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CONFIDENTIAL

COMMUNITY CARE : CARE OF THE ELDERLY

Note by the Secretary of State for Health.

I was asked to prepare a further paper for the group, setting out in the light of discussion costed options for providing further help towards care of the elderly at home, without introducing new entitlements; examining the best way of introducing an assessment of the need for residential care before income support was paid; and discussing how to ensure better co-ordination between the existing agencies active in community care.

2. Officials have prepared the note attached which deals with the issues involved and the choices before us.

3. Care of the elderly raises just about all the issues addressed by Roy Griffiths in his report, especially the balance between residential care and care at home. Looking at this again in the light of our earlier discussion, it seems to me that 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 as against care at home without simply looking as if we are restricting an existing and prized entitlement to help with residential care costs. 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, we should ensure that responsibility for overseeing 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 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.

4. 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 bigger 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.

5. This brings us to the NHS. I believe that our best option in England will be for health authorities to take on a new role in relation to community care. My preference for an NHS solution, however, is not just because we have seen substantial flaws in the alternatives. I see a number of positive advantages :-

The medical and nursing dimension. While much community care work does not have a direct medical or nursing component, we must recognise the fact that any care test

will have to incorporate a medical and nursing judgement, since a crucial factor will be whether the person concerned is still capable of looking after him/her self or being looked after at home. The framework for taking these decisions can therefore best be established by health authorities, who will be able to draw on the experience gained in developing procedures for the admission and discharge of hospital patients. Health authorities will, however, need to be careful not to over emphasize the medical and nursing element - they will also need to involve other professional workers like social workers.

Link to policies on the mentally ill. As my other paper explains, I believe the NHS should be the lead authority on the mentally ill. On this basis health authorities will already be involved in decisions on residential care and packages of care.

Experience of cash limited budgets. Health authorities now have considerable experience of operating within these conditions.

Government's commitment to priority care groups. Development on these lines will emphasize the Government does not want the priority care groups (the elderly, mentally ill, physically and mentally handicapped) to take a back seat. It will help to counter criticism on this score of our White Paper 'Working for Patients'.

Avoiding build-up of entitlements. The role I envisage for health authorities should minimize the risk of new 'entitlements' developing.

THE NEW ROLE OF THE HEALTH AUTHORITIES

6. In their new role in community care, health authorities would have two main responsibilities :-

* health authorities would be the gatekeeper for income support payments for those in residential or nursing home care. In practice this will not include local authority homes since income support is not normally paid to those in local authority homes

* where someone was judged able to stay at home or in sheltered accommodation if some additional support were provided, health authorities would seek to ensure that such support was forthcoming. It would not be part of the authorities responsibilities in this role to provide the service themselves.

Instead they would encourage its provision by other statutory and voluntary bodies, which might include health authorities discharging their other functions.

7. In carrying out these responsibilities, there would be four principal ingredients :-

first, health authorities would need to arrange for a care assessment to be carried out for those seeking income support for residential or nursing care. This could be done directly by the authority or they could arrange for it to be done by someone else e.g. a GP supported by a primary care team or a voluntary body which had the necessary expertise.

Second, health authorities would in appropriate cases seek to arrange the provision of individual packages of home care by another agency, whether statutory or voluntary. Health authorities as community care "facilitators" would not contribute directly to individual packages - it will not be desirable for local authorities to be given any encouragement to shift their responsibilities onto central government.

Third, authorities would stimulate the supply of care services for those in their own homes or in sheltered accommodation. For example authorities could enter into contracts with private bodies or make grants to voluntary agencies to develop such services. The aim would be 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.

Fourth, authorities will need a new and separate budget for this purpose, which would be cash limited and ring fenced. It would not be available for virement to other health service programmes.

8. It will be important to ensure that health authorities do not either become lobbies for much greater Government expenditure or use their new role to divert demand into the social security budget. But I believe that the new less political health authorities we are putting in place will approach this new task in a responsible and even-handed way. The overall effect should be to reduce the level of expenditure and improve value for money, as compared to the simple continuation of previous arrangements.

9. Giving a greater role to health authorities raises the question of whether central Government would be held more

accountable for what happens in individual cases. The role envisaged for health authorities should minimize this risk. Central Government are, of course, substantially involved at present through social security.

10. I accept that we could make a much bigger impact on the balance between residential care and care at home if we were to transfer the budget for the care element of income support to health authorities, along the lines Roy Griffiths proposed for local authorities. While I do not rule this out once health authorities have become established in their new role, but to do this straightaway would produce too much initial turbulence.

TIMING AND HANDLING OF CHANGE

11. I envisage three stages in carrying forward these proposals :-

> Early announcement. We would announce our proposals before the Summer recess. The announcement would endorse the overall objectives of Roy Griffith's report, but explain that the Government considered that in a number of respects they could be better achieved in other ways.
>
> Legislation. We would establish the enabling legislative framework in next session's NHS Reform Bill, with any social security consequentials in next session's Social Security Bill.
>
> Gradual implementation. The role of health authorities, particularly in stimulating the growth of a greater range of service providers and in different care packages, would develop over time. In particular their capacity to discharge this role effectively would be greatly enhanced once they have taken on their role as purchaser and planner of services under our NHS reform proposals.

12. I propose to take advantage of this phased programme to test out our proposals on a voluntary basis over the next two years. In particular we need to be confident that we can operate a care test effectively and that our approach will not disturb existing patterns of family behaviour.

13. I therefore propose to invite a small number of authorities to volunteer to try out the new arrangements in a number of different ways.

> Care tests. Authorities would be invited to carry out tests themselves, through GPs and primary care teams and through voluntary bodies.

Care in home. Authorities would be invited to try out different ways in arranging care packages - by themselves, through GPs, by voluntary bodies and by local authorities.

RESOURCE IMPLICATIONS

14. I do not see my proposals as leading to a net overall addition to public expenditure as compared to the increase expected on present trends, save possibly on start-up costs. The likely costs and savings will be easier to identify when we have the results of the different health authority models. Meanwhile, officials have estimated that the cost of administering the sort of care test I have in mind (the first two points in para 7) would be £30 million a year.

CONCLUSION

15. Colleagues will have noted that much of my approach reflects the approach taken by Roy Griffiths - particularly the case for an assessment of need for residential care, the importance of striking a proper balance between residential care and care in the home, the value of an agency with an enabling and stimulating role and, overall, the need to take the initiative on community care.

16. But, as I have made clear, I believe that the role that Roy Griffiths assigned to local authorities would be better played by the health authorities. I invite colleagues to endorse this and my proposals for carrying matters forward.

K. C.

17 April 1989

IN CONFIDENCE

COMMUNITY CARE: OPTIONS

1. This paper, prepared by DH in consultation with OGDs, sets out options for addressing the issues identified at the Prime Minister's meeting on 21 March. Section 1 deals with a "care test" for social security support for residential and nursing home care; section 2 with ways of stimulating home care; and section 3 with collaboration between agencies.

2. The paper adopts the principles established at the discussion on 21 March:

2.1 Fundamental organisational and structural change is ruled out.

2.2 The key emphasis should be on enabling people to live independently for as long as they are able.

2.3 People have a responsibility for meeting their own needs and for helping to meet the needs of those they care about: support should underpin those responsibilities, but not transfer them to the State.

2.4 Residential and nursing home care should be supported by public funds only when adequate care and support can no longer be provided at home. Social security payments to meet the cost of residential and nursing home care for those unable to pay themselves should be made subject to an assessment of individuals' care needs, and whether they could be met in a more cost effective way at home.

3. The two annexes describe current services and arrangements for collaboration. They suggest that four points need to be kept in mind:

3.1 Local authorities are currently major players, having a wide range of statutory duties and powers, and spending £1573m in 1985-86* ,compared with £270m on hospital and community health services and £353m on social security payments for residential and nursing home care. Social security spending has continued to rise rapidly - to just under £1 billion - so these relativities will not have been maintained. Unless radical changes in responsibilities are envisaged their role will continue to be important and proposals for change will need to take account of that.

3.2 This paper addresses some of the issues that affect all client groups while focussing mainly on the elderly. It may be helpful to look at any proposed changes in relation to the needs of individual client groups. Mental illness has already been addressed separately. Other changes will be judged by their perceived effects on the needs of elderly (including mentally infirm elderly), mentally handicapped, and physically disabled people.

3.3 Any new service developments should be targetted on the most vulnerable. The intention would be to create a clear assumption that those who can, for instance elderly people who are asset rich and relatively able, will take responsibility for their own care for as long as possible. Public support should be reserved for those unable to fend for themselves through disability and lack of money.

3.4 Continuing complexity of community care from the point of view of the user suggests a need to focus on ensuring that points of access and skilled advice are properly in place and available to potential users.

*The most recent date for which comparable figures are available.

SECTION 1: ASSESSMENT OF NEED FOR RESIDENTIAL CARE

Introduction

1. This section looks at how a care test might be introduced to establish need for residential and nursing home care before the relevant Income Support could be paid. It describes a minimalist version,which simply seeks to establish whether residential care is necessary in the current circumstances: and an enhanced model which not only takes into account the existing availability of other services but also seeks to stimulate the development of home care services that might not otherwise have been provided. For each model the paper considers how the test might be administered; its costs and whether any form of appeals system is needed; the Agency which might administer it; and how financial incentives to choose the most cost-effective care might be introduced. In 1986, there were about 136,000 places in local authority residential care and over 142,000 places in private and voluntary residential homes, plus 44,000 places in private and voluntary nursing homes. Unless administered by local authorities the tests would not apply to people seeking places in local authority residential homes.

2. A care test might have the effect of preventing people who clearly did not need this form of support from entering residential care at public expense. But it is extremely unlikely that a care test alone can have a significant impact on the growth of social security expenditure. Most people, prefer to stay in their own homes if services are available to help them to do so, and for them residential care is a last resort. Unless the agency administering the test also has the ability to stimulate better home care, most people's choices of residential care (however reluctantly made) are likely to be confirmed.

The Care Test

3. All applicants for income support for residential or nursing

home care would be required to pass a care test before benefit could be paid. This requirement would apply to those currently living in the community and those who might be discharged from hospital. Applications from existing residents of homes who have exhausted their own resources could be treated in the same way as others, although it seems inconceivable that they be forced back into the community. This represents a potential loop-hole. In order to minimise unnecessary cost, the test would be applied after DSS had carried out an initial means-tested filter.

4. Whatever form of care test is favoured, it will be virtually impossible not to introduce some form of appeal mechanism. There is no immediate analogy within the existing system - but some form of professional panel would be necessary. This will carry a cost.

A Minimalist Care Test

5. In its most narrowly drawn form, the care test would be restricted to ensuring that publicly funded residential and nursing home care was provided only when necessary on care grounds and alternative support in the community was either unsuitable, inadequate or too expensive. Account would need to be taken of the range and suitability of comunity services available, but there would be no requirement on the assessor to seek to arrange alternative packages of care. The test would include assessment of an individual's medical and social circumstances, including need for medical and nursing care, social and domestic support and housing requirements.

6. Advice would be needed from doctors, nurses, social workers and occupational therapists. Providing this advice would generate costs from those who contribute. The task could be co-ordinated by staff employed to seek the necessary professional advice and arrive at a decision for each case, or could be "contracted out" to nominated professional teams.

7. It would be for consideration which Agency should take on this assessment function. DSS might seem a suitable candidate, as the test would be closely linked to benefit entitlement, but the work would be very different from anything they do at present and would involve skills and expertise they do not possess. There is also the risk that a test run by them would be seen as unlikely to be independent.

8. The cost of this minimalist form of care test would be of the order of £10m pa, and if done "in-house" about 300 staff might be required to co-ordinate assessments and reach decisions. This conservatively assumes 60,000 assessments pa, each taking 1 man day, and a cost of £30,000 pa per assessor, including overheads.

Advantages and Disadvantages of a Minimalist Test

9. A minimalist care test is a low cost device that would respond to the concern that people are unnecessarily drawn into residential care. However, it has clear shortcomings:-

- it would not do anything to stimulate improved home care, so would be more likely than not to "pass" the great majority of applicants;

- if - on the other hand - it did filter out significant numbers, it would give no assurance that their needs for home care would be met;

- there is a strong chance that a test of this sort would be seen by those who passed it as conferring a right to a place in a residential home, with the costs met from public funds;

- there is a danger that such a test would be portrayed as a crude cost-cutting device, rejecting individuals' own judgements of need without facilitating an alternative;

- the prospects of achieving net savings would be uncertain.

An Enhanced Care Test

10. An enhanced care test might go some way to overcome these problems. In this model, the assessment process would again include advice from doctors, nurses, social workers and occupational therapists (again this would generate a cost) and perhaps also voluntary bodies, families and carers before arriving at a decision as to whether residential care was needed. But those carrying out the process would have the additional task of identifying what might enable the applicant to continue to live at home, and of acting as a "care broker" or "case manager", deciding how a package of care might be put together to meet those needs in the most cost effective way.

11. The key requirements for those administering the process would be a good understanding of the range of services and benefits available, and an entrepreneurial approach to the organisation of home care "packages" using the private sector, voluntary bodies, volunteers as well as the publicly provided services.

12. For those judged capable of being supported at home, the assessors would either:

i. seek to arrange, with statutory, voluntary and private agencies, the management and delivery of suitable "home care packages", leaving the costs and any liability to charges to lie where they fell; or, in addition,

ii. in making such an arrangement, have a capacity to bring it about by injecting funds of their own.

The latter possibility is discussed further in paragraph 17.

13. The cost of the enhanced care test (leaving aside any additional funds for home care and their administration) would be

of the order of £30m pa, and if done "in-house" about 900 assessment staff would be needed. Assumptions here are as in paragraph 8, but allowing 3 days per assessment.

Advantages and Disadvantages of the Enhanced Test

14. Such an enhancement of the assessment process should make its introduction easier to present positively. The assessors would provide advice leading to better informed choices, and could thereby stimulate new forms of home care. But again there are certain problems:-

- assessment alone would not guarantee that services were provided by the statutory, voluntary or private sectors;

- by identifying and recognising people's needs, assessment could generate expectations which might not be met within available resources;

- there is a danger of creating a new incentive for people to apply for residential care in order to get their home care needs confirmed, and gain access to any new sources of funds.

Agency to Administer Enhanced Care Test

15. DSS is not an obvious candidate for administering this form of test. Social security officials are not well placed to form complex judgements about health and social care needs, nor to play any part in putting together packages of care. Although DSS might contract out the task, their interest in home care services is less direct than other candidates. Ministers have already indicated that they do not wish to set up a new authority in the community care field. The care test would therefore need to be administered by one of the existing agencies.

16. This suggests four possible options:-

A. voluntary organisations

B. local authorities

C. NHS - either DHAs or FPCs.

D. Central Government (perhaps through a "Next Steps" Agency).

Each is described and evaluated below.

A. Voluntary Organisations

i. In theory, Government could contract with a voluntary body active in this field (eg Age Concern), or with a consortium of several organisations, which would employ assessors to operate the care test. The voluntary body would either decide applicants needed residential care, so entitling them to receive benefit, or would advise on alternative package of services. Independent of Government, the organisation would be seen as able to give objective information and advice on the best care for the individual. Its employees would be likely to be committed to looking after people at home.

ii. The voluntary sector could be expected to have strong reservations about becoming direct agents of central Government in administering a social security benefit with a strong regulatory aspect, and many would question whether that was an appropriate function for voluntary bodies. Section 2 addresses the more promising prospect of further stimulating the voluntary sector contribution to home care services.

iii. Other problems in this option include:-

- no clear line of accountability for spending of public money;

- possible creation of a new and powerful body of advocacy

for consumer needs and increased public expenditure.

B. Local Authorities

i. Local authorities could co-ordinate the assessment process. They would be well placed to advise on home care needs and services, independently of the social security system. Some reluctance on the part of local authorities to take on this role is likely. Although they are used to assessing people's needs and ability to pay for services, they or their staff may be unwilling to become involved in what they would perceive as part of the assessment for social security payments without themselves having control of the resources.

ii. Other disadvantages:-

- without further attention to financial incentives, local authorities might see advantage in maximising the numbers who pass the care test;

- LAs might be biased in favour of their own in-house services;

- co-ordination of the assessment need not necessarily be a professional task but an LA model might lead to dominance of professional social workers in the assessment process.

C. NHS: DHAs or FPCs

i. Health Authorities (either DHAs or FPCs) could be given the task of administering the assessment process. They would need either to create a new body of staff to do so or to "contract out" the task to nominated teams. Access to potential sources of advice would be good. Health authorities would have strong financial incentives to minimise demand for health services.

ii. Points to consider include:

- health authorities have no direct experience of managing or delivering non-health services, which can be crucial in enabling people to live at home rather than in residential care;

- DHAs and FPCs may find it difficult to take on new responsibilities at a time when they ae facing major change on a number of other fronts;

- DHAs would have incentives to maximise the numbers of peple who either pass the care test (and so move onto the social security budget) or who are moved back into the community supported by local authority, and the former might prove easier in practice than the latter;

- Ministers would be more directly accountable for the results of assessment than under a local authority model.

D. Central Government ("Next Steps" Agency)

i. The Department of Health or DSS could run the assessment process through an Ibbs-style Agency set up for the purpose. If DH were to run it, the agency could perhaps come under the aegis of the Social Services Inspectorate, itself a candidate for Agency treatment and well-respected in the social services field. It would employ staff to co-ordinate assessment and, through a local or Regional structure, would provide a point of contact for advice and information on community services, being well placed to span both health and social services. The Agency would be independent of the social security system, and able to ofer impartial advice, untainted by the vested interests of some of the other possible authorities.

ii. But again there are significant drawbacks:-

- the service would have to be based on a far more localised structure than is currently the case;

- the assessment function would not square easily with the Department's desire to withdraw from direct service delivery;

- Ministers would be made directly accountable for the assessment process;

- the Agency would add to civil service numbers and to running costs.

Apart from the first, these disadvantages would apply whether DH or DSS were running the Agency. In addition, DSS might not be seen to be impartial.

FINANCIAL INCENTIVES

17. Whichever Agency administers the test, it will be easier to meet its objectives if there is a financial incentive to choose the most cost-effective form of care. There is a number of ways of achieving this, although some are likely to be more effective than others:-

A. <u>Unified Budget for Residential and Domiciliary Care</u>

The most effective way of tackling perverse incentives. It involves the transfer of part, at least, of the cost of income support for residential care to an Agency also having responsibility for funds to support home care. Ministers have already indicated strong reservations about such transfers to local authorities. They have also ruled out a transfer of local authority responsibilities to another agency. The only available option approaching a unified budget therefore appears to be one in which an agency other than local authorities (eg health authorities) becomes responsible for paying at least the "care" costs of public support for residential and nursing home care (leaving DSS

with responsibility for basic income support) <u>and</u> for administering some new programme expenditure in support of home care. New cash payments, or vouchers, for individuals would be the possibility least likely to interfere with existing statutory responsibilities for services. Another possibility would be a fund to support new home care developments. These are discussed further in Section 2.

B. <u>Budgetary Limits for Residential Care Expenditure</u>

The Agency administering the care test could be given a fixed limit for expenditure on residential care for the financial year, and would make its assessments within that limit requiring any excess applicants to wait. There could be penalties for exceeding the limit which would be easier to apply to a DH or DSS Agency than to local authorities or the voluntary sector.

C. <u>Home Care Funds</u>

Option B above could be accompanied by providing new funds for home care services, to be administered by the assessment agency in support of people judged not to need residential care. Options for stimulating home care are considered further in section 2 of the paper. Any new stimulus for home care could either be confined to applicants for social security support judged not to need residential care (in which case it could be administered by the 'care test' agency) or could be targeted less restrictively. The less restrictive approach would avoid creating a new perverse incentive to <u>apply</u> for social security in order to secure better home care.

EXPENDITURE EFFECTS

18. The effects of a care test on public expenditure depend on a number of uncertain factors. Because of demography, increased

public expenditure is to be expected in any event. The growth in income support for residential/nursing home care would depend on the effectiveness of the care test in diverting applicants to home care, and preventing health and local auhtorities from transferring ownership of their own homes to the independent sector. This will, in turn, depend on the availability of adequate and suitable home care.

19. The care test might divert anything from 5% to 20% of applicants depending on what financial constraints or incentives were created, how it was exercised and what home care was available. Any diverted applicants would be entitled to the income support and other benefits available to people living in the community which could use up about a third of the "saving" in support for residential care. Home care costs could be as much as the balance of the reduction in support for residential care, depending on its quality and quantity.

20. Given that the care test would require new expenditure, that other improvements in the management of home care might create additional costs, and that the effect of the changes might be to increase expectations and demand, the prospect of any significant reductions in growth of expenditure would be highly dependent on Ministers' ability to withstand such pressures.

21. Another key factor will be future decisions on the uprating of income support for residential and nursing home care. The introduction of a care test is likely to create expectations that income support will be sustained at levels adequate to meet the costs of the care judged to be necessary. If that was reflected in the decisions on uprating, it would have a tendency to push that item of expenditure upwards in relation to the numbers of people supported in that way. On the other hand, real increases in the income support limits might add to the perverse incentive to go into residential care, which would be at odds with the general thrust of policy.

SECTION 2: HELP FOR SUPPORTING PEOPLE AT HOME

INTRODUCTION

1. This section describes options for improving the care of elderly people at home. Elderly people are used as a proxy for other client groups, although each group has its own particular needs which may be best met through specifically targetted initiatives.

2. The options reflect the guiding principles laid down by Ministers:-

- help should not weaken the responsibilities of individuals or their families, nor the role of voluntary agencies;

- the voluntary and private sectors should be given active encouragement to extend their own roles;

- help should not create new entitlements but aim to provide a contribution towards the cost.

NEEDS OF PEOPLE AT HOME

3. Vulnerable elderly people and their carers have a range of needs to be met if they are to be able to continue to live at home. These include:-

- help with domestic tasks (eg cleaning);

- help with transport (eg to shop, maintain social contacts etc);

- social contact and support (eg to combat loneliness);

- help with accommodation (eg arranging repairs, adaptations, heating etc, or a move to sheltered housing);

- support to enable carers to continue to care (eg arranging respite from the daily routine);

- help with personal care (dressing, bathing, chiropody, and any specific health needs requiring nursing attendance);

- information and advice on what is available, and what might best be arranged.

It is unlikely that one person will need all these services at any one time, but over a number of years an individual or his family or carers may find that they require a range of help and advice of the sort described above.

4. At present these needs may be met from a variety of sources, but mainly local authorities, community health services, and the voluntary sector. In contrast with residential care, the private sector contribution to home care is less prominent and impossible to quantify, but it is clear that some home care needs are being met through the private market (eg home nursing agencies and domestic helps). Some local authorities are seeking to develop a more "mixed economy" for home and day care, most obviously through quasi-contractual arrangements with the voluntary sector. What follows is a "menu" of possible initiatives rather than a recommended package.

INFORMATION AND ADVICE

5. Many people would be able to cope better and for longer at home if they had basic information about the help and support available and some advice about how to obtain them. Improvement in home care could be brought about by improving access to such information and advice, although there would be danger - if done in isolation - of stimulating demand which could not be met.

6. Selected voluntary agencies might be asked to improve and develop the information and advice available to frail elderly people and their carers, in consultation with the voluntary, private and statutory agencies. this could be backed by some central grant. Depending on the scale of such an initiative, it might cost £5m pa. and last for 3 years (ie 1 project in 108 LAs. 1 1/2 full timers per project at £20,000 each + dissemination etc costs).

FURTHER DEVELOPMENTS OF BEST PRACTICE

7. The Government has already supported 28 pilot community care projects, focussing on the transition from hospital to community care, and costing £19m over 3 or 4 years. Their evaluation is complete, and there is a need to disseminate the results to inform and improve practice more widely.

8. Some authorities have pioneered valuable developments in home care eg Kent social services department where, in one part of the county, staff have been given indicative budgets for residential and home care and targets requiring home care to be provided where possible within 80% of the cost of residential care.

9. The Department of Health could mount an initiative focussing on the need to develop "home care packages" for the most vulnerable elderly people at risk of being driven unnecessarily into residential care. The voluntary sector, engaging with the statutory agencies and the private sector, would be encouraged to act as a catalyst at the local level, helping the statutory agencies to develop services more closely attuned to personal needs. A secondary aim could be to ensure that maximum possible use was made of the voluntary and private sectors.

10. Such an initiative might cost £ 1.25 m, spread over 3 years*, in order to enable selected voluntary bodies in selected areas to carry out the catalyst function.

A COMMUNITY CARE DEVELOPMENT FUND

11. Building on the initiative described in paragraph 7 above, something similar might be done, but focussing on home care services rather than the transition from long-stay hospital care.

12. The Department of Health would invite any agency - voluntary, private or statutory - to produce credible, worthwhile and innovative plans for improving home care services, developing case management, and supporting carers. They would be required to take account of the parts capable of being played by each of the relevant agencies, and their existing statutory responsibilities. The Department would offer a discretionary contribution rather than undertaking to meet full costs.

13. The plans would be required to meet specific objectives eg:

- targetting on the most vulnerable;

- making the most of the "volunteer" contribution;

- stimulating the "mixed economy" of service provision (ie the private and voluntary sector contribution);

- listening to the voice of the consumers, and their immediate carers, if any;

- those bidding to meet part of the cost.

* Experimental schemes in 4 areas. 3 full time staff each at £20,000, plus overheads.

14. In effect, the Government would create a community care development fund, focussing on care for people at home. Bids would be considered within an annual budget, but as part of a rolling programme, which would probably be time-limited. The fund could either be administered "in-house" or (more probably) through a managing agent. Evaluation and/or accountability reports, would be required.

15. The cost of such an initiative would depend on its scale (eg how many areas were to be covered, and how much support was to be given). There could be a capital, as well as current element in the programe (eg for day centres). To make a significant impact, it seems likely that at least £50m-£100m would be required over a 5-7 year period. The intention would be to stimulate service development. If time-limited, the existing statutory agencies would be expected to take up long term funding responsibilities.

CASH FOR INDIVIDUALS

16. An obvious way of stimulating the supply of home care from the private sector is to provide would-be consumers with cash (or vouchers) to buy such care. (Existing social security payments for the disabled are already intended for this purpose, and any initiatives of this sort would need to be consistent with decisions on disability benefits.)

17. The Government might create a fund on which an agency could draw to enable people in need of home care to buy the necessary services. An obvious agency for this purpose would be that appointed to administer the "care test" for residential care, since it could readily have access to the necessary information about needs.

18. To avoid entitlements, payments would have to be discretionary, depending on people's ability to pay and level of disability. Overlap with existing entitlements would have to be avoided. Budgetary management would need to take account of the

likelihood that the majority of payments to buy care would be continuous rather than time-limited.

19. If pursued, this option might include the community care grants from the Social Fund and the budget of the Independent Living Fund as part of the budget.

20. The costs of such an approach would need further analysis. Preliminary work suggests that there might be 2m* people seeking such payments (although experience suggests that forecasts of this sort under-estimate demand). To be credible, payments might range between £20-£50 per week on average. The annual cost would therefore be between £2080m and £5200m.

SUPPORT FOR CARERS

21. Carers - family, friends and neighbours - are key links in the network of suport which help elderly people live at home. Their lot can be made a great deal easier by timely offers of support, information and services from statutory and voluntary agencies. The needs of carers could have a prominent place in any possible new initiative, including extra funding for voluntary bodies working in this field.

HOUSING

22. Suitable housing is a vital element in keeping people out of residential care. People may often only need some relatively minor adaptations to their own homes. Any initiative should acknowledge the importance of this aspect of community care.

* OPCS Survey, disability categories 5-10, in private residence, less 20% guesstimate of people able to pay.

DEVELOPMENT OF LOCAL AUTHORITY HOME AND DAY CARE SERVICES

23. A separate way of promoting the development of home and day care services, would be through local authorities who have the main statutory powers. Central Government currently has no direct means of influencing the level, nature and direction of their expenditure. A targetted specific grant would give the centre some ability to promote better management and extend the targetting and availability of these services.

24. The development of local authority home and day care services has been patchy and uneven. Some authorities have taken steps to provide targeted and flexible personal and social care for vulnerable people, making greater use of the voluntary sector, while others have yet to move away from a traditional form of "home help" service. The Social Services Inspectorate has identified ways in which the management of home care might be strengthened. The objectives of a specific grant for domiciliary services would, in the light of this work, be to improve the targeting of services, extend the use of the private and voluntary sectors, increase the intensity and flexibility with which they are delivered, broaden the range of tasks involved to include personal care, and make services more widely available for people living with a carer.

25. Specific grants, targetted in this way with the aim of encouraging local authorities to go further down the "mixed economy" road, might cost about £30m pa., including central administration, and could be time limited.

SECTION 3: COLLABORATION BETWEEN AUTHORITIES AND JOINT PLANNING

1. The annex shows that the requirement on local authorities and health authorities to collaborate is enshrined in legislation, as is the structure and framework through which this collaboration should be achieved. Also, that some £100 m of resources currently underpins it. The real efficacy of this somewhat bureaucratic framework is, however, open to question. It was always the intention to re-examine collaboration and joint finance in the light of outcomes to Griffiths. The ramifications of the NHS Review also make reappraisal appropriate.

Collaboration at Ground Level

2. Collaboration works on several levels. In the past, the focus has been on senior management in the relevant authorities/ bodies. Current concerns have shifted attention to collaboration at ground level and there is evidence that some success is achieved informally, at levels below the bureaucratic framework, where services are delivered to clients. Previous sections of this paper emphasise the importance of agencies working together to co-ordinate and deliver services to individual clients. They contain a range of proposals that directly lead to a strengthening of joint working at the local level. In particular there is a large body of work and much interest in the development of systematic case management in community care (ie an initial point of contact for the client who would assess need and make sense of the different services available to the client no matter what the point of referral). Joint finance, if it is retained in some form, could be used specifically to pump-prime these types of development.

Macro Level Collaboration

3. The annex deals in some detail with the perceived flaws in the arrangements for collaboration at authority level. It was always the intention to re-vamp the arrangements in the light of the "Griffiths" outcome. The "Griffiths" solution to community care would have dealt with many of the difficulties of joint planning

and working but a different, more disagregated, approach is now emerging. In addition, the NHS Review will have a marked effect on boundaries, cross agency working, and the shape and functions of health authorities.

4. Current arrangements are complex and enshrined in legislation. The intention, once Ministers views are firm, is to reinstate a comprehensive review of collaboration and joint finance that addresses current needs. It will need to be conducted in consultation with health and local authorities and the voluntary sector. It is difficult to predict the outcome at this stage but the focus is likely to be very much on:-

- establishing and enforcing clearer objectives
- building in more teeth and power to influence change
- closer monitoring of performance against objectives.

5. Collaboration at the planning and development level is as important as at the point of delivery.

ANNEX

Joint Planning and Collaboration

1. Following the National Health Service Reorganisation Act 1973 health functions were removed from local authorities. However the interdependence of health and personal social services make it essential to have effective arrangements for joint planning, to secure the best balance of services and to make the best use of the resources available. The Act therefore placed a duty on these authorities to collaborate and established joint consultative committees. The functions of the committees were to advise the two sets of authorities on the performance of their duties to co-operate with one another; and on the planning and operation of services of common concern.

2. JCCs comprise representatives of district health authorities, any local authority wholly or partly within the HA area, voluntary bodies and Family Practitioner Committees. The committees have thus been left to decide for themselves how to carry out their duty to collaborate. They are expected to advise the authorities represented on them

i. on the key services for client groups for which it is desirable to establish a joint approach to planning

ii. at operational planning level on priorities for joint planning year by year

iii. at strategic planning level, on a broad strategy for future development of each service marked out for joint planning.

3. Almost all JCCs are supported by a Joint Care Planning Team (JCPT) of senior officers, including FPC representation, and where appropriate, people from outside with expert knowledge including voluntary organisations. The function of JCPTs is to advise on the development of strategic plans and guidelines covering priority services.

4. Joint Finance was introduced in 1976 - also by statute - to further encourage joint planning and collaboration and to promote the emerging change in service provision, from hospital to community care. Joint Finance is top sliced from NHS resources. It is channelled through HAs and spent by the JCCs which can make grants for projects and services run by HAs, LAs and voluntary organisations to assist with the provision of personal social services, education and housing in the community care context. Housing associations and statutory housing bodies may also receive payment for housing provision. It was seen as a pump priming resource to enable services in the community to be built up. The joint finance allocation in 1988/9 was £113 m. Apart from some specialised specific grants it is currently the only mechanism available for directly channelling resources to local authorities.

Does it Work?

5. One one sense it could be claimed that joint finance is working successfully. Although it has fluctuated, take up is high (it is a ring-fenced resource). It is used very flexibly to meet a wide range of community and primary care needs. But a series of reports and DH's own evaluation study have raised serious doubts about whether it is really meeting its stated objectives.

5.1 Although in some places they work very well indeed, JCCs are widely seen as ineffectual talking shops whose main function is to "rubber stamp" joint finance spending. Their real impact on collaboration and joint working is insignificant.

5.2 JF resourcing of projects is time limited, and tapers in later years. The parent body is then required to accept responsibility for continuing funding. Although this is seen as a mechanism for transferring resources from the NHS to LAs, to reflect service changes, LAs have become increasingly reluctant to commit themselves to long term funding. More and more, therefore, take up has been dominated by health authorities.

5.3 JF spending has to be approved by the JCC but, in practice, it is a very flexible dedicated resource. The diverse range of projects it supports is, to an extent, to its credit. However there are doubts about how well some of them fit into "community care" categories.

5.4 Effective joint planning by health and local authorities and voluntary organisations has always been recognised as essential to the development of a full range of health and social services. So far progress has been patchy and over the country as a whole and these services have not been developed as well as they should have been had the scope of joint planning been fully exploited. Concern about this led to the setting up of the Joint Working Group on Joint Planning in 1984 which addressed the structure and working of the machinery.

6. The Working Group identified many flaws in the joint planning system and they took the view that the failure to plan jointly stemmed from the lack of any clear structure, aims or accountability for joint planning. In their view JCCs could and should play a much more positive role. They pointed out that JCCs have a statutory role in considering proposals for joint finance and making recommendations and spent much of their time fulfilling this obligation, where their main activity should be stimulating joint planning and working. Joint finance would then fall into its proper place as an aid to collaboration not an end in itself.

7. Their report "Progress in Partnership" produced in 1985 made five main points:-

7.1 There was a need for an 'engine to drive joint planning', rather than relying on the commitment of individuals. The Working Group envisaged JCCs performing this function.

7.2 It argued for full joint plans for all client groups covering all agencies. These should be at both strategic and operational levels and emcompass all agencies including FPCs and voluntary organisations.

7.3 Plans should be based on the total resources available to all agencies for the particular client group, including staff and finance, both capital and revenue.

7.4 It called for improved use of joint finance by:

a. linking its allocation to jointly produced strategies and

b. not penalising local authorities for expenditure incurred under joint finance arrangements.

7.5 Small, genuinely joint planning teams should be established at local level for each client group and senior officers should be identified as having specific responsibility for joint planning.

8. The report was followed by issue of a draft guidance circular for comment by interested parties. The response was fairly critical. It was widely seen as a mistake to seek organisational solutions to problems which had to do with attitudes and relationships; the emphasis should be on objectives not mechanisms; the guidance did not tackle the fundamental obstacles of the different NHS/LA systems, lack of coterminosity, and the need for substantially increased and reasonably stable financial resources, including penalty free joint finance and (possibly national) bridging finance. There were also comments that the circular often reflected existing practice; there should be a feasibility study of '[illegible] management' and greater collaboration between government departments; DHSS should issue guidance on what constituted good strategic and operational plans, and more should be said on housing, education, social security, implementation of plans, terms of transfer for staff, the Care in the Community Programme and the key role of DHAs.

9. In short, respondents acknowledged the value and importance of effective joint planning, agreed improvements in the system were necessary and welcomed the draft circular in principle. However, they also criticised it as too prescriptive, detailed inflexible and bureaucratic. Most wanted it withdrawn as it would exacerbate problems not solve them.

10. At that point, the Government set up Sir Roy Griffiths Review of Community Care, and further action on joint planning mechanisms was put on ice pending the outcome.

Annex

PEOPLE, SERVICES AND FINANCE

1 This paper sets the scene by:

- identifying and quantifying the kinds of support needed and the main users of services; and

- outlining how they are currently organised and financed.

2 Non-Health Support

Non-Health services have four main elements:

- residential care;
- day services;
- domiciliary services; and
- housing services.

3 **Residential Care** is used by around 225,000 people, the vast majority of whom (around 90%) are elderly.

4 Residential care homes provide a spectrum of services, depending on the policies adopted and the nature and degree of residents' needs in addition to accommodation. The services can include:

- intensive personal care (getting up, toiletting, management of incontinence, feeding etc.);
- therapy services;
- preparation for more independent living;
- social and leisure events; and
- short-term respite care to relieve burdens on carers.

5 **Day Services** are used by over 100,000 people. Slightly under half of these users are mentally handicapped people. Some 30% are elderly and the services are also used by physically disabled and mentally ill people.

6 Day services also cover, for example:

- adult training centres for mentally handicapped people with services ranging from intensive personal care to support for individuals in work;

- day centres for elderly people, with services ranging from luncheon and social clubs to more intensive forms of care; and

- day services for the mentally ill - day centres can provide a range of support services to help maintain mentally ill people in the community. Such services are not well developed at present.

7 Day services can have a vital part to play in meeting relatively high levels of need in the community , particularly for individuals who are otherwise reasonably independent or are supported at home by families, other informal carers and other statutory services.

8 **Domiciliary Services** are used by people in most client groups, although the majority of services are provided to elderly people.

9 Elements of domiciliary care include:

- home help services supplied to some 550,000 consumers. In some areas this service has developed from basic domestic cleaning and other support to provide a more broadly based service, covering many personal care tasks;

- "meals on wheels": some 850,000 meals are provided each week, around 2/3 in people's own homes, 1/3 in luncheon clubs and day centres;

- special equipment and adaptations to property: supplied to physically and sensorily handicapped people in their own homes, as well as to elderly people;

- professional support and advice: needed by individuals in all client groups , particularly those adapting to independent living ,and their informal carers.

10 The range of services required by different people varies enormously. Some need only minimal support, others with more extensive needs require an intensive range of services to prevent admission to residential care. Increasingly people with multiple needs are being helped to live at home by the arrangement of "packages of care" combining - for example - home help, meals, day services, voluntary, community nursing and social worker support, meeting round - the - clock needs.

11 **Housing Services** Suitable housing is essential for all people in these groups if they are to maintain their independence in the community.

12 Housing services include:

- Over 400,000 sheltered housing units, primarily occupied by elderly (80%) and physically handicapped (15 %) people;

- Other special needs housing;

- related warden services; and

- housing management services to maintain people in their own accommodation - e.g. improvements and repairs.

13 Health Services

The health contribution to community care has five elements:

- nursing home care;

- community nursing services;

- other community health services;

- general medical and other family practitioner services; and

- specialist health services.

14 **Nursing Home Care** is required primarily by elderly people, who occupy the majority of the 44,000 places. Nursing homes provide 24-hour availability of nursing support in addition to the type of services provided in residential care homes (although research suggests that the distinction between health and non-health services is not always rigid in practice).

15 **Community Nursing Services** make a major contribution to care, particularly of elderly people in the community. In 1986 46% (almost 1.6 million) of first visits by district nurses were made to elderly people, as were 8% (1.1million) of visits by health visitors.

16 **Other Community Health Services** heavily used by elderly people include occupational therapy, physiotherapy and chiropody services. The latter are particularly important for elderly people, 1.6m of whom received treatment in 1986 (90% of the total workload).

17 **General Medical Services** The G.P. is often the first point of contact for people in need of community care services. Additionally the G.P. is a key member of the primary health care

team, which incorporates community nursing staff and often includes a social worker. It can cover the full range of community health service provision.

18 **Specialist Health Care** Particularly important for mentally ill people, this includes domiciliary visits by doctors and specialist community psychiatric nursing staff, as well as day hospital and outpatient provision.

The Providers and Managers of Community Care

19 The bulk of non-health services are provided by local authority social service and housing departments. Their directly-managed provision includes:

- 45% of residential care places (larger proportion for non-elderly people);
- 69% of sheltered housing places;
- the vast majority of day and domiciliary services for all groups; and
- the vast majority of professional support services.

20 Social service departments also sponsor people in private and voluntary residential homes. This sponsorship has fallen considerably over recent years because of the availability of social security support to people living in those homes.

21 The private sector contribution to non-health care includes:

- 98,000 residential care places (35% of the total); (this has increased from 34,000 since 1979 reflecting the availability of social security payments.)
- an increasing proportion of sheltered housing services, currently 7% of the total; and
- very few day or domiciliary services, although the latter sector are beginning to develop.

22 Voluntary and not-for-profit suppliers cover a wider range of services than the profit-making sector. Their main contributions are:

- 42,500 (15% of total) of residential care places;

- 100,000 housing association sheltered housing places (24% of total);

- the major element of specialist provision for some smaller client groups, most notably sensorily handicapped people;

- some domiciliary, day and hostel services, often complementary to local authority provision and receiving public sector support.

- some hospice care and services for terminally ill people

23 With the exception of private sector provision of nursing homes, virtually all the health components of community care are provided directly by health authorities. (Family practitioner committees in the case of the general medical service). Some health authorities have also developed their own residential care services .

Financing Community Care

24 The main sources of funding for community care services are:

- direct payment by individuals from their own resources for private or public sector services;

- direct public funding of services by public bodies: health authorities, local authorities and the Housing Corporation; and

- reimbursement for charged services through the social security system.

25 **Direct Payment** The main areas of charged community care services are:

- private and voluntary sector residential and nursing homes - many individuals are able, at least initially to meet the full costs of fees. Some, however, become dependent on social security funding (see below) for the continuation of their care, as their capital is exhausted;

- local authority residential care for the elderly - fees and charges, centrally controlled, meet 37% of the direct costs of these services;

- local authority meals services - around one-third of the costs of these services are recovered from charging.

Charging policy for other services varies between local authorities and can make a significant contribution at local level in some areas. Health Authorities cannot charge for their services.

26 **Direct Funding by Public Agency** The largest contribution to the funding of all services comes from health and local authorities' own budgets. Spending on health and social services for the main client groups has risen steadily in recent years - a total real terms increase of 18% in the period 1976/77 - 1984/85 in spending on elderly, mentally ill and mentally handicapped people. A top-sliced section of health authority funding - "joint finance" - is allocated specifically to pump-prime new community care developments in both sectors.

27 Health and local authorities fund services offered by the voluntary sector. Local authorities can "top up" social security payments for people under 65. Contractual arrangements for the supply of significant areas of mainstream service provision with either the private or voluntary sector are few.

28 **Social Security Support** through supplementary benefit (now income support) became available as of right to help meet fees in independent residential care and nursing homes in the 1980s, artificially making this form of care appear cheap to both eligible users and individual statutory agencies, irrespective of whether overall public expenditure costs were greater than for alternative forms of support. With public finance for other services rationed according to priorities, a "perverse incentive" towards residential care financed through open-ended social security benefits was created. This has led to:

- rapid growth in private sector provision of residential care, with a virtual standstill in public sector provision (illustrated graphically in figure 1);

- dramatic increases in the number of claimants in homes

and, until they were brought under control, in the average levels of payments;

- an incentive for individuals and authorities to opt for independent sector residential care over domiciliary services, irrespective of precise care needs and cost-effectiveness;

- concern that individuals may receive inappropriate services and poor value for money.

29 Taken together these factors produced an increase in public expenditure on social security support for residential and nursing home care **from £10m in 1979 to £770m at an annual rate in November 1987**

30 Expenditure per resident has been brought broadly under control, but the growth in the number of residents is still continuing - increases of 69% for residential care homes and 153 % for nursing homes were recorded in the two years to November 1987.

31 The momentum of this trend cannot continue indefinitely, but there is a real danger of a fresh boost to expenditure if local authorities seek to sell their own provision, so transferring costs to the social security budget, and if health authorities continue to stimulate independent provision to accommodate hospital leavers.

32 The community care grant element of the Social Fund is designed to support community care policy by helping people to support themselves in the community, rather than moving into institutional care, or to restablish themselves in the community after a stay in such care. Grants have other functions, including easing exceptional pressures on families and helping with travelling costs in certain crisis situations. Unlike other elements of the social fund, grants are not repayable. The total budget for grants this year is £60m.

33 Social Security disability benefits are under seperate review within DSS in the light of recent work on prevalence of disability by OPCS. The table below shows the benefits available, which are non-contributory, together with expenditure and the estimated average number of receipients in 1987-88:

	EXP (£M)	NO (THOUS)
Attendance Allowance	897	670
Invalid Care Allowance	184	80
Non-contributory Invalidity Pension/Severe Disablement Allowance	295	265
Mobility Allowance	596	490
Total	1972	1505