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PRIME MINISTER

COMMUNITY CARE

You were anxious during the NHS review that Ministers' attention should not be distracted by the follow up to the Griffiths Report on Community Care. But, now that the NHS review is complete you agreed last month that progress should be made on community care. You are having a meeting next Tuesday with Kenneth Clarke, John Moore, Nicholas Ridley, Malcolm Rifkind, Peter Walker, John Major and David Mellor to take stock.

I enclose some papers you may like to look at over the weekend.

Flag A	minute from Kenneth Clark
Flag B	Department of Health paper on community care
Flag C	Department of Health paper on services for the mentally ill
Flag D	brief by Ian Whitehead
Flag E	further background note by Ian Whitehead.

I also enclose for general background a copy of the Griffiths report itself, together with the separate report that came out at the same time by Lady Wagner (to which Ian Whitehead refers and in which he comments in particular Chapter 3).

Cabinet Office brief will be available on Monday.

The issues here are complex, and it is difficult to see a clear way through. There are also substantial differences of view between Ministers.

Kenneth Clarke suggests in his minute at Flag A that you need to start by standing back and considering the underlying policy issues, before plunging into the organisational issues on which Griffiths focussed. I am sure that is right. You cannot hope next Tuesday to have more than a Second Reading debate.

(PAUL GRAY)

17 March 1989

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COMMUNITY CARE: THE BACKGROUND, PROBLEMS AND OPTIONS

Paper by the Department of Health

I. The Immediate issue

1. There has been a growing feeling on the part of service users and providers that they have been left to struggle with the complexities of community care policy - which is now some 20 years old - because its implementation has not been sufficiently well focussed or managed. These feelings have been effectively endorsed in a series of reports between 1985 and 1988 - from the Social Services Select Committee, PAC, NAO, Audit Commission - which showed progress to be patchy, slow and incomplete. Weaknesses in funding and organisation have been identified as the critical issues to be addressed, the most obvious symptom being the explosion of Income Support expenditure by DSS to assist people in residential care and nursing homes.

2. At the same time, community care policy per se has been consistently reaffirmed and can demonstrate real achievement. There have been desirable reductions in long stay hospital populations and greatly improved throughput of geriatric in-patients linked to changes in geriatric practice. This has enabled larger numbers of vulnerable people to lead more independent lives in the community, who - in earlier times - would have been admitted to and remained in institutions. This has been achieved though progressive, if slow and variable, development of services in the community. It is where those services are lacking, or insufficiently well organised, that implementation of the policy has been least effective.

3. In 1986 the Government commissioned Sir Roy Griffiths to review options to improve the use of public funds for community care. He reported in February 1988. His work, and the debate generated by it have raised widespread expectation of action to reform the funding and management of community care, and frustration at the absence of decisions to date.

II. What is community care?

4. Community care can mean different things to different people and can embrace a wide variety of things. For present purposes it can be regarded as the means by which people who are vulnerable by virtue of old age, mental illness, mental handicap, or physical disability are enabled to live in their own homes, or equivalent domestic settings. The needs of younger physically disabled people can be considered separately, but are frequently linked with those of the other groups.

5. Medical and nursing care contribute importantly to achieving that objective. But frequently the critical factors in determining whether a person can stay at home are more practical such as quality of housing, help with personal tasks (dressing, feeding, toiletting), with domestic tasks (cleaning, washing, cooking), with transport, with aids and adaptations, with personal budgetting, with social life etc. Support for caring relatives and friends is often as crucial as support for the individual directly concerned. These services are largely delivered by the Personal Social Services Departments of local authorities.

6. The original drive for community care policy came from a desire to reduce the numbers of elderly, mentally handicapped and mentally ill people in long-stay hospital care, following a number of scandals in such institutions and a determination to improve the quality of life of the people concerned in more normal settings. Between 1974 and 1986 the long-stay hospital provision was reduced as follows:

Average daily number of beds occupied in NHS hospitals in England

	(Thousands of beds)	
	1974	1986
Elderly	51	49
Mentally Ill	90	62
Mentally Handicapped	50	34
Total	191	145

7. At the same time Health Authorities (HAs) have been re-designing services to provide much more out-reach and community based work. They are reluctant to admit people just for custodial care. The emptying of long stay hospitals still colours the debate although the issue now is much more about support outside hospital - largely through the local authority, voluntary and private sectors - for people who have never been admitted. This is also where the big numbers are. It is relatively straightforward to close beds, but much harder to build up the necessary wide range of services, across agency boundaries, from a very low base.

8. Government has supported and helped the transition from hospital community care by requiring health authorities and local authorities to set up joint planning arrangements, including the voluntary sector, and by providing top-sliced NHS finance to fund community care projects (£113m in 1988/89). Also, the community care grants in the Social Fund (budgetary provision of £60m in 1988/89) are intended to help people leave or avoid institutional care, although so far it is too early to say how successful these will be.

9. Local authorities have a wide range of statutory powers and duties to help vulnerable people in the community, and are currently responsible for meeting non-health care needs in their areas. They are able to charge for these services (subject to means) and do so to an extent that varies from place to place.

10. The major new feature in the community care debate is the rapid growth of private residential and nursing home care, mostly for elderly people, and funded to a considerable extent by special income support payments to residents. The debate is now as much about residential versus "home" (including "day") care, as about hospital versus "community" care.

11. The range of non-hospital services provided, and recent trends in their provision, are shown in Annex A. Two points are worth noting:

- residential and nursing home care has increased by significantly more than would have been expected as a result of the increasing numbers of elderly people in the community;

- although non-residential services generally have increased in real terms, all but meals on wheels have declined in relation to numbers of people aged 75 and over (partly perhaps because of the proportion who have found their way into residential and nursing home care).

III. Who needs community care services?

12. Estimates of future community care needs are difficult to make. On the one hand, numbers in need can be expected to be growing, because of the increasing elderly population; increasing chances of surviving with a handicap; and the effects of switching from in-patient to community based care. On the other hand, the largest group (elderly) is likely to benefit from improved health and personal prosperity.

13. Increases in the elderly population can be reliably projected, as shown in the following table and annex B.

Growth in Elderly Populations (thousands)

	1980	1990	2000	2010
65-74	4,648	4,463	4,268	4,531
75-84	2,328	2,794	2,882	2,819
85+	530	776	1,049	1,185
TOTAL	7,506	8,033	8,199	8,535

On present trends about 5 per cent of the total are likely to suffer from moderate to severe senile dementia - an increase of about 50,000 over the period.

14. Available evidence suggests that most elderly people want to stay in their own homes for as long as possible. Support for their carers (relatives or friends) will continue to be critical (85 per cent of senile dementia sufferers are cared for at home). The increasing age of people caring for elderly relatives is an emerging issue, and there is an emerging conflict between the desire to encourage people back to work, and prolong their working lives, and the desire to rely on relatives for "first-line" home care.

15. The most obvious trend in care for elderly people has been the rapid growth of private residential and nursing homes, closely connected with the availability of social security Income Support (IS) payments covering the cost of such care. IS spending on allowances for residential and nursing home care has increased from £10m in 1979 to £878m in 1988. The trend is displayed in Annex C.

16. Services required by people at home are not easy to estimate. Community nurses play a major part in meeting health needs. There is a strong tendency amongst LAs to spread services thinly, to meet the largest number of demands, rather than to target them on those most vulnerable, and there is an obvious financial incentive to make the most of the availability of income support for residential care.

17. Numbers of mentally handicapped and mentally ill people in the community are also hard to estimate. The limited information available suggests that in each group there are likely to be about 150,000 people in the community who are sufficiently disabled to require significant support. Mentally handicapped children being cared for by ageing parents unable to provide care indefinitely are an emerging need, and there is the serious and well known risk of mentally ill people being "lost" on discharge from hospital. Specific mental illness issues and possible initiatives are addressed in a separate paper.

18. There is a large and vociferous population of younger physically handicapped people in the community ($1^3/4$-2 million people under 65 - but undifferentiated by severity of handicap). Their needs can be considered separately, but are often linked to the Government's general position on community care.

19. People do not fall tidily into these categories. Large numbers of elderly, for example, suffer some form of physical disability, and significant numbers are mentally ill.

20. Although it is not directly relevant to this paper, the Government's review of disability benefits needs to be kept in mind.

IV. Perceived weaknesses in present arrangements

21. Poor value for money in the present arrangements results from:

- lack of comprehensive control over expenditure;
- a "perverse" financial incentive structure favouring residential and nursing home care;
- poorly defined and not always well co-ordinated responsibilities for arranging personal care, and associated weaknesses in accountability;
- poor or inadequate assessment of priorities and targetting of resources in relation to individual need.

22. Although the scale of income support for residential/nursing home care can be contained by controlling the average size of payments, there is no limit on numbers (subject to means test). The incentive to make maximum use of this open-ended facility is not constrained by any assessment of individuals' needs or consideration of alternative means of care which could be cheaper and/or better, and homes have an incentive to admit the least dependent of those who qualify.

23. As a result, a lot of resource goes to support people in residential care, some of whom may not want or need to be there. That resource is not available to the agencies who could make other, and more appropriate, care choices. One of the complexities of community care is that each individual requires a different "package" of services. There is currently inadequate assessment of individuals' needs in the community setting and poor co-ordination of services at strategic, middle-management and at user levels. What happens to people can be as a result of the vagaries of the system rather than a proper assessment of need.

24. Growth in income support for this care is set to continue not just because of demography but also because the incentives within the systems encourage users and providers of services to maximise take-up. A current DH projection taking account of those factors is:

Projections of IS spending on Residential Care and Nursing home allowanees (£ billion at current prices)

1989	0.9
1992	2.9

DSS believe the 1992 figure is likely to be too high. Current DSS PES provision is £1.85 billion.

25. The extent to which recipients could be more cheaply and/or better provided for in non-residential settings is debatable. The limited research evidence available suggests perhaps 23 per cent of people entering residential care from the community (and 17 per cent of all those entering such care) might have been supported for longer in their own homes had suitable day and domiciliary services been available. Much would depend on the availability of non residential services and how effectively they were managed.

26. There is no local responsibility for the cost-effectiveness of income support for this care.

27. Where progress in other forms of community care has been made it has rested on committed individuals working against or in spite of, rather than through, available mechanisms. Lack of clear responsibilities can lead to duplication or neglect.

28. Poor quality and inappropriate care can readily result. The incentive towards residential care reduces demand for "day" and "home" care, and militates against individuals' preference for support in their own homes, and Government's desire to support independent living.

29. Consumer choice is limited by the absence of any incentive for well-managed, and suitably targetted home care services; and consumers face a bewildering array of organisations, with no focal point clearly charged with enabling them to respond to their difficulties.

30. Although there is a thriving private market for residential and nursing home care, the private sector has much less incentive to develop non-residential services. Providing such an incentive would improve consumer choice and value for money.

31. At present the limits on the fees that can be met from income support are not uprated in line with prices. These limits are coming under increasing pressure, and there is a real risk of some vulnerable people in residential care being unable to afford the fees. The numbers are not yet significant, but "hard cases" are likely to increase. HAs cannot lawfully "top up". LAs cannot normally "top up" for people over pension age. Closure of some homes is reported, although the numbers so far do not appear to be significant.

32. The availability of income support has been a significant safety-valve in helping some dependent people to avoid long-term hospital care, and can be crucial in supporting valuable group homes run on domestic lines eg for mentally handicapped people; but not all people needing such care are eligible for income support, and "bed-blocking" remains a serious concern to hospital managers. It would be likely to increase if income support were constrained without improved means of enablling hospital patients to be discharged into the community with adequate support there.

33. Accountability for community care is dispersed and diffuse. The absence of comprehensive accountability locally is particularly apparent.

V. Main remedies so far advanced

34. The following options have been set out in some detail in the reports of Sir Roy Griffiths, the Audit Commission, and the Inter-Departmental Group of officials. Only their key features are outlined here.

A. Audit Commission - Integrated budget (ie transfer of income support resources to budget holder) - HAs "lead" agency for mentally ill - LAs in lead for other client groups.

B. Sir Roy Griffiths - integrated budget under LA control - all client groups - "enabling" role - specific grant funding - emphasis on LA planning systems - payment of grant conditional on Government approval of plans.

C. Official group - as B, but with requirement of competition, monitored by Audit Commission, to limit LA's ability to build up own services at expense of mixed economy. Ministers also wish to consider other means of constraining, or prohibiting LAs' provision of services, subject possibly to requiring them to be providers of last resort.

The official group also described other ways in which the sort of integrated budget advocated by Sir Roy Griffiths might be managed ie through health authorities, or a new agency of central government which might or might not embrace community health as well as social services. All such options would require a major transfer of functions from local authorities to the central government agency.

VI. Government's objective

35. In considering possible remedies Ministers will wish to decide which of the specific problems in section IV they wish to tackle, and with what priority.

36. A feature of this subject, however, is that action to deal with any one aspect of the subject will almost certainly affect others.

37. It may be helpful to consider adopting some guiding principles for any action. Possible objectives might include

- Ensure the identified non-health care needs of dependent people in the community are met as far as available resources allow.

- Ensure publicly funded residential and nursing home care is provided when and only when it is necessary alternative support in the community being unsuitable for the individual, inadequate or too costly.

- Control growth in social security spending on residential and nursing home care.

- Avoid unnecessary use of NHS resources.

- Improve value for money.

- Encourage private and voluntary provision for domiciliary services.

- Improve targetting of domiciliary services on those most in need.

38. All the options in section V are based on a judgement that the greatest benefits are likely to flow from an approach that pulls together the relevant financial and managerial responsibilities. If B and C are ruled out, because of doubts whether local authorities would manage effectively the increased resources and responsibilities that would be placed on them, and/or the necessary support in Parliament would not exist; and if a complete transfer of local authority functions to an existing or new agency of central government is also ruled out, other approaches, not based on the same presumption, will need to be considered.

39. One possibility, described in a separate paper, is to develop a specific approachfor community care of long-term chronically mentally ill people, and to consider separate strategies for other client groups.

40. Two additional options, which have not yet been discussed with all the departments concerned, could be considered:

Option D. Simply apply some form of "care test" to applicants for the income support allowances, with the aim of deciding, in the light of available services, whether residential/nursing home care is necessary. Those that "passed" the test would receive the appropriate allowance (subject to the existing means test). Those who "failed" could be referred to health and local authorities who would remain responsible for domiciliary services. The costs of applying such a test might be from 6m to £15m pa at current prices, depending on the tasks to be carried out. Any reduction in IS allowances would be offset in part by IS payments in the community, and the costs of providing domiciliary care. If 10 per cent of applicants "failed" the test, the net effect might be to achieve significantly reduced growth in total public expenditure (possibly as much as £30m in 1992), although this could reduce if the new care test increased the pressure to provide higher payments, ar attracted new applicants.

Option E. A more comprehensive approach would be to appoint a local agency - which could be a district health authority or family practitioner committee - both to administer a "care test" as in option D, and to act as an "enabling" authority to secure domiciliary care both for those who "failed" the test and for hospital patients ready for discharge but unable to return home without some intervention to secure appropriate domiciliary care and therefore "blocking" beds for longer than necessary. Such an agency might cost around £54m pa at current prices depending on the numbers of people needing to be dealt with by it. The reduced growth in IS allowances might be larger than in option D, but so would be the offsetting IS costs in the community, and costs of domiciliary care. This approach could be more effective in diverting people from residential care because it would combine the "care tests" with some ability to put in place some domiciliary services as a serious alternative. For the same reason this approach should ensure more hospital beds would be released. Such an agency might, or might not have as part of its budget the "care"

element of IS allowances for residential/nursing home care. If it did not, it would not directly tackle the perverse incentive. The agency might take over the existing responsibilities and relevant finances of health authorities and local authorities for the registration and inspection of private nursing homes and residential care homes. The agency would not provide or run any services itself. It would purchase provision from health authorities, local government or the private sector. For this purpose relevant resources and responsibilities would be transferred from health authorities and local authorities. The net effect might be to reduce growth in total public expenditure more slowly than in option D (perhaps £10m in 1992).

41. Either of these approaches could be accompanied by other, lower key initiatives focussing on the development of best practice, and improvement of quality assurance.

Other issues

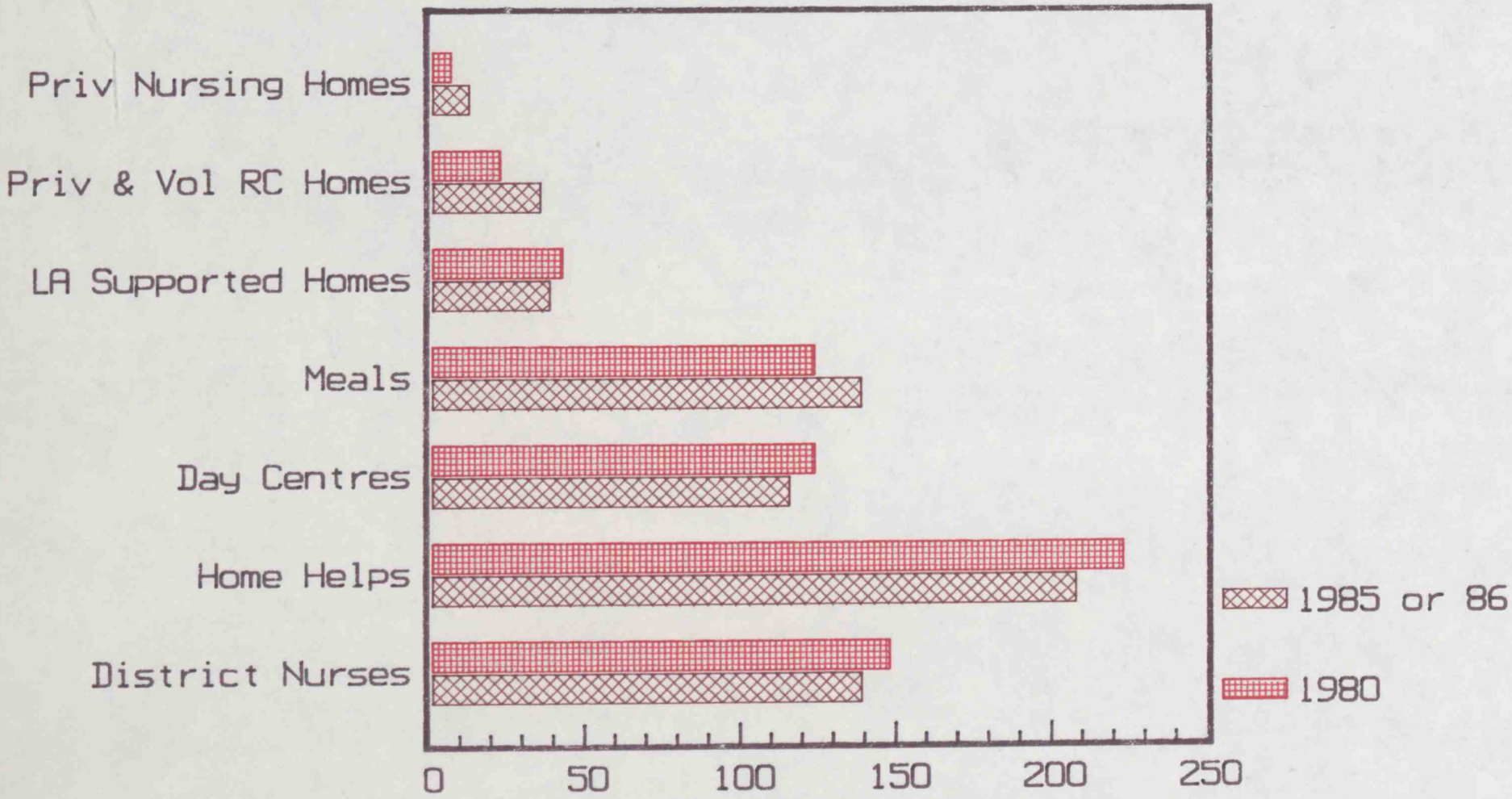
42. Any conclusions will need to address implementation issues, including needs for legislation, desired timetable etc.

43. The remit given to Sir Roy Griffiths, and his report, have raised expectations of wide-ranging reform. Anything less may need to be presented as part of a comprehensive statement on community care policy and its future implementation.

44. Whichever course is adopted further work will be needed on specific issues.

14 March 1989

Trends in Support Services By Year



ANNEX A

TABLE 2

ACTIVITY DATA

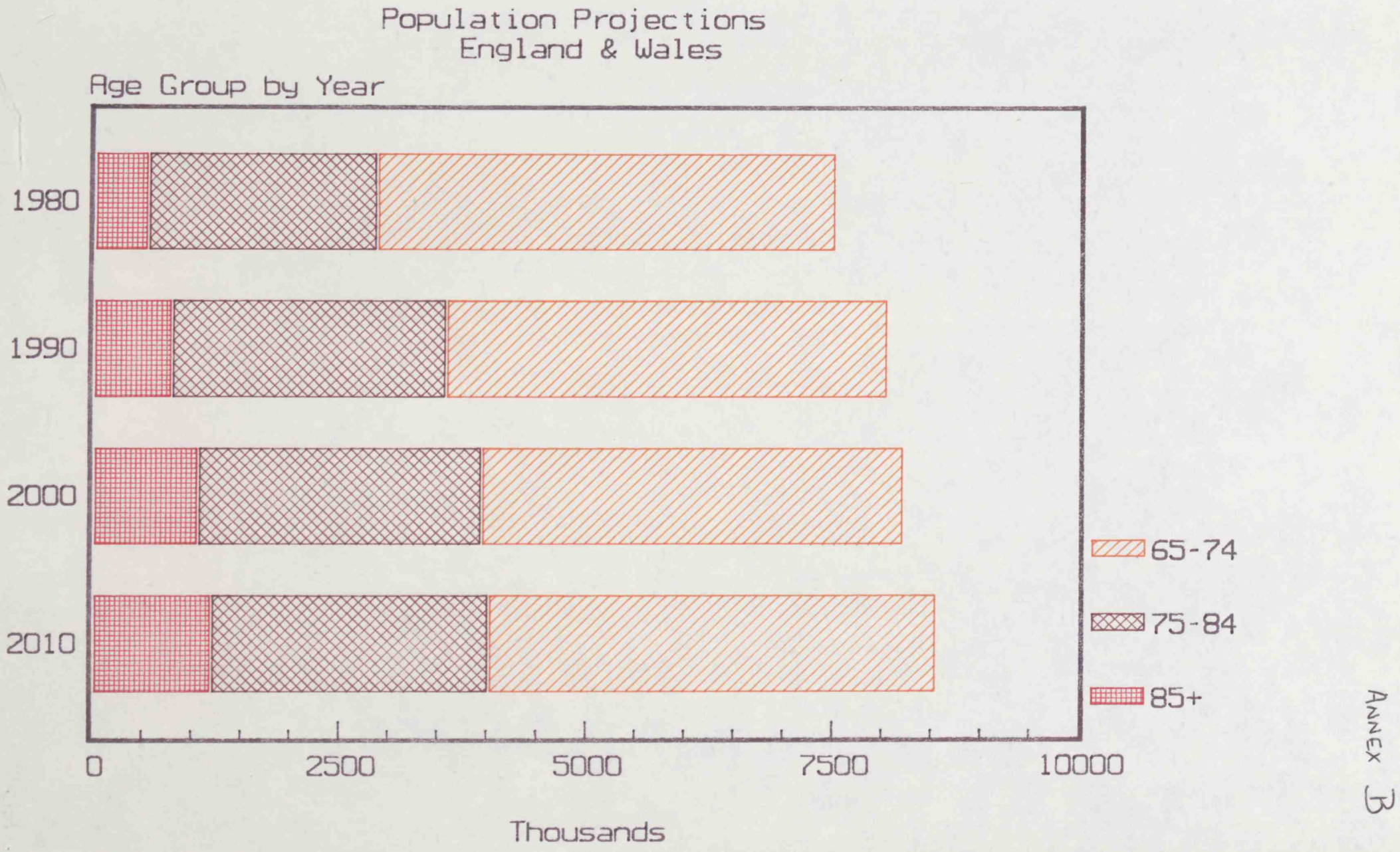
	1980	1986
Private and Voluntary Residential Care Homes	76,609	141,011
Private Hospitals and Nursing Homes	20,000	44,000
LA Residential Homes (Places)(1)	123,638	126,490
Meals (million)	41.7	44.1
Home Helps (No of users over 65)	636,048	646,596*(1985)
Day Centres Places	89,870	103,998
Numbers	1,400	1,673
District Nurses - WTE	13,905	15,187
- Numbers Nursed (Thous)	3,421.0	3,435.7
Community Psychiatric Nurses - WTE MI	1,080*(1981)	2,530
- MH	230*(1981)	1,100

(1) Includes places in unstaffed premises

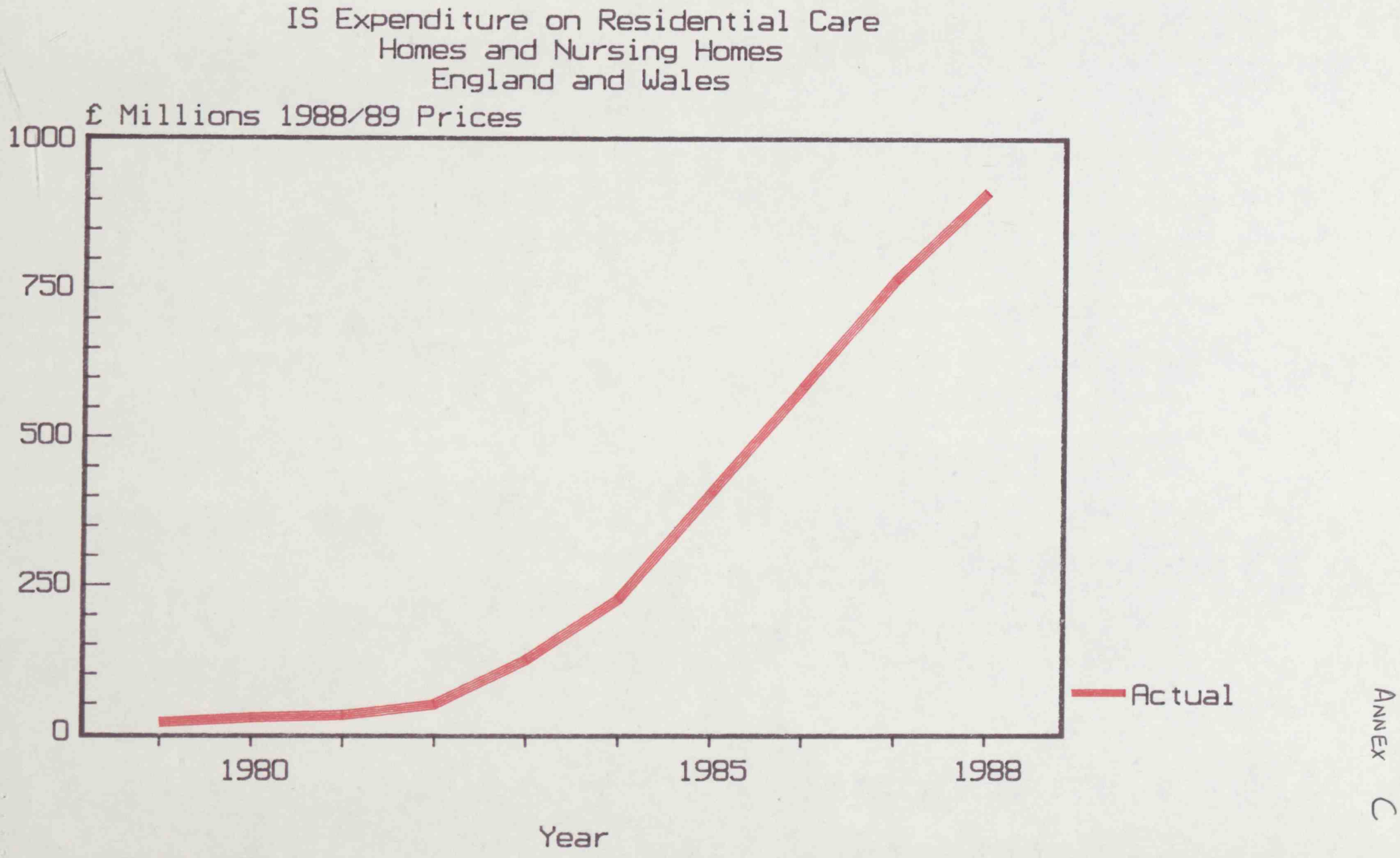
TABLE 3

EXPENDITURE ON PUBLIC SERVICES [£m)

	1980/81	1986/87
LA Residential Homes	910	1001
Meals	57	66
Home Helps	319	404
Day Centres	189	263
HA District Nurses	183	230


Population Projections
England & Wales
Age Group by Year
1980
1990
2000
2010
65-74
75-84
85+
0
2500
5000
7500
10000
Thousands

ANNEX B


IS Expenditure on Residential Care
Homes and Nursing Homes
England and Wales
£ Millions 1988/89 Prices
1000
750
500
250
0
1980
1985
1988
Year
Actual

ANNEX C