need for effective collaboration in training matters at the local level to tackle this should be addressed by all authorities, both during the implementation period and as an ongoing task.

Multi-racial society

8.9 Both policy and action need to respond to the multi-racial nature of British society. The emphasis on the responsibility of the social services authority to assess need, and arrange appropriate package of services for individuals within their own situations, should help to ensure that the different needs of people with different cultural backgrounds are properly considered. All staff involved will need to be trained to develop the appropriate knowledge and skill to do this successfully.

Voluntary Sector

8.10 To develop the potential contribution of the voluntary sector further, financial support for its role needs to be provided on a clearer basis, fully understood by all concerned. I therefore see a need for clear agreements to be made between public agencies and not-for-profit bodies on the basis of public agency funding. This may be, for example, on a fee per client basis, or a contract providing that the not-for-profit body should provide a given level of service. In either case, this

should allow the social services authority to hold the not-for-profit body to account for the proper use of public funds. Equally, to allow voluntary bodies a greater degree of certainty in their planning, a reasonable degree of notice should be given before the basis of funding is changed, and public agencies must recognise that short - term project grants are not an appropriate way of providing reliable funding for ongoing work .

8.11 In addition to the direct provision of services, the voluntary sector fulfils a variety of other roles, including those of : -

- self-help support group
- information source/ source of expertise
- befriending agency
- advocate for individuals
- constructive critic of service providers
- public educator
- pilot of new approaches to services
- campaigner.

All or a substantial number of these roles may often be combined in one small organisation. As these can be vital in helping to make the best use of public funds , they may often merit some public financial support. This is probably best provided as a general core grant to the voluntary organisation, from the social services authority at the local level, or from DHSS for national organisations . Informal support, for example by way of advice, will also be valuable.

CONCLUSION

Implementation of the proposals will increase the ability of managers in all community care services to ensure that :

- the right services are provided in good time, to the people who need them most;

- the people receiving help will have a greater say in what is done to help them , and a wider choice;

- people are helped to stay in their own homes for as long as possible, or in as near a domestic environment as possible, so that residential, nursing home and hospital care is reserved for those whose needs cannot be met in any other way.

These are the ends to be obtained. If the proposals themselves concentrate on means, that is because I was asked to look at systems and found that the blockages to progress lie there.

Ensuring that for each locality someone, at both the political and managerial levels, is charged with delivering community care policies and is given control of the necessary resources will help both to create new opportunities to improve the quality of services available and to obtain better value for money from them. What up to now has been exceptional progress, in spite of the obstacles, should become the norm.

Merely to tinker with the present system would not address the central issues and would forego the benefits that could be obtained from more concentrated action. The opportunity exists to create a partnership in the delivery of care - between central and local government; between health and social services; between government and the private and voluntary sectors; between professionals and individuals - to the benefit of those in need. The proposals as a whole - and no single one on its own - are aimed at enabling that opportunity to be taken.

mjd 3/125m

CONFIDENTIAL

FROM: MISS M P WALLACE
DATE: 16 February 1988

PS/CHIEF SECRETARY

GRIFFITHS REPORT

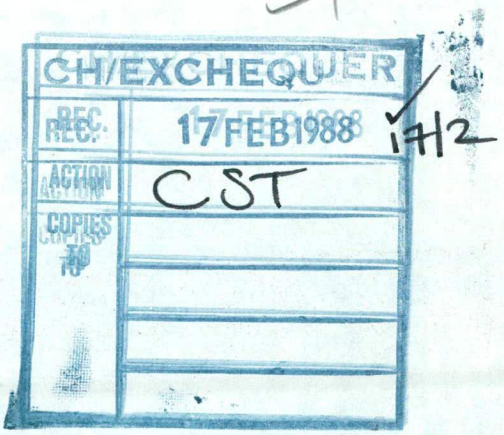
The Chancellor was grateful for the Chief Secretary's minute of 15 February. He has commented that the Report sounds very bad indeed - as we always feared. It also seems to run wholly counter to our policy towards local government. Officials will need to work fast with DHSS officials (and probably DoE as well) to work out a way of neutering it. Otherwise, it will be the Housing Benefit story all over again.

MOIRA WALLACE

CONFIDENTIAL

BF 23/2

17/2/88



17/2

PRIME MINISTER

spoke to Jill

SIR ROY GRIFFITHS' REVIEW OF COMMUNITY CARE

You will recall that in December 1986 Norman Fowler, after consulting you and colleagues, asked Sir Roy Griffiths to review the use of public funds to improve the effectiveness of their application to community care.

Sir Roy has just completed his report and submitted it to me at the weekend. I am sure you will wish to see the report straightaway. A copy is attached. Chapter 1, pages 20-23, summarises the proposals.

We gave Sir Roy a formidable task. The Audit Commission and the Social Services Committee had been critical of the effectiveness of community care, and especially of the application of public money to it from a variety of sources. Our invitation to Sir Roy to look at the problem was our response to this. The criticisms have since been echoed by the NAO, who expected that he would have to consider "fairly radical solutions" in his review.

He has brought to the work the logic and penetration that one would expect. But he has inevitably been confined by the fact that local authorities have a major place in the provision of community care. He has sought a solution that would spell out responsibilities and insist on performance and accountability. This has led him to the conclusion that local social service authorities should assess the community care needs of people in their locality, and should take a comprehensive view, in an enabling rather than a providing role, of these needs and the services that should respond to them.

This is an understandable response to the task he was set. But I think that, from a broader point of view, he has reached some wrong conclusions. There has been a welcome growth of private sector provision of community care. I do not believe that local authority "enablers" who are themselves providers of competing services would deal even-handedly with the private sector. More generally, I doubt whether our supporters would understand a policy which would steer vulnerable members of the community more firmly towards the local authorities, of whose record we are highly critical.

So we have a dilemma. Sir Roy's report recommends a logical way of tackling the diffusion of responsibility for community care which nevertheless takes us in the wrong direction politically. There may be ways round this, for example by emphasising the purely enabling role of local authorities, cutting back their responsibilities as providers and tightening up the framework within which they would operate while at the same time encouraging the private sector alternatives. But all this will need time and thought. Meanwhile, we have the Griffiths report, which is widely anticipated, and must decide what to do with it.

The report is one of two we have been expecting which will touch on community care. The other will be from Lady Wagner's working party on the role of residential care. Her work was commissioned in March 1986 by the National Institute of Social Work, with Norman Fowler's support, and the report is being published next month. The handling of that report is for the Institute, but they are certain to publish and I believe we have no choice but to do the same with the Griffiths report. My preference would be to publish it soon, saying only that this is an important contribution to the debate on community care which we shall consider alongside Wagner. We could add that we would be bringing forward our own proposals on community care in due course, in the light of these reports. We should emphasise that Sir Roy's proposals are primarily concerned with non-health services. Although they do not have a direct bearing on the review of the NHS the two are certainly relevant to one another.

but what will Wagner say?

CONFIDENTIAL

A number of colleagues will be interested in the Griffiths report and I had been planning to write to colleagues in E(A) about publication and handling. But given the political sensitivities, I suggest you might want to hold a smaller meeting of Ministers to discuss the immediate problems. I am therefore at this stage copying this minute and the report only to Nigel Lawson, Nick Ridley and John Major.

JM

17th February, 1988

CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

22 February 1988

Dear Geoffrey,

SIR ROY GRIFFITHS' REVIEW OF COMMUNITY CARE

The Prime Minister was grateful for your Secretary of State's minute of 17 February with which he forwarded Sir Roy Griffiths' report on community care.

The Prime Minister agrees that the report gives rise to major difficulties, in particular the role proposed for local authorities. She accepts that it would be difficult to do other than arrange for early publication of the report, in parallel with the report of Lady Wagner's working party on the role of residential care. But she has commented that it is necessary to consider precisely what should be said about the Griffiths report at the time of publication; vague generalities could arouse the wrong expectations. The Prime Minister would therefore be grateful if your Secretary of State could now propose the precise terms of an announcement to accompany publication of the Griffiths report.

I am copying this letter to Alex Allan (HM Treasury), Roger Bright (Department of the Environment) and Jill Rutter (Chief Secretary's Office).

Yours,
Paul

(PAUL GRAY)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

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CONFIDENTIAL

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FROM: **CHIEF SECRETARY**
DATE: **23 February 1988**

CHANCELLOR

cc:
Mr Anson
Miss Peirson
Mr McIntyre
Mr Potter
Mr Saunders
Mr D Rayner
Mr Call

GRIFFITHS REPORT

John Moore has now circulated Sir Roy Griffiths' report on community care (though only to the Prime Minister, Nicholas Ridley and ourselves).

2 The report is unacceptable and unpalatable though perhaps not quite so much as it originally appeared on the basis of the summary chapter alone. But it still presents us with the formidable difficulty that Sir Roy proposes to require local authorities to assess the need for (and to finance partially) residential care, including such care provided by the private sector. I do not favour this approach.

3 We should, of course, bear in mind that there is a very real problem in existing community care arrangements. People may enter privately-provided residential care at will, and, if they qualify for supplementary benefit, the DHSS foot the entire bill (board, lodging and care). That is, DHSS operate a means test but not a care test. As a result, expenditure on social security payments for residential care has risen dramatically from £10 million in 1979 to £460 million in 1986. Half of those in private sector homes now have their expenses met from benefit, compared with only 10 per cent in 1981. Residents in local authority homes do not qualify for such support, and so the growth of local authority homes has virtually halted. The risk is that people are put in residential care who could manage in their own homes, helped by meals on wheels etc, at far less cost to the public purse. Studies suggest that the numbers in residential care who do not need it are still relatively small. But so long as local authorities have a financial incentive <u>not</u> to provide the cheaper services, whose cost falls on them, the problem is liable to get worse.

4 Sir Roy has tried to solve this problem by proposing to give local authorities the financial responsibility for meeting the full costs of any residential care, except for a basic Residential Allowance, payable on a means-tested basis from the social security programme. In Sir Roy's view, this would give local authorities a neutral framework within which to choose between contributing to residential care costs and providing services at home. However, that was not what we intended when he was asked to take up the matter following the Joint Working Party (of Central Government and local authorities) which reported last year and recommended a very similar solution.

5 As John Moore says, I am sure we cannot support a policy which would steer vulnerable members of the community more firmly towards the local authorities, and would put the private sector providers of residential care even more at the mercy of hostile authorities than they are already. This is quite unacceptable.

6 We thus have two immediate problems:-

- the short term handling of the Griffiths report

- the longer term resolution of the problem identified in paragraph 3 above.

7 As regards the handling of the report, I endorse John's proposal of quick low-key publication, with a statement along the lines he suggests. (I understand that the Wagner report will make various recommendations concerning registration and inspection of residential care).

8 As for the longer term arrangements for the provision of community care, I have asked officials to work up some further options quickly. We will want, if we can, to find some way of

reconciling our different objectives here. On the one hand, we should aim to curb the rapid growth in social security spending for residential care and to encourage more provision of local services so that people can stay in their own homes where that is a more cost-effective solution. On the other hand we shall not want to harm the important role of the private and voluntary sector in provision of residential care.

9 Our officials see some attractions in what Sir Roy proposes, because local authority social workers do already carry out much of the assessment of need which would be required, and are well placed to expand that work. I do not share their enthusiasm for this approach. But there are other possibilities, such as giving the job to the health authorities (until 1974 the hospitals employed social workers direct) or to Family Practitioner Committees or to DHSS social security officials. These all need to be considered, together with suitable arrangements for the financing of the care thus decided on and for enabling private sector provision to continue to flourish.

10 As soon as we can, we should review these further options, so that we can consider what we want to advocate at the meeting with the Prime Minister which John proposes, and thereafter.

JOHN MAJOR

(Approved by the Chief Secretary and signed in his absence.)

RM6.7

CONFIDENTIAL

BF 26/2 pmp

FROM: MOIRA WALLACE
DATE: 24 February 1988

PS/CHIEF SECRETARY

cc Mr Anson
Miss Peirson
Mr McIntyre
Mr Potter
Mr Saunders
Mr D Rayner
Mr Call

GRIFFITHS REPORT

The Chancellor was most grateful for the Chief Secretary's minute of 23 February. He agrees with the Chief Secretary's conclusions, and has commented that we shall need to move fast.

MOIRA WALLACE

29/2/88 BF 3/3

CH/EXCHEQUER
REC. 29 FEB 1988 29/2
ACTION CST
COPIES TO

CONFIDENTIAL

Prime Minister

Ch/ Mr Moore's office rang to emphasise that measured tone of this minute reflects not a climbdown but merely wish not to expose unease about Griffiths report all round Whitehall. CST's office are pursuing advice in good time for No 10's deadline upon 1/3

NPS:

REVIEW OF COMMUNITY CARE

In December 1986, having consulted you and colleagues, Norman Fowler asked Sir Roy Griffiths to review the use of public funds to support community care, and advise on ways of improving effectiveness. I have received his report, and am circulating copies with this minute. Chapter 1 summarises his proposals.

The main issue facing Sir Roy was the disparate way in which public funds are currently committed to community care. Although the main statutory responsibilities, and much the greater part of the expenditure, rest with local authorities, social security entitlements for people in residential care have made a rapidly increasing and sizeable contribution, and some funds are available from NHS sources. Sir Roy has also had to grapple with the not always clear distinction between health and non-health care.

The current arrangements have prompted widespread criticism, from amongst others - the Audit Commission, the Social Services Committee and the Comptroller and Auditor General. Faced with how public funds could be managed to better effect Sir Roy has sought a solution that would concentrate responsibility at local level, while recognising multiple interests, and tighten accountability for plans and performance. He has concluded

E.R.

that, because of their primary existing role in this field, and the absence of more attractive alternatives, local social service authorities should be responsible for assessing the needs of people in their locality; taking a comprehensive view, in an enabling rather than a providing role, of the services that would most effectively respond to them; and arranging the delivery of suitable packages of care, through informal carers, voluntary and private bodies, and their own services. He proposes a central control and planning machinery, linked to the payment of specific grant, which he recommends should be used, amongst other things, to ensure that social service authorities make maximum use of the private and voluntary sectors, and improve consumer choice.

There is a great deal in the report with which I think we should all agree. The aims and objectives, from the point of view of effective management and delivery of policy, are entirely acceptable, and the package offers a valuable opportunity to bring expenditure on residential care within proper budgetary discipline.

We shall have to consider very carefully, however, the role he proposes should be given to local authorities. Although he sees this as enabling - in line with what Nicholas Ridley is seeking - I am far from sure that the arrangements which he proposes would ensure that local authorities dealt even-handedly with the private sector. There has been a welcome growth in private provision of residential care. We do not want to reverse that trend. And we need to do more work to turn Sir Roy's vision of a market for private non-residential care services into a reality.

More generally, we have to consider the reactions of our own supporters, many of whom are likely to be deeply sceptical of an enhanced role for local authorities. The available options will have, in my view, to be studied further.

[redacted]R.

Other important and potentially controversial issues of substance include:

- changed social security entitlements for people in residential care;

- transfer of part of the Social Fund to local authorities;

- implications for the territorial departments.

We shall need to consider all the substantive issues collectively. Legislation would be required to implement the main changes. The resource and public expenditure implications need further analysis. Sir Roy had recognised that his proposals require further work. I am considering how this might best be organised to take account of departmental interests.

I have also received a report on residential care from a working party chaired by Lady Wagner, which was set up by the National Institute of Social Work, with Norman Fowler's support, in March 1986. That report is to be published by the Institute on 9 March. The proposals will need to be considered alongside those in Sir Roy Griffiths' report.

Against that background, I propose early publication of Sir Roy's report. Delay would stimulate speculation, and expectation of a more considered response than we shall be ready to make. I propose to make a short written statement on publication saying that the Government will be considering the proposals along with those in Lady Wagner's report; would take account of reactions; and would bring forward its own proposals in due course. A written answer to that effect is attached to this letter.

I hope it will be possible to publish on Wednesday 16 March. I have a number of Parliamentary questions asking about publication which have to be answered on 8 March. I propose to say in

[redacted]R.

reply that I have received the report, and am arranging for it to be published on that date.

I invite agreement that:

- Sir Roy's report should be published and that I should say in answer to questions on 8 March that I have received the report, and that it will be published on 16 March;

- I should simultaneously make a statement as in the attached written answer;

- we should consider collectively the substantive issues, taking account of reactions, with the aim of reaching conclusions on a sensible and practical way forward.

Copies of this letter and the enclosures go to members of E(A) and Sir Robin Butler.

JM
29 February 1988

[redacted]R.

DRAFT WRITTEN PQ ANNOUNCING PUBLICATION

Question: To ask the Secretary of State for Social Services when Sir Roy Griffiths' review of Community Care will be published, and if he will make a statement.

Suggested reply

Sir Roy Griffiths' report is being published today, and copies are being placed in the libraries of both Houses.

The report makes wide-ranging proposals affecting the responsibilities of local government; individuals' social security entitlements; central funding and control of community care services; and aspects of the Social Fund.

The Government will be considering the proposals, taking account of the report of the committee chaired by Lady Wagner on residential care, and of reactions to both reports; and will bring forward its own proposals in due course.

BF 9/3

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Secretary of State for Social Services

The Rt Hon John Wakeham MP
Lord President of the Council
Privy Council Office
Whitehall
LONDON
SW1A 2AT

March 1988

RESIDENTIAL CARE: REPORT OF THE WAGNER COMMITTEE

In March 1986, with Norman Fowler's support, the National Institute of Social Work (NISW) commissioned a comprehensive review of residential care. The full terms of reference were:

> "To review the role of residential care and the range of services given in statutory, voluntary and private residential establishments within the personal social services in England and Wales; to consider, having regard to the practical constraints and other relevant developments, what changes, if any, are required to enable the residential care sector to respond effectively to changing social needs; and to make recommendations accordingly."

(not the Government) Lady Wagner has sent me an advance copy of her report, which is to be published by NISW on 9 March, when Lady Wagner will chair a press conference.

The summary of recommendations is enclosed with this letter. Most of them are about the way in which residential homes should be run, and the standards and principles that should pertain. Here the main issues for the Government arise from the proposals for

- a uniform system of registration and inspection;
- independent inspection;
- specific areas of good practice where central policies and guidance will be expected.

E.R.

All of this is - and will be seen to be - relevant to current concerns about the treatment of people in residential settings, particularly those who are old and infirm.

But the report also proposes that local authorities should have the leading responsibility for strategic planning of accommodation and the design of suitable "packages" of home care for individuals; and that anyone for whom residential care is an option should have access to a nominated social worker. These proposals thus raise the same difficult political issues as are raised in Sir Roy Griffiths' report on community care.

We shall have to assess the financial implications of the proposals, as the report acknowledges. First impressions suggests that the Committee may have been over-idealistic about what is practicable. It is more than disappointing that they have failed to cost their proposals.

The proposals affecting the role of local authorities, including the proposed study of a voucher system, will have to be considered alongside Sir Roy Griffiths' report on community care.

This was an independent review, and a holding statement on publication is all that will be required or expected. Although Ministers were involved in the commissioning of this review, I do not consider a formal statement by way of Written Answer is necessary. In reply to inquiries, I intend to authorise the response shown in the attachment to this letter.

I shall be considering the substantive issues in consultation with those colleagues directly concerned.

Copies of this letter go to the Prime Minister, other members of the Cabinet, the Chief Whip and Sir Robin Butler.

JOHN MOORE

E.R.

PROPOSED LINE TO TAKE

The Government will consider the committee's proposals and make known its conclusions in due course, while taking account of Sir Roy Griffiths' report on community care.

The Government attaches importance to securing proper arrangements to protect the dignity, personal rights, and safety of all those in residential care. Where the Committee recommends changes in practice and services to meet particular needs, the Government will want to take account of the views of service providers, as well as the financial implications which the Committee acknowledges need to be evaluated, before deciding on any central guidance. Those directly concerned will be consulted before decisions are taken, but there is much that can be pursued through local initiative without waiting on central guidance.

RECOMMENDATIONS

Positive Choice

1. Local authorities should take the lead in the strategic planning of accommodation and support services. (Chap 6.10)

2. A statutory duty should be placed on local authorities to propose a reasonable package of services, enabling a person to remain in their own home if that is their choice and it is reasonable for them to do so. (Chap 3.22)

3. Statutory and voluntary agencies should use every means available to contact informal carers in their area, so as to find out what support they may need. (Chap 5.9)

4. Further study should be given to a system of Community Care Allowances, which would enable people with special needs to procure care services of their choice. (Chap 3.19)

5. Anyone for whom residential provision might be an option should have available to them the skill of a nomiated social worker, whose primary responsibility will be to act as their agent; a nominated social worker should always be appointed where a prospective user has no relative and is deemed unable to exercise effective choice. (Chap 3.6)

6. Local authorities should develop systems of delegated budgeting where nominated social workers exercise direct control over financial resources. (Chap 3.16)

7. The public library service in each locality should coordinate, and periodically update, comprehensive information on the range of services available. (Chap 3.2)

Rights of the Individual

8. Every adult person entering a residential establishment with a view to an extended stay should be entitled to a trial period during which nothing would be done to dispossess them of their previous accommodation. At the end of the trial period, acceptance of the terms and conditions of the residential establishment should constitute a contract binding on both sides. (Chap 4.14)

9. All people in residential establishments capable of arranging their own affairs should be entitled to retain their pension or allowance book, and to pay from it the agreedsum for accommodation and services. Residents should be eligible for Housing Benefit in the assessment of their accommodation commitment. (Chap 4.15)

10. No one should be required to share a bedroom with another person as a condition of residence. (Chap 4.12)

11. In new residential homes as from 1990, and in existing homes as from 1995, there should be only two double rooms to every ten rooms. (Chap 4.12)

12. Each person in a residential establishment should be entitled to a personal key for their own room. (Chap 4.9)

13. There should be a statutory review every six months for those residents who are unable to exercise effective choice or give effective consent. (Chap 3.17)

14. Each local authority should have a clear and well-publicised complaints procedure, and comparable measures should be taken by private and voluntary agencies. (Chap 3.21)

15. People who require assistance in presenting their complaints should have the services of an advocate or personal representative who is entirely independent of those providing the service. (Chap 3.23)

16. Information about the agency's complaints procedure should be made available to children and parents. Children in all forms of residential care should have access to an independent advocate. Consideration should be given to extending the system of guardian ad litem to enable families and children to request a guardian ad litem to safeguard children's interests. (Chap 10.22, 23)

17. The differing levels of capital disregard and of personal allowance in the local authority, voluntary and private sectors should be brought into line at the higher levels. (Chap 4.16)

Particular Needs

18. Residential services for children should be among the options available to children and their parents, and should be developed to offer: respite care; a staged transition from hospital to family care; integrated education and care; a means of keeping siblings together. (Chap 10.13)

19. Greater importance should be attached to the educational and health needs of children in care. (Chap 10.20, 21)

20. The needs of children and young people from ethnic minority groups should receive particular attention. (Chap 10.15)

21. Adequate accommodation should be made available to young people on leaving care. (Chap 10.25)

22. Education and training for young people with mental handicap should aim at enabling them to live with minimum support in ordinary housing. (Chap 10.35)

23. The Government should ensure that adults with physical disabilities receive sufficient financial help to enable them to purchase the services they require. (Chap 10.31)

24. The provision of supportive accommodation to enable people with disabilities to leave the parental home needs to be expanded. (Chap 5.13)

25. Investment is needed to extend the range of services in the community for people with or recovering from mental illness. (Chap 10.43)

26. Residential services should be developed for a variety of purposes for people with alcohol and drug problems. (Chap 10.50)

27. Proper provision must be made for elderly mentally infirm people. This will entail close cooperation between health and social services. Nursing home type facilities should be developed in association with existing residential establishments. (Chap 10.61)

1.2.3.

CONFIDENTIAL

FROM: MISS M E PEIRSON

DATE: 2 MARCH 1988

CHIEF SECRETARY

cc Chancellor
Mr Anson
Mr Phillips
Mr Hawtin
Mr Turnbull
Mr R I G Allen
Mr Pickford
Mr Saunders
Mr White
Mr Call

Mr McIntyre
Mr Potter

CH/ A case for taking it all at one go on 8/3? mpw 2/3

COMMUNITY CARE: GRIFFITHS AND WAGNER REPORTS

1. Mr Moore has written as expected to the Prime Minister, giving the Griffiths report wider circulation and proposing a low key publication. He mentions also the Wagner report, which we are getting from DHSS and will advise on separately: DHSS say that Mr Moore will shortly be writing round about it, and that some of its proposals are similar to those in the Griffiths report while others are aimed at improving the quality of residential care for all groups (but have not been costed).

2. The draft PQ seems fine. The only possible problem is that Mr Moore proposes to say on 8 March that he has received the Griffiths report, whilst not publishing it until 16 March. I do not see how he can defer saying on 8 March the sort of things he proposes to say on publication. Otherwise expectations will be aroused. I suggest that you respond proposing that he uses the draft on 8 March, amended as necessary (see suggestion in draft minute attached). Then nothing need be said on 16 March. (DHSS say that 8 March might indeed be feasible for publication; 16 March has been suggested in order to distance the Griffiths report both from the Wagner report (9 March) and the Budget. They might reconsider 8 March.)

Why distance from Wagner when main public line based on taking 2 together?

3. Although Mr Moore circulates the Griffiths report to the whole of E(A), he makes no proposals about how to carry forward

the collective consideration of the matter: he says he is considering. The Treasury will of course need to be represented.

4. I attach a draft minute from you.

MISS M E PEIRSON

CONFIDENTIAL

DRAFT MINUTE FROM CHIEF SECRETARY TO PRIME MINISTER

REVIEW OF COMMUNITY CARE

1. I have seen John Moore's minute to you of 29 February. I agree with him that the proposals in Sir Roy Griffiths' report require further collective consideration. I should of course like my officials to be associated with any work which is done before further proposals are put to us.

2. I also look forward to seeing the Wagner report, and John's proposals on that.

3. I agree with John in thinking that the best way of handling Sir Roy's report is a low key publication on the lines he suggests. I am just a little doubtful, though, about John's saying nothing more on 8 March than that he has received the report and that it will be published on 16 March; that might arouse expectations of a substantive response. I suggest that it might be better to use the proposed draft reply on 8 March, simply amending the first paragraph to read something like "I have received Sir Roy Griffiths' report; I am arranging for its publication on 16 March, and copies will then be placed in the libraries of both Houses.". Then nothing need be said on 16 March.

4. I am copying my letter to members of (EA) and Sir Robin Butler.

CONFIDENTIAL

Prime Minister

Mr. Saunders
CX Robinson Mr Phillips
Miss Peirson Mr Hawtin
Mr Turnbull
Mr Call

REVIEW OF COMMUNITY CARE

In December 1986, having consulted you and colleagues, Norman Fowler asked Sir Roy Griffiths to review the use of public funds to support community care, and advise on ways of improving effectiveness. I have received his report, and am circulating copies with this minute. Chapter 1 summarises his proposals.

The main issue facing Sir Roy was the disparate way in which public funds are currently committed to community care. Although the main statutory responsibilities, and much the greater part of the expenditure, rest with local authorities, social security entitlements for people in residential care have made a rapidly increasing and sizeable contribution, and some funds are available from NHS sources. Sir Roy has also had to grapple with the not always clear distinction between health and non-health care.

The current arrangements have prompted widespread criticism, from amongst others - the Audit Commission, the Social Services Committee and the Comptroller and Auditor General. Faced with how public funds could be managed to better effect Sir Roy has sought a solution that would concentrate responsibility at local level, while recognising multiple interests, and tighten accountability for plans and performance. He has concluded

E3/2

that, because of their primary existing role in this field, and the absence of more attractive alternatives, local social service authorities should be responsible for assessing the needs of people in their locality; taking a comprehensive view, in an enabling rather than a providing role, of the services that would most effectively respond to them; and arranging the delivery of suitable packages of care, through informal carers, voluntary and private bodies, and their own services. He proposes a central control and planning machinery, linked to the payment of specific grant, which he recommends should be used, amongst other things, to ensure that social service authorities make maximum use of the private and voluntary sectors, and improve consumer choice.

There is a great deal in the report with which I think we should all agree. The aims and objectives, from the point of view of effective management and delivery of policy, are entirely acceptable, and the package offers a valuable opportunity to bring expenditure on residential care within proper budgetary discipline.

We shall have to consider very carefully, however, the role he proposes should be given to local authorities. Although he sees this as enabling - in line with what Nicholas Ridley is seeking - I am far from sure that the arrangements which he proposes would ensure that local authorities dealt even-handedly with the private sector. There has been a welcome growth in private provision or residential care. We do not want to reverse that trend. And we need to do more work to turn Sir Roy's vision of a market for private non-residential care services into a reality.

More generally, we have to consider the reactions of our own supporters, many of whom are likely to be deeply sceptical of an enhanced role for local authorities. The available options will have, in my view, to be studied further.

E.R.

Other important and potentially controversial issues of substance include:

- changed social security entitlements for people in residential care;

- transfer of part of the Social Fund to local authorities;

- implications for the territorial departments.

We shall need to consider all the substantive issues collectively. Legislation would be required to implement the main changes. The resource and public expenditure implications need further analysis. Sir Roy had recognised that his proposals require further work. I am considering how this might best be organised to take account of departmental interests.

I have also received a report on residential care from a working party chaired by Lady Wagner, which was set up by the National Institute of Social Work, with Norman Fowler's support, in March 1986. That report is to be published by the Institute on 9 March. The proposals will need to be considered alongside those in Sir Roy Griffiths' report.

Against that background, I propose early publication of Sir Roy's report. Delay would stimulate speculation, and expectation of a more considered response than we shall be ready to make. I propose to make a short written statement on publication saying that the Government will be considering the proposals along with those in Lady Wagner's report; would take account of reactions; and would bring forward its own proposals in due course. A written answer to that effect is attached to this letter.

I hope it will be possible to publish on Wednesday 16 March. I have a number of Parliamentary questions asking about publication which have to be answered on 8 March. I propose to say in

E.R.

reply that I have received the report, and am arranging for it to be published on that date.

I invite agreement that:

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- I should simultaneously make a statement as in the attached written answer;

- we should consider collectively the substantive issues, taking account of reactions, with the aim of reaching conclusions on a sensible and practical way forward.

Copies of this letter and the enclosures go to members of E(A) and Sir Robin Butler.

JM
29 February 1988

E.R.

DRAFT WRITTEN PQ ANNOUNCING PUBLICATION

Question: To ask the Secretary of State for Social Services when Sir Roy Griffiths' review of Community Care will be published, and if he will make a statement.

Suggested reply

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The report makes wide-ranging proposals affecting the responsibilities of local government; individuals' social security entitlements; central funding and control of community care services; and aspects of the Social Fund.

The Government will be considering the proposals, taking account of the report of the committee chaired by Lady Wagner on residential care, and of reactions to both reports; and will bring forward its own proposals in due course.

RM6.34

CONFIDENTIAL

FROM: MOIRA WALLACE
DATE: 3 March 1988

PS/CHIEF SECRETARY

cc Mr Anson
Mr Phillips
Mr Hawtin
Mr Turnbull
Miss Peirson
Mr R I G Allen
Mr Pickford
Mr McIntyre
Mr Potter
Mr Saunders
Mr White
Mr Call

COMMUNITY CARE: GRIFFITHS AND WAGNER REPORTS

The Chancellor has seen Miss Peirson's minute of 2 March. He thinks there is a very strong case for taking the whole thing at one go on 8 March.

MOIRA WALLACE

st.ts.docs.25.7.88

CONFIDENTIAL

FROM: MISS M E PEIRSON

DATE: 25 JULY 1988

CHIEF SECRETARY

cc: Chancellor
Mr Anson
Mr Phillips
Mr A J C Edwards
Mr Turnbull
Mr McIntyre
Mr Potter
Mr Saunders
Mr A M White
Mr Call

COMMUNITY CARE POST-GRIFFITHS: INTERDEPARTMENTAL REPORT

Mr Rayner's submission below summarises the conclusions of the report of the interdepartmental group which has been considering the Griffiths report. The next steps, we understand, are for Mr Moore to write to his colleagues next month and for the Prime Minister to hold a meeting in early September. There is no need for immediate action by you.

2. I am afraid that the general tendency of the report is to favour a Griffiths- type solution, ie giving a bigger role to the local authorities. The group felt that:

a. something needs to be done to stem the very rapid growth in social security payments (see below);

b. the only change to make a real difference will be to give a single agency financial responsibility for all types of care;

c. creating a central government agency would be very disruptive in the short-term (because it would take existing social service responsibilities for the elderly away from local authorities) and probably more expensive in the long-term as well.

3. We (Treasury officials) agreed, but insisted that the various central government options got a fair hearing. The choice among them depends on whether health care is to be added to non-health care

or kept separate; that in turn depends on the likely outcome of the health review (remembering that, if the health authorities or FPCs are to be reorganised, that may be as much as they can cope with, without taking on non-health care as well).

4. The social security problem is that benefit payments for residential care have risen from £10 million in 1979 to around £800 million in 1987-88 and, if present trends continue, will reach £2000 million by 1993. That is bad. But we cannot eliminate the further growth: the best we can hope to do is to change financial responsibilities so that more people stay in their own homes and receive domiciliary care. If a quarter of potential new clients stayed at home, and if domiciliary care cost three quarters of residential care (excluding the housing benefit element of the latter), the report suggests a saving of £75 million pa by 1993; but the saving could well be greater.

5. The alternative of minimal change to existing arrangements, which would not give a single agency the responsibility for both domiciliary and residential care, would not achieve even that saving.

MEP

MISS M E PEIRSON

CONFIDENTIAL

FROM: D RAYNER

DATE: 25 JULY 1988

1. MISS PEIRSON (see covering note)
2. CHIEF SECRETARY-

cc Chancellor
Mr Anson
Mr Phillips
Mr A J C Edwards
Mr Turnbull
Mr McIntyre
Mr Potter
Mr Saunders
Mr A M White
Mr Call

COMMUNITY CARE POST-GRIFFITHS: INTER-DEPARTMENTAL REPORT

You decided, having seen a sketch of the alternative organisational options for delivering community care following the publication of Sir Roy Griffiths' report on 17 March, that you would leave it to Mr Moore to make the running and come forward with proposals.

2. The inter-departmental group of officials (including Treasury) set up by Mr Moore to review the various organisational options has now produced its report. You probably will not want to read most of it, for it is long and turgid; the Summary and Conclusions are in chapter 1, and you might also read chapter 9. There is very little on costs: mainly in chapter 8, paras 8.2 to 8.10.

3. While the report does not come down in favour of any particular option, the balance of the argument in the report (as in the Griffiths and Firth reviews before it) is in favour of a local authority-based solution (effectively an improved version of the Griffiths model, with greater safeguards to ensure fair competition between local authority and private residential care). But we have ensured that a fair hearing is given to at least 3 central government options.

4. There is no action for you at present, unless you wish to inject any thoughts at this stage. We understand that Mr Moore will write to you and other colleagues with his proposals on the report next month.

The report's conclusions

5. The report (rightly in our view) concludes that 'no change', or only 'minimal change' to the existing arrangements, would be unacceptable. It is essential from the Treasury's point of view that the massive rate of increase in social security expenditure on residential care in recent years is ended. Tinkering with the present arrangements will not achieve that. Instead, a single "care authority" has to be given the financial responsibility for all types of care (for those who cannot afford to pay for it), whether residential (private or local authority) or domiciliary.

6. The report concludes that the only feasible options are either an LA-based model (ie Griffiths "plus") or some form of central government authority - either a new Community Care Authority (taking over the present LA responsibilities plus the care costs of private residential care), a Primary Care Authority (adding on to those non-health care services the Family Practitioner services and the community health services of the DHAs), or a Health Authority model (bringing together all DHA services and the LA community care services, but not the FPC services). Each of these options should control the growth in social security expenditure, allow the development and effective management of a unified community care budget, remove the 'perverse incentive' towards residential care (at the expense of eg cheaper domiciliary care), improve the diversity of supply, and make care more appropriate to individuals' needs through personalised care packages. (Either of the two options bringing in a part of health care would of course need to be considered alongside the proposals emerging in the NHS review.)

7. Options rejected by the report are Joint (CG and LA) Boards, an organisation based on the local social security offices, and a model based on the FPCs but without the further responsibilities of the Primary Care Authority.

LA-based option

8. The report considers an option which represents an improvement on the Griffiths model since it involves a statutory requirement on local authorities to introduce competition for

existing services, and to offer choice to consumers. This should therefore ensure a "level playing field" between the private sector and local authority provision of residential accommodation, thereby maximising choice and efficiency. We are aware that you and other Ministers see some difficulties in giving LAs more responsibility in this field. While the report reaches no conclusion about the relative merits of the options, it is clear that this one has a number of advantages over the central government options.

Central Government options

9. The main drawback with any central government option is the severe disruption (and associated costs) involved in splitting LA social services departments down the middle, with the new body given responsibility for community care. Within the CG options, the main question, which can best be resolved when more is known about the likely outcome of the health review, is whether to bring in some of the health care or not.

10. The central government options bringing together health care and non-health care (either the Health Authority option or the Primary Care Authority) have the advantage of bringing together most of the services which might be required by an individual. However both have the corresponding disadvantage of imposing a greatly increased management role on the authorities in question. Even if the health review suggests some restructuring of either the DHAs or the FPCs, that would not necessarily be an argument for adding community care to the restructured organisations. While it would in principle allow a more integrated approach to resource allocation and management, setting up new organisations of such size would involve very substantial short and long-term costs and disruption.

11. There could also be a further significant difficulty with the health authority model if HAs remained unable to charge for their services. At present, social services departments recoup 12% of their revenue from fees and charges (some 37% in the case of residential care). That would be lost unless HAs were given comparable powers.

12. On the other hand, the non-health model, the CCA, might be politically contentious, giving rise to accusations that this option had been chosen for no better reason than to take away from local authorities a further large and important area of their responsibilities. And as with the health options, the upheaval and costs involved in setting up a CCA would be considerable, and would give rise to severe transitional problems. It would probably mean that management effort - at least initially - was concentrated as much, if not more, on setting up new systems than on developing services and promoting competition.

Costs

13. The report does not provide detailed costings of the various options. Chapter 8 identifies a number of expenditure pressures common to both the LA and CG models. It notes that these would undoubtedly be less for a LA option although, against that, the CG options (once established) would offer a better prospect of expenditure control than leaving decisions about spending to LAs. The items costed include the introduction of an assessment of care needs, imposed as a requirement on clients who wish to enter residential accommodation at public expense (the report estimates the cost at £6 million a year); developing new management information systems (£15-20m); and training (£12-13m). Against these costs are the anticipated savings on social security and from the introduction of increased competition and a budgetary discipline. Together, these savings are (very broadly) estimated at £125m a year by 1993. There would however be further transitional costs arising only under the CG options, for example staff transfer costs (£50-60m), redundancy costs (£15-30m), possibly significant capital costs for new accommodation (£50m), together with the costs associated with splitting up LA social service departments (£50m). All of the costings in the report are quoted for illustrative purposes only, and do not make any assumptions about how far they would have to be incurred; this would of course depend on the availability of resources.

14. There were two particular areas of disagreement amongst members of the group. The first centred on whether an LA-based option should be underpinned by a community care specific grant. The DHSS representatives were strongly of the view that a specific grant was necessary to give central government adequate leverage over local decision-making; we and the DoE argued that only a

temporary specific grant, targeted to ensure that existing individual entitlements to support in independent residential and nursing homes were preserved, would be appropriate. Experience suggests that specific grants are better at levering extra spending than at persuading LAs to take the decisions that government wants.

15. The second point of disagreement concerned the "loophole" of hospital care for the elderly. We argued that, other than under the health authority option, a care authority would have a considerable incentive to avoid costs by pushing the elderly into (or refusing to take them out of) hospitals, where all the costs are at present borne by the health service, in order to prevent the residential care cost falling on its own budget. We suggested that this might be resolved by giving a health authority the power to cross-charge the care authority for hotel charges, once the person was judged medically able to leave hospital. The other members of the group (and DHSS in particular) did not accept that this would be a significant problem, arguing that, by the same token, it could lead to charges against health authorities for community care services needed by patients on hospital waiting lists, and that the proposed solution might give HAs an incentive to discharge patients before it was medically appropriate.

Handling

16. Decisions need to be taken on broadly the same timescale as the NHS Review, lest options be foreclosed unnecessarily. We understand that Mr Moore will put forward his conclusions on the report next month, and that the Prime Minister is expected to call a meeting early in September. We do not consider (and the report agrees) that 'minimum change' - still less no change - are attractive options. Neither would tackle the fundamental public expenditure problem, let alone address the care delivery and market development objectives or help to improve value for money. It is therefore to be hoped that Mr Moore will conclude that action must be taken to bring together responsibility for community care decisions and finance so that effective expenditure control can be exercised.

D RAYNER

ST

~~9/2/88~~ - 26/7/88

27/10/88

psl/82A

CONFIDENTIAL

FROM: A C S ALLAN
DATE: 26 July 1988

PS/CHIEF SECRETARY

cc Mr Anson
Mr Phillips
Miss Peirson
Mr Call

COMMUNITY CARE POST-GRIFFITHS: INTERDEPARTMENTAL REPORT

The Chancellor has seen Miss Peirson's minute of 25 July to the Chief Secretary.

2. He does not believe in the fashionable doctrine of "care in the community" as the universal answer. In many cases, institutional care is manifestly right, and the closure of a large number of small institutions, under the banner of "care in the community" is causing untold tragedy. (He does not believe, at the end of the day, it even saves any money).

A C S ALLAN