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cc Ballard
cc P.L.
cc Richard Wilson

CONFIDENTIAL

PRIME MINISTER

COMMUNITY CARE

Your Ministerial Group are meeting on 19 April. I shall be circulating for that meeting further papers on care for the elderly and the mentally ill.

2. I am to see you for a preliminary word on 11 April because I thought it would be very helpful to discuss with you before the meeting my general approach to the main issues and how I propose to handle an area of growing sensitivity.

3. We all recognise that Roy Griffiths' report on Community Care has focused considerable interest on what was already a significant social issue. The problems it sought to address are substantial. Interest has been further stimulated by our White Paper "Working for Patients", in part because it did not, seek to deal with community care matters.

4. The growing public interest and concern with these matters reinforces my view that we should aim to reach early conclusions on the way forward and make an announcement setting out our conclusions before the Summer Recess. As part of this exercise we need to identify those matters on which we can move forward without legislation and those which do need legislation, but could if necessary be incorporated without too much difficulty in either the NHS Reform Bill or in the Social Security Bill which are down for the next Session.

5. There are a number of different options, as our first meeting made clear. But if we are to convince people that we are making an effective response, we must deal with three central elements:

First, we must introduce a more even-handed system which does not favour residential care without simply looking as if we are restricting an existing and prized entitlement. In my view this means balancing the introduction of a care test for residential care by better help for those able to stay at home or in sheltered accommodation.

Second, and consistent with our approach in the NHS Review, we should ensure that responsibility for over-seeing these new arrangements is in the hands of an existing body which can be relied on to run the system and target help in the most effective way.

Third, we must encourage the development of a variety of service providers and the spread of best practice both in the public and the private sector. We should not turn the present arrangements upside down, but build on them in a way which underpins the support of individual and family carers.

6. I have gone again over the different possibilities for taking charge of this work. In brief my conclusions are:

* Roy Griffiths' solution was to give local authorities a lead role for the whole of community care with responsibility for the budget and for enabling care needs to be met whether at home or in residential care. As I made clear in my earlier paper to the Group, I do not consider local authorities have the capacity, or in some cases the willingness, to take on this important role in an effective and even-handed way.

* Another possibility would be to establish a central government agency, not as a new body but under the auspices of my Department or the Department of Social Security. I think we are all agreed that this would merely complicate matters further and give us the problem of creating and controlling a new public agency.

7. This leaves us with the NHS. I believe that our best option is for health authorities to take on a new role in relation to community care. Under it they would have two functions:

First, as gatekeeper for social security payments for those in residential or nursing home case.

Second, as purchaser or supporter of home care services for those judged able to stay at home or in sheltered accommodation.

8. To do this, health authorities would need a new and separate budget. The budget:

* would be cash-limited and ring fenced. It would not be available for services financed from health programmes;

* would pay for the assessment of need for residential or domiciliary care. This could be done by the health authority or, more likely, by arranging for other bodies to carry out the assessment;

* could be used to contribute towards the provision of packages of care for people at home or in sheltered accommodation to supplement those already available through existing agencies, including local authorities. Such contributions could be made in a variety of ways including cash credit to pay for particular services or to pay specified bodies to provide services;

* could be used to pay for contracts with private bodies or grants to voluntary agencies to develop service to help people to stay in their own home or sheltered accommodation. The aim of the contracts would be to act as catalysts to encourage the development of new services. These services, once established, could also be purchased by individuals or families with their own resources including those from insurance arrangements.

8th April 1989

KC

REACTIONS TO THE GRIFFITHS REPORT

Formal Responses to DOH

1. Ministers indicated on the report's publication that, although there was to be no formal consultation exercise, they would take account of reactions to the report in in drawing up their own proposals. To date, the Department has received over 250 responses, mainly from individual local and health authorities and members of the public. The majority have been positive with a general welcome for the recommendation that a statement on the objectives and priorities of community care be produced and for the appointment for a designated Minister of State.

Key Professional Responses

2. A number of formal responses by professional and management bodies have now been received. Others have indicated their views through the press and public statements. Summarised below are the reactions to date of most of the key organisations in the field :

Broadly Favourable Reactions

Association of County Councils - report has received all party support. Confident that County Councils can rise to the new challenge. The ACC have requested further discussion with Ministers about methods of funding.

Association of Directors of Social Services - welcome report and call for Government lead in reforming community care. Advocate establishment of community care development agency which would advise Ministers on service objectives, allocate grant and monitor performance.

Association of Metropolitan Authorities - welcome report and express willingness to respond constructively in discussions about implementation. But have taken opportunity to press for extra resources.

Audit Commission - hope that Government will act quickly to implement the report's recommendations. Payment of grant to local authorities should be made conditional on further progress to mixed economy model of provision. Commission would be willing to monitor and report on such progress.

BMA General Medical Services Committee - report should be implemented as a broad package of proposals, subject to further discussion on details.

National Association of Health Authorities - welcome in particular the emphasis on assessment of individual needs.

King's Fund - support the "exciting possibilities" stemming from

the report and its radical proposals. Have also produced a survey of management reactions, showing virtually total support for Griffiths in social services, with small majority of health managers also in favour. Both groups emphasised the need for early action.

Age Concern - welcome the report and urge Government to implement it as a package.

Mencap - report provides sound basis for solution to problems of community care. Hope Government will take early and positive action.

National Council fo Voluntary Organisations - broadly supportive, but express doubts about ability of voluntary sector to provide a major element of mainstream service provision.

BRITISH ASSOCIATION OF SOCIAL WORKERS - welcome the report, point out the tasks involved have implications for both organisations and resourcing. Emphasise that services must remain free at the point of delivery, concerned at the proposed extension of means testing.

Reservations Expressed

Royal College of Psychiatrists - support the proposal for a Minister of State for community care, but have reservations about the report's recommendations as they affect mentally ill people. The NHS should retain responsibility for the care of mentally ill people. The report places too much emphasis on the scope for private provision.

MIND - also has doubts about implications for services for mentally ill people.

Regional Chairmen and Regional General Managers - advocate making community care the responsibility of a new "community care and family practitioner authority", bringing together social care and primary health care and directly accountable to Secretary of State through Regions. A supplementary report recommended that GPs be made budget-holders and local managers for community care.

Royal College of Nursing - responded with an immediate rejection of report on grounds that it undervalued the contribution of nursing to community care. A fuller report emphasised the need for a national policy and national direction as the only answer to a problem (that of the growing numbers of dependent elderly) which they feel has been consistently underestimated. Called for establishment of a single authority uniting all health and personal social services functions.
services

Institute of Health Service Managers - welcome clarification of responsibilities, but wish to retain flexibility at local level over which agency takes the lead.

"COMMUNITY CARE: AGENDA FOR ACTION"

SUMMARY OF RECOMMENDATIONS

1. All agencies involved in community care should actively seek consumer views, and be guided by them in planning action.

2. Public agencies should recognise and act upon the support provided by informal carers .

3. Public agencies should assess the needs of an individual in his or her own situation and arrange packages of care in that light.

4. Social services authorities should designate "care managers" to be personally responsible for managing the delivery of a package of care to individual consumers.

5. There should be a designated Minister in DHSS responsible for community care , who should be accountable to Parliament for, inter alia, :-

(a) promulgating a definition of community care, its values and objectives;

(b) distributing central government funds to social services authorities;

(c) ensuring that national policy objectives and timescales are consistent with the resources available.

6. The major contribution to community care should be the responsibility of local government social services authorities .

7. Social services authorities should be responsible, inter alia, for :

(a) Seeking out individuals in their area who have previously unknown community care needs.

(b) Ensuring that the needs of individuals for social, domestic and personal support are regularly assessed and that arrangements are made to meet those needs within the resources available.

(c) Developing and sustaining informal and voluntary care resources and encouraging good practice in the private sector.

8. Regional and District Health Authorities should continue to be responsible for medically required community health services.

9. General medical practitioners should be responsible for informing the social service authorities of their patients' community care needs.

10. The responsibilities of public housing authorities should be limited to the arrangement and, in some cases, the financing and management of the "bricks and mortar" of housing.

11. Authorities should have powers to undertake joint action, including powers to act as agents for each other.

12. Funding of the community care responsibilities of social services authorities should be a financial partnership between central and local government, with the former providing around half the resources necessary to achieve national objectives through a specific grant.

13. The distribution of specific grant should be determined by needs indicators. Its release should be dependent on the existence of processes for setting and achieving costed objectives within a given timescale at the local level.

14. Within the specific grant system, there should be targeted specific grants for:-

(a) building up community services to enable people currently in long stay hospitals who do not need to be there to be discharged;

(b) the transfer to social services authorities of responsibilities for providing public funding to support individuals in residential and non-acute nursing homes.

15. There should be a general presumption that social services authorities should charge consumers the full cost of services provided by or through them.

16. The funds required to meet the community care objectives of district health authorities should be separately identified within their allocations.

17. Public finance for residential or non acute nursing home care should only be provided following an assessment of the need for care and of the financial means of the applicant.

18. Subject to a means test (consistent with that for income support), a social security residential allowance (of the order of £70 a week) should be payable to people receiving any form of residential care. Any additional costs could be met by Social Services Authorities.

19. District health authorities should be responsible for providing health care and treatment to residents of residential and non-acute nursing homes, and have an appropriate input into the inspection and regulation process.

NAT HEALTH: Expend / Eff - pr 20