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FROM: CHIEF SECRETARY
DATE: 18 April 1989

PRIME MINISTER

COMMUNITY CARE

We are to meet again tomorrow to discuss this subject. Kenneth Clarke has circulated some proposals, and John Moore and Peter Walker have put in some ideas. I too have been giving considerable thought to the remit which we took away from the last meeting, and I should like to offer some comments on Kenneth's proposals, with which I am in general very sympathetic.

2. Taking the elderly (and handicapped) first, I support Kenneth's proposal that health authorities should take responsibility for carrying out care assessments for those seeking income support for residential or nursing care. It is, I think, the best option available. I also agree that the small units of staff which the health authorities would establish for that purpose should also, where residential care was considered unnecessary, take an active role in seeking out and coordinating the various domiciliary services that were needed. Such services would be those already provided by local authority social services, the community health service, voluntary agencies, the private sector, the government's own disablement advisory service, etc. I understand, indeed, that some such units have been tried out on an experimental basis already, and have apparently worked well. As Kenneth says, there would be a cost in running such units: subject to further examination of the details, it is a cost I think we should be prepared to incur.

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3. We should recognise, of course, that this new activity by the health authorities is likely to increase the demand for the services provided by, in particular, the local authority social services and the voluntary agencies. I consider that we should make it clear that we will take into account the likely increased pressure on local authority spending when reaching our decisions in future on revenue support grant; and that we shall look sympathetically at the need for increased section 64 grants for voluntary bodies, which are widely - and rightly - seen to be caring institutions of just the kind needed in this area, and which are very cost effective.

4. However, I do not think we should go further than that and, as Kenneth suggests, give the health authorities a budget to spend on actually purchasing domiciliary services. I have several reasons for this. I do not think the health authorities could handle the added burden. Moreover, the pressures on central government to take over all responsibility in this area, and to provide rapidly rising standards of service, would be immense. Local authorities would be relieved of the responsibility, for all potential clients would apply to the new budget holders. The costs could quickly rise to very high levels, with no chance of them being offset by a reduction in other forms of public expenditure.

5. For that reason I am sceptical about whether we should, as John Moore suggests, move to a joint budget for the health authorities, encompassing the care element of residential support, though it is a proposition that I am sure we should keep in mind.

6. I should like to add a couple of further suggestions. First, I understand that some of the residential homes offering a high degree of care to the severely disabled (including the elderly), which include in particular homes run by voluntary bodies, are finding it difficult to manage within existing income support limits. Rather than be pushed into a real increase in income support limits for residential homes generally, which would cost a great deal and is probably not justified in many parts of the

country, I propose that we should set up a new fund, of say, initially, £5 million pa, similar to the Independent Living Fund we have established to help individual severely disabled people in their own homes. The new fund would be for discretionary grants to severely disabled people in residential homes encountering the kind of difficulty outlined above. It might be appropriate to use the same mechanism as the Independent Living Fund, but that is a matter which I would of course need to discuss with John Moore.

7. We could include in such a fund discretionary grants to support people in those hospices which at present do not charge and so do not benefit from our income support arrangements.

8. This package of measures would be modest, but positive. It would create minimum disruption of present organisations and responsibilities. It would be close to the Griffiths principle, because the local authorities would retain full responsibility for their own spending. It could be implemented speedily: we could take account of it in this year's public expenditure Survey.

9. We might consider also whether it could help with the problem of the mentally ill. I agree with Kenneth that these people have to be considered as a discrete group, but it might be possible for the new health authority units to be charged with keeping in touch with the mentally ill who are discharged from long stay mental hospitals, and ensuring (as far as possible) adequate care for them, either in their own homes or perhaps in some cases sheltered housing.

10. I do not believe we should go further and announce any of the initiatives suggested by Kenneth in paragraph 8 of his paper, at least until they have been costed and agreed. Most, if not all, of those initiatives seem likely to have public expenditure implications, and we need to consider those carefully before taking decisions. Furthermore, Kenneth said in his note for our last meeting that he had set in hand a review of the quality of services across the country. I understand that the results of that will be available around the end of the year: would it be possible for the report to be brought forward, or a preliminary report to be presented, so that we can consider the evidence before deciding whether any significant changes in policy are required?

11. To summarise my suggestions, whilst I do not support Kenneth's idea of a new budget for the health authorities to spend on domiciliary care, and feel that the initiatives he proposes in his paper on the mentally ill should be costed before we decide that any significant changes in policy are required, I do support his proposal for new care assessment teams attached to health authorities, which would not only assess the need for residential care but also coordinate the provision of domiciliary care. I consider also that we should make it clear that we will be prepared to recognise any likely increase in local authority costs resulting from that initiative in our future decisions on rate support grant, and that we should look sympathetically at any need for increased grants to voluntary bodies to meet the additional burdens they may face.

12. In addition, I suggest a new fund to help with the high degree of care offered by some residential homes (and hospices).

13. By presenting a package of measures like this, we could show that we were serious about wanting to improve the access of the elderly and others to the services they need to enable them, as they wish, to stay at home. We would be making a very positive contribution to the need for better coordination and information in this field.

14. I am copying this minute to Kenneth Clarke, John Moore, Nicholas Ridley, Malcolm Rifkind, Peter Walker, David Mellor, Mr Wilson (Cabinet Office) and Mr Whitehead (No. 10).

JOHN MAJOR