The Government has now announced that from 1991 local authorities will take the lead in coordinating community care, including services for people with a mental handicap. The Commission supports the change but warns that considerable efforts will be needed in local authority social services departments if its objectives are to be achieved.

Existing local authority services for people with a mental handicap are under pressure. The closure of mental handicap hospitals, changing ideas on methods of supporting clients, an ageing population and greater expectations from users, have placed increasing demands on social services departments.

Well-managed community care, especially in domestic-sized houses, provides a significantly higher quality of life than hospital care. But nearly 60% of the combined local/health authority budget is still locked up in hospital provision and can only be released when residents are settled in the community.

Joint resettlement programmes have been proceeding in some parts of the country but overall there has been relatively little progress. Sixty per cent of local authorities have not reached agreement with their local health authorities on the financial and practical arrangements for resettlement. Of those who have, few have yet implemented the programme. Considerable difficulties remain on the negotiation of 'dowries' for people leaving long-stay institutions. Often 'dowries' are inadequate or not paid in perpetuity.

As a result there is a lack of adequate support for clients and carers living in the community, particularly respite and day care for young adults who are more profoundly handicapped. Second there has been rapid unplanned growth in residential care in private and voluntary homes, driven by the availability of social security benefits. This care may be both unsuitable and more expensive than is necessary. Overall, public money is not being spent in the most effective way.

Though almost all local authorities now accept the broad lines of government policy only 15% have an action plan to achieve their strategy. Care management implies decentralisation of management and budgetary control yet barely 3% of local authorities have achieved this. Only one in three is developing individual programmes for clients, which must be the basis of the
implementation of the new policy. Most local authority services are still provided in the traditional settings of training centres and hostels. There is a lack of effective leadership in managing the shift from 'service provider' to 'enabler' role. Local authorities should take the opportunity presented by the two year interval before full implementation of the new policy to:

— accelerate negotiations with local health authorities;
— improve the standard of cooperation and collaboration with other agencies, promoting innovative use of resources; and
— develop the reality of care management with budgetary arrangements and organisational adjustment to match.

**INTRODUCTION**

**THE PURPOSE OF THE REPORT**

1 In a statement to the House of Commons on July 12 the Secretary of State for Health announced the broad lines of the Government's response to Sir Roy Griffiths' report: *Community Care: Agenda for Action* (ref 1). The Government has accepted many of the recommendations in that report. In particular the Government 'accept Sir Roy's recommendations that two sources of public funding [from social security offices and local authorities] should be brought together and allocated on the basis of a proper judgement of an individual's needs'. Furthermore, the Government 'have concluded that the best way forward will be to build on local authorities' existing responsibilities'.

2 The Audit Commission welcomes this statement of policy. Many details remain to be resolved, but the Government has accepted the central argument in the Commission's own report (ref 2), to the effect that the existing funding arrangements are fundamentally flawed. In the Secretary of State's words 'they cannot ensure that priority is given towards supporting people at home where that is possible and desirable'.

3 Legislation will be required to effect these changes, so the new funding and management arrangements will not be in place until 1991. But in the meantime there is much that could be done to prepare the ground. This applies particularly to the development of new management skills. The change in management attitudes required to make the new arrangements work will be as radical and crucial as the changes in funding.

4 The second area in which progress can be made is in the development of cooperation between health and social services authorities. The Secretary of State recognised in his statement that 'further efforts will be needed to improve coordination'.

5 Over the past year auditors appointed by the Commission have been carrying out local audits of one important part of the community care spectrum: services for people with a mental handicap. They have done so using an audit guide prepared by the Commission, on lines set out in a paper, *Community Care: developing services for people with a mental handicap* (ref 3) published at the end of 1987.

6 This latest paper pulls together the results from a large sample (50) of those audits. It therefore presents probably the most comprehensive information available on the current state of these services across the country.

7 Inevitably, auditors have found many examples of the kind of funding problems and perverse incentives which the policy change is designed to resolve or remove. The paper reviews them - not for the perverse pleasure of wallowing in the difficulties of a system which ought soon to be a thing of the past, but to present a clear picture of the situation which now exists. Clearly, if a community care strategy for mentally handicapped people were to be devised *ab initio*, one would not start from here. But the web of problems that have developed over the last two decades must first be unravelled.

8 More importantly, the paper goes on to describe the ways in which some authorities are already coming to grips with the problems of cooperation between different funding bodies. Collaborative schemes have been developed in a number of places; they could be the model for change elsewhere. And there are positive developments to report in the field of care management: again, they could with benefit be copied elsewhere.

9 The aims of the paper are, therefore:

— to describe the baseline from which services must now be developed further; and
— to point up the good practices identified by the Commission from which others can learn.
The paper is in five sections:

— Section one briefly describes the overall pattern of demand for and supply of services;
— Section two looks at joint planning and the resettlement of National Health Service (NHS) mental handicap hospital residents;
— Section three considers some wider aspects of service development and the extent to which social services departments are working constructively with other agencies;
— Section four reviews the extent to which services are developing in accordance with good practice to meet the demands placed upon them;
— Section five makes some suggestions for change, within the context of the new policy framework.

(Most of the paper's conclusions arise from work in England. The position in Wales is somewhat different, and is described briefly in an Annex).

1. THE BACKGROUND

The environment within which local authorities are trying to develop services for people with a mental handicap is difficult for three reasons:

— the population served is changing with fewer handicapped children but more older people outliving their parents;
— the NHS hospital closure programme involves the transfer of residents into the community, and provision of community services for severely handicapped people who would otherwise have been admitted to hospital;
— there is a growing awareness that people with a mental handicap have greater potential for development than was previously thought; to fulfil that potential individuals need care tailored more closely to their particular requirements.

12 These changes all point to a need for more accommodation in the community, with training and other day time opportunities for people to achieve their full potential.

13 There are about 124,000 adults with a mental handicap in England. Epidemiological evidence suggests that the make-up of this population is changing. A reduction in the number of children born with a mental handicap, which should in due course cause the population to fall, has so far been offset by an increase in the number of adults due to greater life expectancy and to a 'bulge' of young adults who were born in the 1960s. The number of mentally handicapped adults in hospital fell by about 14,000 from 1980-86, while the number of places in local authority, voluntary and community based homes rose by only 11,000. As a result the total number of residential places has fallen at a time when an increase is needed to accommodate growth in the adult population (Exhibit 1). At the same time, of course, the sums spent through the benefit system on supporting mentally handicapped people have risen, but as the Secretary of State said in July, 'the rapid growth of residential and nursing home care has been unplanned and largely based on the availability of social security benefits'.

14 The number of places at Social Education and Adult Training Centres has risen by about 11,000 to 51,200 over the same period but is still considerably short of the 1991 target of 74,500 plates in the Government's White Paper (ref. 4). This may not, however, be a bad thing. There is a move away from congregating adults with a mental handicap in large training centres. More places in further education, work experience, employment and other activities outside the centres are being encouraged. The number of these places is difficult to calculate but is at present unlikely to make up for the shortfall in training centres.

Exhibit 1
NUMBER OF RESIDENTIAL PLACES IN ENGLAND
Community places are not compensating for the loss of hospital beds

<table>
<thead>
<tr>
<th>Year</th>
<th>Place Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>LA</td>
</tr>
<tr>
<td>1980</td>
<td>VOL</td>
</tr>
<tr>
<td>1981</td>
<td>PRIVATE</td>
</tr>
<tr>
<td>1982</td>
<td>HOSP</td>
</tr>
</tbody>
</table>

Source: Department of Health
Exhibit 2

CHANGES IN EXPENDITURE AND UNIT COSTS
Rising expenditure has still been associated with a fall in the total number of places.

Source: Department of Health

15 Community care requires a shift in expenditure from NHS long stay facilities to expenditure on smaller scale residential places, domiciliary and day support. To some extent, this switch is taking place. Local authority expenditure has risen by 80% in real terms over the last decade while NHS expenditure has remained constant. But unit costs have risen by 50% in the NHS (nursing staff per occupied bed has risen by 80 per cent) and 60% in local authorities. So rising expenditure has still been associated with a fall in the total number of places (Exhibit 2).

16 Some of the increase in unit costs in local authorities does not represent money well spent. The Commission’s auditors have found examples of ill-planned and under-utilised provision, together with inefficient working practices. But these are isolated cases, and the main reason for rising unit costs is undoubtedly the fact that small scale staffed accommodation is often more expensive than large homes, hostels or hospitals (Exhibit 3).

17 The overall picture which emerges from this analysis is of public sector services under strain, with only patchy delivery of full government policy of providing good quality community-based care settings for this client group. At the same time, it is impossible to argue that value for money is being maximised, since the availability of social security benefits for residential but not domiciliary support distorts provision towards more expensive options.

Exhibit 3

ILLUSTRATIVE COSTS OF RESIDENTIAL SETTINGS
Staffed group homes can cost more than hospital places

Source: Davies L.M., Research in South Western Regional Health Authority and South Wales
2. JOINT PLANNING AND HOSPITAL RESETTLEMENT

Health authorities have been the traditional providers of residential care: at the peak in the late 1960s there were just under 60,000 places in NHS mental handicap hospitals. The number has now fallen to around 30,000 and further, perhaps more rapid, reductions are in prospect. At least two regions are hoping to close all of their provision by the end of the century, though a temporary pause in the closure programme has recently been announced by the government. The Secretary of State has told the Chairmen of regional health authorities that he will not approve the closure of any mental or mental handicap hospital unless he is satisfied that proper alternative services are in place.

The movement of residents from hospital to community can be achieved by transferring them to local authority social services departments, small community units run by the NHS, or to the private or voluntary sectors. The proportions in each case are hard to assess, though it seems likely that around half go to private or voluntary supported accommodation and about a quarter to the local authority.

A 1983 Department of Health and Social Security (DHSS) circular (ref 5) set up the financial arrangements to encourage the transfer of more residents into the community. In principle, people moving out of hospital bring with them a revenue contribution to their care, known as the 'dowry', which is payable by the health authority responsible for the hospital. The amount of each 'dowry' is negotiated between the paying and receiving agencies. The 1983 circular also states:

'As vacancies arise in community care facilities supported from NHS funds in this way for people moving out of hospital, the vacancies may be filled by other people moving from hospital or by people who would otherwise imminently need to be admitted to hospital'.

This implies that the transfer of funds should be made in perpetuity for the support in the community of future generations who previously would have been admitted to hospital. Not all health authorities, however, are willing to pay 'dowries' in perpetuity.

Some cease payment on the death of the resettled residents (or even earlier), thus reversing the financial transfer. And 'dowries' are not usually paid if residents die in hospital. This money 'saved' by the NHS is therefore not available for clients who 'replace' those who die in hospital within a stable total population. This is of particular concern to local authorities which are now having to cope with people with profound handicaps leaving special school who, in the past, would very probably have been admitted to hospital. A letter sent to the Commission by one mother affected describes the problem (Exhibit 4).

THE PLIGHT OF CARERS
Pressure on local authorities grows with the lack of NHS beds or finance

Exhibit 4

Letter from parent of mentally handicapped son

"I am writing to draw your attention to the lack of community care for my son Malcolm. Malcolm is seventeen years old and severely mentally and physically handicapped. He is incontinent, tube fed four hourly, has frequent epileptic fits and needs daily treatment for severe lung problems. Before the introduction of community care Malcolm would have been automatically offered a bed in a long stay hospital. The concept of community care was to be that people stayed in their own community with the support required. In practice what has happened is that parents are expected to continue caring for their handicapped children indefinitely with little or no help .......

I am not sure how much longer I can continue to keep up this level of care without help. I would like to know why Malcolm is not entitled to live in residential ordinary housing as an alternative to long stay hospital like other children in this area namely A.B., S.C., E.R., (share care) and M.C. What life have the parents of these children had and got now compared with me? I am being penalised for looking after Malcolm for seventeen years."
The Commission's 1987 paper (ref. 3) identified several other concerns in relation to this resettlement programme:

- Transferring money is not enough on its own: some system for transferring skilled staff is also needed for the resettlement programme to succeed;
- The inner cities, particularly inner London boroughs, face particular difficulties as their residents are traditionally scattered across out-of-city hospitals in differing health authorities, so complicating negotiations for resettlement;
- While a mechanism is available for financing settlements from hospitals into community facilities, financial mechanisms are inadequate for those who would in the past have been admitted to hospital: a 'two tier' service may therefore be developing;
- The balance of provision between agencies arises haphazardly rather than by reference to internally consistent plans which assess service needs.

The evidence assembled during the recent audits suggests that little has changed since the Commission's report of 1986 (ref 2). With some notable exceptions progress is slow, both in agreeing joint strategies and in getting resettlement programmes underway. The Social Services Inspectorate (SSI) confirms this lack of effective joint planning in a recent report on day services for people with a mental handicap (ref. 6). The July 12 announcement, and the legislation which will follow, is intended to change the rules of the game, and the climate within which it is played. But it is as well to begin with an understanding of the tensions which have built up in the past.

PROBLEMS IN AGREING JOINT STRATEGIES

In 1988, out of the 50 local authorities assessed, 60% had not agreed joint strategies with their health authorities for the resettlement of hospital residents, although just under half of them were in negotiation (Exhibit 5). Those authorities which had not yet reached agreement cited a number of so far intractable problems:

- A lack of sufficient trust or common purpose between the different agencies. The health authority sometimes by-passes the local authority in developing resettlement programmes;
- A shortage of bridging and/or long-term finance;
- Health authorities were unable or unwilling to commit to 'dowries' in perpetuity and local authorities reluctant to accept NHS residents unless all costs are refunded in full by the health authority;
- The different geographical coverage of the authorities involved: local authorities are often faced with the need to negotiate with three or more health authorities.

Audit reports suggest that approximately 20% of both local and health authorities have exhibited insufficient commitment to joint planning. Social services managers find they have enough problems trying to provide improved, or sometimes barely adequate, support for people already in the community, the numbers of whom are growing with hospital closures. Where health authorities have not offered to pay 'dowries' in perpetuity there has been little incentive for local authorities to spend time on resettlement negotiations. This has been especially true where the 'dowry' offered looked unlikely to finance the total cost of appropriate support in the community.

Health authority funds, however, are also tight and there is an understandable reluctance to transfer NHS
money to a local authority when there is insufficient mutual trust, or when health service managers do not support the social services' model of care which may be on offer. In particular, health authorities vary enormously in their attitude towards providing funds to local authorities to compensate for the loss of admission to hospital. Most provide no directly attributable finance although one DHA has accepted the consequence of its policy and provides £800,000 a year in compensation.

27 Auditors also report a difficulty with the transfer of hospital staff to local authorities. (Case Study). The 1986 Commission report (ref 2) highlighted this problem but little progress seems to have been made since then. Not only is there no national mechanism for reconciling NHS pay, training and conditions of service with those of a local authority, there is sometimes mutual professional suspicion between the agencies' employees. Nurses are reluctant to transfer and local authority staff reluctant to welcome them.

28 This lack of progress has created growing problems for local authorities (Exhibit 6). The most severe pressure points are at either end of the adult age range: clients growing older and outliving their parents, and young, profoundly handicapped adults. The latter group is often the most urgent category. In the past these people would have been cared for in a hospital setting. Local authority social services departments are unused, in many cases, to supporting such people and have had neither the staff nor facilities to cope adequately. (In at least one authority the only solution to

Case Study
PROBLEMS TRANSFERRING NHS STAFF

<table>
<thead>
<tr>
<th>Problem</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Job opportunities in local authority</td>
<td>County Council agreed to reserve half of new 'core and cluster' posts and half of vacancies in established community services for NHS staff</td>
</tr>
<tr>
<td>2. Recognition of NHS qualifications</td>
<td>County Council will recognise nursing qualification as equivalent to that of social worker</td>
</tr>
<tr>
<td>3. Protection of accrued annual leave, sickness, maternity and retirement benefits</td>
<td>Protection agreed</td>
</tr>
<tr>
<td>4. Compensation for removal and disturbance</td>
<td>Local authority allowances provided</td>
</tr>
<tr>
<td>5. Access to training</td>
<td>Wide eligibility guaranteed. Health authority to provide £80,000 a year towards training</td>
</tr>
<tr>
<td>6. Enhanced benefits on early retirement</td>
<td>Special consideration to be given to staff approaching retirement</td>
</tr>
<tr>
<td>7. Mental Health Officer status which allows staff with 20 years' experience working with mental handicap to double their pension rights for each year worked and retire at 55</td>
<td>To ease what appeared an insurmountable problem the health authority has agreed that anyone moving to the Council will automatically be entitled to redundancy pay the moment they transfer</td>
</tr>
</tbody>
</table>

In addition trade union representatives were allowed two seats on the Joint Management Team and staff unwilling to transfer may be re-trained for other NHS posts.

Despite this settlement the authorities have been disappointed with the reaction. Senior nurses have been reluctant to apply for community based posts. Possible reasons include:

- marginally inferior local authority salaries
- no enhanced payments for unsocial hours
- disincentives associated with status. Local authority posts may not be viewed as prestigious as those in NHS

Source: 'Demonstrating Successful Care in the Community' PSSRU
day care has been to keep some students in the local special school until they are 21. Even with this temporary respite some 14 very severely handicapped young people will be leaving school in the next four years. Adequate day support is not, however, the only problem. Parents are under severe strain from the unremitting, heavy tasks involved in caring for profoundly handicapped young adults (Exhibit 4). Auditors report the growing concern of parents in this situation. At the very least, increased respite care is needed. Local authority facilities, unused to such profound handicap, are not often able to cope. In addition, some auditors report that the number of respite places is falling as they are increasingly required for emergency, long term admissions caused by illness or death of elderly carers.

RESETTLEMENT IN ACTION

Where no joint strategy exists, and sometimes where one does, health authorities themselves are resettling residents either into private or voluntary residential homes (where social security residential care allowances finance costs up to £165 a week outside London) or else into NHS units, sometimes built in the grounds of the hospital. Indeed, some 3200 places in NHS community units were available by 31 December 1986 (Table 1), the latest date for which figures are available. As can be seen the average number of beds per unit is 9.1, with a high of 14.2 in North East Thames and a low of 4.8 in North Western. The latter reflects the RHA’s commitment to an ordinary life for its residents, resettling them in domestic sized houses. A home with nine beds for clients is not usually regarded as an ordinary domestic sized house.

Some local authorities consider that some NHS community units, particularly those sited in hospital grounds, are simply a smaller version of the traditional mental handicap hospital and are not as appropriate to the effective support and development of individual people with a mental handicap as small houses in the community. Research in the South Western RHA and South Wales supports this view (Ref 7). Both small houses in hospital grounds and others in the community were included with other residential settings in an evalua-

Table 1

<table>
<thead>
<tr>
<th>Regional Health Authority</th>
<th>Number of units</th>
<th>Number of available beds</th>
<th>Average beds per unit</th>
<th>No. of beds as % of hospital beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>England (RHA)</td>
<td>352</td>
<td>3200</td>
<td>9.1</td>
<td>8.8</td>
</tr>
<tr>
<td>Northern</td>
<td>13</td>
<td>127</td>
<td>9.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>22</td>
<td>116</td>
<td>5.3</td>
<td>4.3</td>
</tr>
<tr>
<td>Trent</td>
<td>35</td>
<td>345</td>
<td>9.8</td>
<td>10.0</td>
</tr>
<tr>
<td>East Anglia</td>
<td>9</td>
<td>55</td>
<td>6.1</td>
<td>4.0</td>
</tr>
<tr>
<td>NW Thames</td>
<td>9</td>
<td>89</td>
<td>9.9</td>
<td>2.6</td>
</tr>
<tr>
<td>NE Thames</td>
<td>19</td>
<td>270</td>
<td>14.2</td>
<td>13.8</td>
</tr>
<tr>
<td>SE Thames</td>
<td>35</td>
<td>320</td>
<td>6.6</td>
<td>15.2</td>
</tr>
<tr>
<td>SW Thames</td>
<td>22</td>
<td>188</td>
<td>8.5</td>
<td>4.1</td>
</tr>
<tr>
<td>Wessex</td>
<td>61</td>
<td>561</td>
<td>8.5</td>
<td>38.0</td>
</tr>
<tr>
<td>Oxford (1)</td>
<td>10</td>
<td>128</td>
<td>12.8</td>
<td>9.0</td>
</tr>
<tr>
<td>South Western</td>
<td>36</td>
<td>494</td>
<td>13.7</td>
<td>17.6</td>
</tr>
<tr>
<td>West Midlands</td>
<td>26</td>
<td>317</td>
<td>12.2</td>
<td>9.8</td>
</tr>
<tr>
<td>Mersey</td>
<td>12</td>
<td>118</td>
<td>9.8</td>
<td>6.4</td>
</tr>
<tr>
<td>North Western</td>
<td>43</td>
<td>207</td>
<td>4.8</td>
<td>6.9</td>
</tr>
</tbody>
</table>

(1) Includes estimates for certain units in Oxford DHA.

Source: Department of Health
tion of costs and quality of life. Houses in hospital grounds achieved a lower score on quality of life than those based in the community. If hospitals resettle all residents into these units regardless of dependency levels, some people may also be receiving a higher level of support, costing more than they need.

31 There can be a number of financial problems when health authorities resettle residents directly into their own or private or voluntary homes:

— Because of deaths and reduced, or non-existent hospital admissions, the number of residents resettled into NHS units is likely to be less than the number of people originally accommodated in the hospital. The hospital funds are transferred to finance the smaller units, but they are supporting fewer people. Given a stable population of clients, those people in the community who might have taken the vacant hospital beds are turning to the local authority, which in turn has received no funds from the health authority for their support. These people are likely to be more severely handicapped and to need more expensive care than many of the local authority’s previous clients.

— Where residents are resettled into voluntary or private homes a question is raised over what happens to the ‘dowries’. In most cases they go to ‘top-up’ the clients’ social security residential care home allowances but in some cases this may not be needed and the money remains with the health authority. (One local authority estimated its ‘top-ups’ to voluntary and private homes averaged £120 per person per week). Even where ‘dowries’ are paid as ‘top-up’ the health authority is likely to cease payment when the resident dies. This money ‘saved’ will not necessarily be spent on other clients with a mental handicap.

— The provision of day support is difficult where health authorities unilaterally place residents in private homes, especially when they are remote from the resettling hospital. This is of particular concern to those south coast authorities where the number of private homes is increasing rapidly. Residents frequently come from hospitals outside the region and have no connection with the locality. This creates an unnatural preponderance of mentally handicapped people in the area. Some authorities become aware of these residents only when the home requests day care, so placing an unplanned, unnaturally high and usually unfinanced demand on local day services. Under these conditions social services departments may be unable to respond.

32 These problems have a common theme: demand for local authority support has increased while the funds available have not. This results in a critical shortfall in resources with which to cater for this increase in demand which, indeed, is likely to come from the most dependent members of the client group.

33 Not all resettlements are unilateral, uncoordinated placements however. Agencies with joint strategies are planning agreed programmes to settle residents into the community. But achievement has been slow and in the last year has been getting slower.

34 The picture is not all gloomy. Forty per cent of authorities have agreed joint strategies. What distinguishes these successful authorities from the rest? The single most important factor is the commitment of individual members and officers (on both sides) to achieving success; indeed, a sense of urgency is sometimes needed to secure positive action. Conversely, when these are not present little happens.

35 It should be noted, however, that even in those local authorities in the sample that had agreed joint strategies (with 28 DHAs) almost half had not yet succeeded in cooperatively resettling any residents into the community. Some of the greatest successes in terms of numbers resettled have been in authorities which have received finance under a DHSS pilot scheme for care in the community. About £20 millions of joint finance (at today’s prices) was top sliced for schemes to resettle NHS hospital residents from a variety of client groups. Eleven schemes were for people with a mental handicap under which 210 people had been resettled by 31 August 1987. Why has development elsewhere been so slow?

36 Apart from the complexity of bringing to completion schemes which involve finance, staff and cooperation from a variety of agencies, particular difficulties have been identified by auditors.

— Health authorities are sometimes unable to finance their contribution towards the cost of schemes. Some joint strategies plan significant developments of new resources with funds from the NHS. Costs over
the timetabled schemes are jointly agreed but significant shortfalls in available health authority funds are identified, or suspected by local authority negotiators. Shortfalls quoted by auditors range from £0.5 million to over £3 million a year.

— Savings from hospital contraction have not materialised as expected. At least 18 local authorities are affected by this in two Regions. A contributory factor to the problem is the manner in which the hospital contraction is carried out. Significant savings are made only when a complete ward is closed. If settlement programmes take individual residents from a variety of wards then costs saved are only marginal. To be cost efficient a whole ward needs to be targeted for closure releasing more funds more quickly. This can apply equally to whole hospitals. At least one DHA is aiming to contract all its hospitals at a similar rate although only so many residents can be absorbed into the community at any one time. DHAs with residents in those hospitals are charged for their care on an average per capita basis and as the numbers contract the unit costs are escalating. The auditor reports that they have trebled in three years and are now over £30,000 a year per resident.

— There is an ‘inflation gap’ between local and health authorities. This is a contentious issue which is beginning to emerge as ‘dowries’ become recurring annual payments. In a significant number of authorities auditors report that health authorities use for budgetary purposes. This may not be the actual rate of inflation affecting local authorities. Costs being borne by personal social services (PSS) for resettled residents are therefore higher than the income received. The difference can be significant. Examples are given ranging from £46,000 to £90,000 for 1986/87.

— Dowries’ paid are insufficient to cover agreed models of care (Exhibit 7). The range of expected shortfall calculated by one local authority was £34 to £176 a week. It was based on an annual ‘dowry’ of £12,500 per person, plus the receipt of various mixes of other benefits such as residential care homes allowance, hostel or housing benefit, income support and disability allowances. Cost of day services has been included in the calculations. Expenditure levels for staffed group homes used in the calculations are similar to those quoted by auditors of other authorities.

37 These problems result in schemes slowing down and sometimes even coming to a halt. Shortfalls in identified health or local authority finance when planning a large resettlement scheme make for caution in proceeding further. Hospital savings which do not materialise mean a shortage of NHS funds from which to pay further ‘dowries’. Escalating unit costs charged to DHAs for residents in hospitals outside their own districts also have the effect of reducing cash to pay for ‘dowries’. (In the two Regions in which hospital savings have not materialised as expected, one RHA imposed a six month moratorium on all new discharges to the community. The second RHA and its affected local and health authorities adopted a joint approach and convened a working party of all the authorities in order to identify a way forward.) An inflation gap in uprated ‘dowries’ means local authorities unexpectedly needing extra funds to pay costs they believed were covered by agreed ‘dowries’. This reduces available funds for development of further schemes.

38 For local authorities the position is now acute. The stark reality is that the moment a hospital curtails or closes its doors to admissions - for the best of motives i.e. that people should not be in hospital - the pressure falls
immediately on the local authority. Young adults leaving special schools, and their carers, are becoming increasingly urgent in their requests for support. How local authorities are attempting to resolve this dilemma, seeking resources from other agencies, is addressed in the next section.

3. OTHER AGENCIES AND RESOURCES

39 Developing a comprehensive service is more than deciding how to spend Joint Finance and trying to come to an agreement on resettlement. It is about planning jointly, with other agencies, the future roles, responsibilities and development of support to clients in order to provide a coordinated service that makes the best use of resources in meeting an individual client's needs. While health authorities and social services departments have the major roles, other players such as housing authorities and associations, voluntary and private bodies, education and leisure departments should be involved, bringing with them expertise and their own resources. Housing is, of course, particularly important. The right domestic location is often the cornerstone of a successful care package.

INCREASING INVOLVEMENT OF OTHER AGENCIES

40 Sir Roy Griffiths in his report (ref. 1) recommends that local authorities should act as purchasers of support and encourage pluralistic service provision with contributions from health, voluntary and private bodies. The Secretary of State has now re-emphasised that local authorities 'should make maximum possible use of the voluntary, not-for-profit and commercial sectors so as to widen individual room for choice, increase the flexibility of services and stimulate innovation. The Government have long urged local authority social services departments to act in an 'enabling' and not just a 'providing' capacity.'

41 It is not easy to convert quickly from a 'provider' to an 'enabling' orientation. The latter requires a far more entrepreneurial approach to service development. Audit reports suggest that over half of authorities display insufficient entrepreneurship for this to be achieved. There is some evidence, however, of an increasing involvement with other agencies and of greater coordination and cooperation between local authority departments (although some auditors report a surprising lack of cooperation between education and social services). Over 60% of the sample authorities are involved in developments with housing associations and nearly three quarters provide planned client support through local voluntary bodies. Housing authorities also allocate property into which social services departments place people with a mental handicap. Some authorities are able to be more generous with their allocations than others, depending upon the size of their housing stock and pressures on it. Collaboration with housing associations and voluntary bodies also allows social security residential care homes allowances to be tapped - a significant source of finance. Some particularly encouraging examples of greater innovation reported include the grant aiding of groups such as 'Crossroads' (which provides a sitting service to clients and carers) and employment specialists such as Mencap Pathway and the Shaw Trust.

42 Government funding, such as that for the Sheltered Placement scheme, and grants from the European Economic Community (EEC), seem less well tapped by local authorities than the more obvious resources such as those involved with housing associations, housing authorities and voluntary bodies. Fewer authorities have set up commercial ventures to produce and sell goods or provide services to the public. So there is still great scope in many authorities for broadening their horizons.

43 The number of placements in private and voluntary homes is rising very substantially. It is not unusual for 30% or more of the PSS residential care budget for mental handicap to be spent in this way. Expenditure has often exceeded budgets by a significant amount - in authorities across the political spectrum. This is not necessarily a reflection of a planned and coordinated service development. It is often due to a reactive response by social services departments to the pressures described in the previous section. When local, planned facilities are full - or unable to cope with the degree of handicap suffered by the person requiring support - placement in a voluntary or privately run home is often the quickest, easiest and cheapest for the local authority to arrange.

44 This is because many resources take time and finance to plan and negotiate before they are ready for clients to use. This can be especially true in authorities which have in the
past provided traditional services only, i.e. hostels and adult training centres. Voluntary associations both prepared and able to engage in service provision may not be strong locally and need to be encouraged. Developments with housing associations take time to come to fruition. Extra staff, whether for traditional or new domiciliary support work need to be recruited and trained. Finance must be found. Meanwhile, a client may require immediate support.

45 The result is growth in voluntary or private care home placements funded, for most of those people given permanent places, by social security residential care home allowances, which grew by 65% between 1985 and 1987. These allowances reduce the financial pressure on local authorities, although 'top ups' are increasingly needed as care home charges exceed the social security allowance.

46 But the problems are not only financial. In many authorities most of these homes are not in the client’s own community, which means lengthy and sometimes difficult journeys for families to visit their handicapped relative. Long distances also make it more difficult for social services’ departments to monitor the client’s welfare and progress. Indeed, directors of social services voice concern about the quality of care in some homes. But clients can be difficult to place and the authority may find itself with little choice.

47 So far the resettlement pattern has also, of course, been heavily influenced by the ‘perverse incentive’ towards residential care inherent in the financial system which currently operates. The social services’ depart-

48 Sound management structures are as important as financial resources. Without them there can be no guarantee that money is well spent. Four elements must be in place:

- objectives for the service which emphasise local, client needs-led support;
- strategies and plans to deliver these objectives;
- an organisational structure which facilitates the development of the service according to the objectives and strategy;
- care management for each client which assesses individual needs and devises programmes designed to develop independence.

49 Care management is the lynch-pin of an individual client needs-led service. It can be described as a system in which a client’s individual strengths and needs are assessed; a package or individual programme plan (IPP) designed and implemented to fit that person’s requirements; progress is monitored; and regular assessment reviews held. It is vital for managers and first-line workers in social services’ departments to become proficient in this system quickly. If they do not, the new post-Griffiths structure will simply not work, founded, as it is, on ‘a proper judgement’ of an individual’s needs.

Exhibit 8
CARE MANAGEMENT
The lynch-pin of an individual client needs-led service
Almost 90% of the sample authorities espouse the philosophy of providing an individual client needs-led service, close to the client's own community and designed to develop as ordinary a life as possible for each person. But to realise this philosophy in practice a local authority must have a strategy for implementing its objectives, complemented by targeted, timetabled and properly resourced short term plans with clearly accountable management. In many authorities this progression is absent. Though 37% have produced community care strategies for people with a mental handicap, only 14% have converted the strategy into a detailed action plan. SSI have also confirmed this lack of progression (ref. 6). Unless the gap is quickly filled local authorities will find it difficult to respond to the challenge which they now face.

Organisational structures in authorities vary, although the general trend is towards decentralisation as social services’ departments reorganise their management structures across all client groups recognising that local, flexible services demand local responsibility and decision taking. If decentralised responsibility for organising a flexible service is to be truly effective, however, then budgetary responsibility must also be devolved. Yet fewer than 3% of local authorities have achieved this. Audit reports also suggest that fewer than 3% of authorities have a satisfactory management information system that would enable a local, flexible service to be organised and controlled.

Over half of authorities assess individual client needs on an annual basis but only one in three claim to be developing some form of individual programme for clients. The frequency by which client progress is actually monitored against programmes where they exist, however, proved difficult to assess. A lack of individual plans has also been confirmed by SSI (ref 6). The provisions of the Disabled Persons (Services, Consultation and Representation) Act 1986 will push authorities further in this direction as they can be required to assess individual clients in respect of services required.

'Key workers' - members of staff nominated to take a key interest in individual clients - are being assigned in a number of authorities; and community mental handicap teams (CMHTs) are being set up to provide specialist support. These teams are made up of staff from both local and health authorities.

Local authority services are still mostly provided in traditional settings: adult training centres (now frequently being renamed social education centres) and hostels. But greater variety is slowly developing: 95% of authorities have some group homes, staffed or unstaffed, and some social services departments place clients with families. The provision of residential support based on small, domestic houses is an essential element in developing 'an ordinary life'. Small, fully staffed houses are particularly likely to cost more, however, than a hospital based service for mentally handicapped people. The Personal Social Services Research Unit (PSSRU) at Kent University reaches this conclusion in its evaluation of the projects in the DHSS 'Care in the Community' initiative (ref. 8). Other research projects, for example that in the South Western RHA and South Wales (Exhibit 3) by L.M. Davies (ref. 7) and an evaluation by Bromsgrove and Redditch DHA of its services for people with a mental handicap (ref. 9) have reached similar conclusions. All these projects, however, conclude that the quality of life for clients is significantly better in small domestic houses than in hospital (Exhibit 9).
Overall, a trend towards providing a more ordinary life for clients can be perceived: hostels are reducing in size and becoming more like home with increased choice and privacy; social education centres provide a wider range of activities and training in daily living skills; more authorities are taking positive steps to get clients into employment. But this is not a universal picture, either between authorities or, sometimes, within authorities. And fewer than 15% of authorities evaluate their support for this client group appropriately.

PROBLEMS IMPEDING PROGRESS

Although the changed philosophy of providing as ordinary a life as possible for clients - 'enabling' people to develop their potential rather than simply 'looking after' them - is endorsed almost unanimously by authorities, reality on the ground is patchy. The most common problems are:

- philosophy interpreted differently by different staff groups, with the officers running units not always sure what is expected of them;
- little movement to realise developments set out in strategy documents;
- traditional services fully occupied with permanent clients;
- lack of a range of service options in day and accommodation support.

In part these problems result from the lack of effective leadership by a manager with sufficient authority, and time, to develop new care models and ensure that a coherent approach to service delivery materialises. Some local authorities assign the development of new service patterns (including resettlement of hospital residents) to someone who already has a full workload in providing existing services. Others give lead responsibility to someone who has insufficient authority over all aspects of the service, while other departments have no-one who provides a natural focus for ensuring services develop in accordance with the stated philosophy.

Lack of effective leadership is not the only problem. There is inadequate definition of objectives, roles, responsibilities and a lack of operational policies for different elements of the service. As a consequence an uncoordinated service can develop and staff morale may suffer. Auditors also identify a lack of clarity on the roles and responsibilities between different members of CMHTs, their management and the teams' roles vis a vis other elements of the service. Too often a team, most of whose members are health authority staff, is imposed on an existing social services structure without sufficient clarification of their respective roles or their professional relationship with local authority staff working with mentally handicapped people. If objectives, roles and operational policies are ill-defined it is not surprising that few authorities have clear standards for service delivery or evaluate quality of services in an appropriately structured and regular manner.

Evaluation of services is another management area in which auditors reported that local authorities were weak, although again there are exceptions. Hampshire County Council is one authority that has set up a formal method of evaluation. This includes a structured annual self-evaluation by units providing services (such as hostels and social education centres). Documents are computerised and link into the annual budgetary cycle. Another element which has recently been introduced is an independent evaluation of units. Surveys of consumer satisfaction with services have not yet been achieved but are intended to form another link in the process.

Staff training is also weak. Although many authorities recognise that a successful shift in service delivery from 'caring for' to 'enabling' clients requires significant staff training, auditors report that fewer than 20% of authorities provide adequate training. One district within a county where staff training for this client group does receive a high profile has a budget of £50,000; many others, however, spend little.

Another difficulty is that many authorities are having increasing difficulty in finding appropriate domestic accommodation for their clients. Housing authorities are faced with a shrinking housing stock and competing demands and some are reluctant to allocate premises to social services departments' mental handicap clients. Meanwhile, housing associations are affected by the Housing Act 1988 and by changes in social security. The Housing Act has altered the associations' funding system as a result of which special needs housing faces an uncertain future after April 1990. Changes to the social security board and lodging allowances from October 1989 are likely to mean a reduced income for some new residents in housing association property from which to pay for their care.
The result is patchy and uncoordinated development of support based on individual client needs and progress to maximum potential independence. Excellent work is achieved by individual staff and groups with vision and determination. But too often their efforts are uncoordinated because the organisational structure fails to provide the leadership and flexibility necessary to develop a service rooted in the authority's philosophy of an ordinary life. Staff training is frequently inadequate, without which appropriate support techniques are unlikely to develop comprehensively. Lack of resources for this and other service developments hamper progress. Meanwhile without proper care management and client training there is little client movement, so few places are available for new referrals. Clearly further measures are needed if substantial progress is to be achieved towards providing a better deal for clients and their carers, and a more effective and efficient use of resources.

Many directors of social services have felt themselves trapped in a vicious circle. Shortage of money leads to inadequate staffing arrangements with poor overall direction and care management. As a result, individual programme plans are not developed and skills are not improved. There is no time to set up cost-effective alternatives and to arrange the social security finance or input from friends, neighbours and voluntary agencies; and there is no point anyway as client skills have not been developed. It is not possible to target services more precisely to produce better quality of life and better value for money. Clients must use traditional services, however inappropriate. This increases pressure on these services from people who should not need them, preventing any release of finance. Because money is tied up in traditional services, there is no money to develop better staff arrangements (Exhibit 10).

There is now an opportunity to break out. An inflow of new funds into the system, even on a modest scale, can allow key staff to be appointed to sharpen objectives at the centre, and promote better care management through devolved budgets locally. Client skills can then be improved, and new alternative services set up - possibly in a small way initially, but in a way which allows external sources of services and finance to be tapped. The 'packages' of care that clients receive are better targeted, deflecting people away from more traditional services, possibly even allowing some modest cut-back. Any such cut-back will release more funds, allowing more staff to be appointed (or allowing training for existing staff to be increased), and allowing a further move up the positive spiral. The creative use of money by care managers means that diversity, flexibility and targeting of services will all increase as the service gradually evolves (Exhibit 11).
5. THE NEXT STEPS

The previous chapters have focused - as auditors tend to do - on the problems. But good practices in each area can be found; they enable the outlines of a successful service to be pieced together. The keys to success are:

— a jointly managed service;
— the innovative use of resources; and
— care management.

A JOINTLY MANAGED SERVICE

One of the more encouraging developments is joint management of services by local and health authorities. At present there are only a few examples but they point the way to successful collaboration. Under these arrangements a joint management group is formed of local and health authority officers overseen by the Joint Consultative Committee. A joint manager is appointed who is responsible for a jointly funded budget. Services and staff can either be seconded from both health and local authorities, so preserving conditions of service, or 'purchased' from these authorities as well as from other agencies. If local and health authorities share common boundaries, it is an obvious, considerable advantage.

A few local authorities are entering into housing consortia with their local DHAs, housing and voluntary associations. This is another form of joint working with pooled resources and expertise. The consortia are usually registered as limited companies, have charitable status and, by registering their residential homes, allow social security residential care home allowances to be claimed. Consortia are new ventures; their long-term viability has yet to be proved.

The Government's announcement on the future of community care will give great new impetus to joint arrangements. The many health and local authorities who will now come together to plan a service should learn from the lessons of those who have in more difficult circumstances, nonetheless managed to negotiate joint arrangements.

THE INNOVATIVE USE OF RESOURCES

The North Western RHA has 'ring-fenced' its mental handicap budget. Some £55 million at 1988/9 prices will eventually be released in 'dowries' through the closure of its mental handicap hospitals. In the West division of East Sussex County Council an agreement with Brighton DHA is enabling first 37 children and now 108 adults to be resettled. NHS funds are being used to finance a jointly agreed strategy. Knock-on benefits include the transfer of local authority clients living in residential accommodation to small staffed houses financed by the NHS, releasing residential places for people resettled from hospital. Health authority finance is also being used to provide resources for a more flexible range of day services, benefiting both community and ex-hospital residents. A contract has now been drawn up to transfer all mental handicap services from Brighton DHA to East Sussex CC. In addition the future use of social services hostels is under review with the aim of enabling residents to transfer to smaller staffed houses where appropriate.

CARE MANAGEMENT

The promotion and coordination of innovation of this type must flow from care management. Community care involves far more than a change

EXHIBIT 12

EXAMPLES OF INNOVATION

Flexible use of resources encourages development of an ordinary life'

(a) adult family placements in Medway (and elsewhere) in which volunteer carers, carefully vetted, trained and supported, provide a valuable alternative to other forms of residential care;

(b) use of Mencap Pathway, Shaw Trust and other employment services to target, place and support clients in work, both sheltered and open. An increasing number of local authorities find investment in these is valuable;

(c) use of volunteer students in Islington (and elsewhere) to partner and support clients in mainstream adult education classes;

(d) integration of clients into 'ordinary' clubs. One case illustrated the significant improvement in self confidence through membership of a running club where the member's mental handicap was not a disability;

(e) use of small satellite day units in Portsmouth (and elsewhere) enabling small groups of clients to use community facilities in their neighbourhood as a change from the large, more institutional social education centre.

Source: Auditors' reports
of address from large institution to small house. It places new emphasis on enabling people to do as much for themselves as possible instead of having things done to them. The old approach of caring for people could be organised centrally in institutions; the new approach of enabling people requires 'responsibility placed as near to the individual and his carers as possible' (ref. 1) in order to allow the degree of flexibility and quick response necessary for:

- continuous assessment and adjustment;
- wider choice adjusted to meet individual needs; and
- assembly of individual packages of care possibly with services from several different agencies.

71 In practical terms, care management requires:

- devolved budgets;
- improved information systems;
- separation of budget holders from service providers;
- introduction of new safeguards; and
- new ways of planning and establishing services.

The implications of these requirements are profound, and will require radical adjustment within social services departments.

72 In future the care manager must be the principal budget holder. This is the most fundamental change and will come as a shock to many social workers and councillors. It will no longer be possible for social services committees to allocate the budget between services, since this will be done from the bottom up by care managers.

Instead they will set broad policy and levels of expenditure and allocate budgets to care managers. How this is done will determine the ultimate shape of the service. The Treasurer's role will also change from controlling service expenditure to monitoring care managers' budgets. And the service providers will have to compete for custom if they are to pay their way.

73 Information systems will have to improve if care managers are not to over-spend and are to make best use of their budgets. And care managers will need to know how to use them, becoming expert at balancing budgets and finetuning expenditure.

74 It will be important to separate the distinct roles of care manager and service provider. As Sir Roy Griffiths said in his report (ref. 1) 'in general ... Social Services authority activities tend to be dominated by the direct management of services which take insufficient account of the varying needs of individuals.' This dominance will remain as long as there is pressure on budget holders to fill places - just as insurance brokers working for insurance companies are under pressure to promote their own company's policies. Instead a three-way arrangement between client, care manager and service provider will be required. (Exhibit 13).

75 Safeguards will be necessary to ensure that clients' needs and wishes remain central and that customer choice becomes a reality - because of the concentration of responsibility into care managers' hands. The first safeguard must be independent audit and evaluation of care management, care packages and services. The second safeguard must be that clients should be able to change their care manager just as patients will be able to change their GP. Care managers could be paid according to the numbers of people on their lists much as GPs are at present, ensuring that they compete to attract clients. A third safeguard may be that clients could have access to independent advocates of their choice to help them to make sure they and their families are getting the best deal.
Finally, care management can only work where care managers have a real choice of services. Sir Roy Griffiths (ref.1) has indicated that social services authorities should stimulate choice and act as development agencies. The development agency must pump prime services, and promote new initiatives to fill gaps. Care managers must indicate to the agency where such gaps are occurring. And under-use of other services will indicate where services are not required.

One example of innovative care management which comes closer to that envisaged by Sir Roy Griffiths than perhaps any other identified by auditors is that developed by Kent County Council in Maidstone. This resettlement project was one of those financed by the DHSS in their 'Care in the Community' initiative. Members of the project team in Maidstone act as care managers, each responsible for a limited number of clients. Following an assessment of an individual's needs, the care manager plans a tailor-made package of formal and informal support. Access to budgetary information enables them to buy-in community care worker support and negotiate access to other services. Client control is enhanced by weekly 'contracts' between user, service purchaser and provider. This service flexibility enables resources to be more precisely matched to people's changing needs.

PSSRU has evaluated the 'Care in the Community' projects (ref 7) and notes that there are problems at Maidstone in monitoring service costs and keeping within allocated resources as the necessary management information system is not yet fully operational.

The last point reinforces the findings of most auditors that management information, though improving, is still inadequate for the flexible, local, client needs-led services authorities are aiming to develop.

PSSRU also observes, however: 'The evidence from projects where budgets have been decentralised, particularly at the level of case management, suggests that such financial autonomy facilitates the creative use of resources' ... 'and the establishment of a service culture in which individual initiative, responsibility and accountability are maximised'. In other words decentralised budgets encourage innovation and a more effective use of resources. This is of great importance.

Local authority social service departments will be working through a challenging transitional phase in the next two to three years, as the financial and management structure in which they operate changes. The work done by auditors over the last year shows that some authorities move into this period considerably better placed to respond than others. This paper has pulled together the general themes. It has been backed by individual reports to each authority making specific recommendations for change. The Commission hopes that these recommendations will be actively pursued by local authorities. Auditors will be monitoring the extent to which they do respond.
ANNEX

SERVICES IN WALES

In March 1983 the Welsh Office published the All Wales Strategy for the Development of Services for Mentally Handicapped People. This document laid down the philosophy and objectives to be followed and set out the new pattern of comprehensive services to be developed for this client group in Wales. These are in line with good practice described in the body of this report for services in England.

The Welsh Office appreciated that 'major savings from the transfer of patients from hospital to community, even if they do materialise, cannot be expected for some years.' Bridging funds, therefore, have been made available by the Welsh Office to finance those new services that are in accordance with the Strategy.

Welsh local authorities were expected to formulate plans based on the Strategy. These plans should have been drawn up with health authorities, other service providers and consumer representatives and submitted to the Welsh Office for approval. Approved plans then form the basis for the allocation of resources by the Welsh Office.

Because the situation in Wales appeared to be in advance of England, with cooperation between agencies, agreed joint plans and extra finance provided by the Welsh Office, audits in the Principality were not carried out in depth. The overviews which were undertaken however revealed both problems common to English authorities and those unique to Wales.

Common problems include the lack of leadership and coordination of services within the local authority and between agencies; inadequate operational policies and insufficient clarification of the roles and responsibilities of CMHTs. The main problem unique to Wales is the difficulty in spending the Welsh Office finance within the year of its allocation. Underspends cannot be carried over to the following year. Annual allocations are announced yearly and authorities have some difficulty in progressing short term plans to ensure all the allocation is spent within twelve months, although some authorities are more successful than others.

Finance from the Welsh Office has, however, enabled a number of initiatives to be realised, including the provision of family aides to support carers with mentally handicapped children; and care workers providing domiciliary support teaching everyday living skills to adults with a mental handicap. An increase in respite care has also been possible in many authorities. Since 1983, according to Welsh Office figures, the number of people receiving support in their own homes has risen from 41 to 1898 (in 1987-8). Large rises have also been seen in community-based day care services.

The impetus provided by the Welsh Office with its Strategy and the provision of finance to encourage the development of good practice has undoubtedly influenced the progress of local community-based services in Wales. The new budgetary arrangements for England will also apply in Wales, as the Secretary of State for Wales announced in a separate statement on July 12.

REFERENCES

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