PROGRESS SO FAR
Caution has been made with the community care changes in English local authorities during the first months following 1 April 1993. Authorities need to continue building on this good start:

SHARPENING ASSESSMENT PROCEDURES

- streamlining cumbersome procedures where necessary
- extending choice to include a wider range of options

DEVELOPING BUDGET PLANNING

- identifying needs more extensively
- setting eligibility criteria for all groups
- underpinning hospital discharge arrangements (successfully managed so far) with better information and planning

DELEGATING BUDGETS

- matching budgets with appropriate financial controls

PLANNING AND CONTROLLING EXPENDITURE

- strengthening financial controls
- managing the special transitional grant, containing commitments while promoting new initiatives (and here authorities should be proactive in developing a wider range of options)

DEVELOPING COMMISSIONING

- monitoring prices in the independent sector, comparing them with the cost of in-house services within a commissioning strategy
- improving contracting arrangements, introducing safeguards where appropriate and developing new forms of agreement suitable for community care services

The changes present a real opportunity to provide care which meets the needs of clients and carers, and is sensitive to their wishes. The foundations have been laid, but for the full benefit to be realised a wider range of options for care must be developed. Many of the necessary initiatives are under way.

The Commission's aim is to ensure that all authorities are well placed to build on this early progress.
1. April 1993 saw the introduction of major changes introduced by the National Health Service and Community Care Act 1990 (the NHSCC Act) to the arrangements for providing care in the community for elderly people, people with physical and learning disabilities, and people with mental health problems. Health and local authorities carry the main responsibility for implementing these changes, with local authorities taking the lead.

2. So far implementation has proceeded smoothly – a major achievement for all concerned given the many forecasts of disaster made before 1 April and the heavy agenda for change which also includes the Children’s Act 1989, the Criminal Justice Act 1991, and local government reorganisation. Most authorities appear to have made a sound if somewhat cautious start. Such caution is understandable, and commendable given the many uncertainties, provided that it does not mask inactivity. There is still much to do, and authorities will need to take care if they are to ensure that steady progress continues without mishap. The steady stream of reports of people in difficulties in the community - particularly people with serious mental health problems - leaves no room for complacency.

3. The changes require authorities to refocus their activities. In the past, the focus has been on providing effective services; from now on, it must be on people and their needs. Finance previously allocated direct to services must increasingly be redirected into budgets for purchasing care for people assessed to need it - either from services provided by local authorities themselves or by others in a mixed economy of care. Assessment must become the focal activity around which all else is framed. But it must be supported by a policy framework, and by procedures, services and systems that can ensure an appropriate response to the assessment (Ref. 1).

4. All of this requires a whole new set of arrangements and initiatives. The Department of Health has indicated that during 1993/94 ‘the first priority will be to ensure that the arrangements being put in place for assessment and securing care and for the management of budgets work effectively’ (Ref 2). Authorities are treading carefully - and rightly so - and a wide range of different approaches is emerging at different speeds.

5. In introducing new arrangements, the focus must be on promoting initiative and creativity, if the vision of greater flexibility and care adjusted to meet the needs of users is to be realised. But authorities must also introduce sufficient controls to allow them to monitor quality and ensure that budgets are balanced. Budgets devolved without adequate directions, controls or information systems could lead to chaos and over- or underspending; but such directions and controls could easily stifle all local flexibility and imagination. Authorities must strike a balance between the risk of run-away uncontrolled expenditure and unmonitored quality on the one hand, and over-restrictive bureaucratic red tape on the other (Exhibit 1). Some restrictions are imposed externally by the requirements of the new legislation or central directions, and here authorities face the extra challenge of taking into account these external requirements.

6. There will be a lot of mistakes - inevitably - as authorities experiment with different approaches. Honest mistakes should be expected and accepted as part of the learning progress. Fear of getting things wrong could stop people getting things right. But it would be unfortunate if the same mistakes were to be repeated across the country. There is much merit in authorities learning from each other wherever possible. Agencies such as the Social Services Inspectorate (SSI) and the Audit Commission have a key role to play in spreading good practice.

7. To this end, the Commission has been monitoring progress with the introduction of the new arrangements this summer focusing mainly on procedures and on financial issues given the Government's initial emphasis. It is too early yet to assess the impact on users and their carers. The SSI is continuing the review process during the autumn of 1993. This paper describes progress in the early months, and is based on enquiries in over 4 out of 5 (83%) local authorities with responsibility for social services in England during the summer of 1993. It
identifies some of the issues that will need to be tackled as the process of implementation progresses. The first section concentrates on meeting needs of users and carers - the main purpose of the changes - looking at assessment and eligibility criteria. The second section then looks at progress with the essential financial and organisational infrastructure needed to underpin a needs-led approach. The key focus throughout is the need to strike a balance at every stage, creating an environment in which flexibility and imagination can flourish within a framework of sound quality and financial controls.

**MEETING NEEDS**

8. The main purpose of the changes is to put the needs of users and their carers at the centre. To this end authorities must introduce assessment procedures at the operational level, and set priorities at the strategic level which translate into eligibility criteria.

**ASSESSMENT**

9. Assessment of needs for community care services is an essential duty laid on authorities by section 47 of the NHSCC Act. It is a key role - because it is at this point that authorities engage directly with users and their carers, and because decisions taken determine authorities' financial commitment. Authorities will rightly be judged by the quality of this process above all else.

10. The Government has issued much guidance on the process (Refs. 3 and 4). The process involves a review of each individual's circumstances, followed by decisions on the services required. The guidance indicates the sort of circumstances that should be taken into account (Box A), and recommends that the scope of the assessment should be adjusted to take account of initial findings, with full multi-disciplinary assessments being reserved for the most complex situations.

11. A critical consideration shaping authorities' decisions is how to contain expenditure within budget, given the new assessment procedures. In the past, assessment was always linked to services. People were assessed against the entry criteria for each service, and admitted or otherwise depending on service availability - the 'gate keeping' approach, which ensured that spending was always within budget. Under the new arrangements, the intention is to put users' and carers' needs first (Ref. 5) adjusting service levels to fit needs rather than the other way around, with presenting need shaping resource requirements. If authorities are to ensure that needs do not generate expenditure that exceeds budgets, they must put in place appropriate procedures. Telling local care managers to 'stay within budgets' is not sufficient; nor is it appropriate to restrict access to the assessment process by making the application process too complicated. The procedures must take account of the law (section 47 of the NHSCC Act).

12. The arrangements are complex and need careful implementation if they are not to overwhelm people applying for help on the one hand or over-commit the authority on the other. They could all too easily create cumbersome bottlenecks requiring excessive amounts of staff time and many are reporting difficulties of this sort. To counter this tendency, the assessment stage should be streamlined so that it is selective and progressive with particular lines of enquiry only pursued when initial checks have indicated that there may be a problem.

13. This complexity could also squeeze out choice and limit a user-centred approach if assessors become bogged down with procedures. So far authorities have resisted this pressure. The Commission found that nearly all (92%) provide potential residents of homes with a list of options, allowing them to visit the homes before making a final decision. Nearly all (92%) investigate any homes not on the list that potential residents have chosen for themselves and most (84%) have written guidelines to staff on how to offer choice. This shows an impressive commitment by authorities to the principle of choice, which should continue to be developed to include an increasing range of options that allow people to stay at home. The remaining few authorities who do not offer choice in this way should introduce appropriate procedures as soon as possible.
Balancing the Books

14. Authorities must strike a balance between commitments and budgeted finance. They have four ways available to them to contain expenditure. First, they can set needs criteria in the light of resources. Second, they can specify how much of each service to provide to each person (hours of home help per week, for example). Third, where they have a power to provide services, they can decide not to do so. And fourth, they can charge for services, provided that people have a 'reasonable' ability to pay (and in the case of residential services they must charge, with the amount depending on ability to pay).

15. Setting needs eligibility criteria is the most effective way of shaping a coherent approach to need while simultaneously containing expenditure. Authorities should aim to set criteria to allow through just enough people with needs to exactly use up their budget (or be prepared to adjust their budgets). What this means in practice is that the authority centrally as part of its planning process (with full consultation with other agencies) must set criteria to reflect priorities and limit expenditure to the amount budgeted: assessors locally must then operate on a day-to-day basis entirely within these criteria. It is therefore the responsibility of the authority itself to ensure that criteria are reasonable and are properly adjusted to prevent under or overspending. It is therefore somewhat alarming to note that many authorities have yet to set clear criteria for many areas of activity, as described in the next section.

NEEDS AND ELIGIBILITY CRITERIA

16. Authorities must define what they consider to constitute a need for services, in such a way that the most disadvantaged are included (Ref. 5) but which still allows the authority to balance its budget. Further more, they must do so in a way that allows local flexibility and adjustment to tailor services to the particular needs of individuals as part of the assessment process. To do all of this will be no mean feat.

17. They will have to start by identifying needs - a complex and difficult process, which will require the rapid development of a methodology. Ideas are beginning to emerge forming a growing body of research - for example, the Social Services Research Group (Eastern Region) has compiled a working paper (Ref. 6) which proposes the combination of top-down approaches using centrally-collected data from the census and other sources with bottom-up approaches involving information from practitioners.

18. Shortfalls identified during assessment are a particularly important source of bottom-up information, and should be recorded systematically for planning purposes. They occur in two ways. First there are the needs of people who fail to meet the authority's eligibility criteria. Where these needs are substantial, they should be recorded by noting the assessment of circumstances (Box A). Thereafter, when criteria are reconsidered as part of the planning process, authorities will be able to judge the effects of changing criteria, and estimate the likely resource consequences of so doing. Second, there are the needs of people who qualified under the criteria for services that can be provided under a power rather than a duty but not provided or only provided in part because of resource shortages.

19. But identifying and collating information about needs is only the first step. A series of other steps is required to produce eligibility criteria, and the District Audit Service of the Audit Commission has proposed an approach (Ref. 7 and 8) which provides a framework for making the key decisions (Exhibit 2). People with roughly similar needs are considered together in 'needs groups' (for planning purposes only - assessment of actual needs for individuals remains an individual process). Numbers are identified, broad service options are proposed and costed, and the expected total cost is then estimated and compared with the budget available. Inevitably, priorities will have to be set to bring the expected total cost into line with the budget - a key role for local authority members. Eligibility criteria are then the encapsulation of these priorities. A 'need-based budget' is also produced, which should form the basis of the community care plan, setting out how authorities are proposing to commission care – both from their own services and from others.

20. Here in particular, the need to strike a balance will be acute. If criteria are too vague they will produce arbitrary and variable results which will reduce equity and may not control expenditure: if they are too tight they will limit creativity. Also they should not target the wrong people inadvertently. For example, many are expressing criteria in terms of physical disability, but research (Ref 9) has shown that physical disability per se is not the key factor that determines potential need for residential care; rather, it is rapidly changing circumstances, such as the sudden incapacity of a carer.
None of this is easy, but progress is underway (Exhibit 4, overleaf). Some 84% of authorities claimed to have estimated needs for 1993/94 with 57% doing so for all client groups. However, 96% claimed to have defined eligibility criteria with 59% having done so for all client groups. It is difficult to see how more authorities can have set meaningful criteria than have estimated need. Furthermore, only 87% of authorities have had their criteria accepted by Committee, with less than two thirds publishing them in community care plans. It is worrying that well over a third of authorities have yet to set criteria for some groups - since how are assessors to judge the need for services without them? However, progress is being made, and auditors will be checking the detail of these arrangements for the 1994/95 community care plans in the Spring of 1994.

Hospital Discharge

One area of need that requires particular attention is hospital discharge. It is at this point that many people – particularly elderly people – are or change in ability, that precipitates a crisis. How should such changing circumstances be encapsulated in clear unambiguous criteria? Here again, the development of a methodology is required.

21. The balance between care of the most disadvantaged and preventive care for those at risk but not yet critical must also be addressed. Where authorities are concentrating on the needs of the most disadvantaged, the eligibility criteria will only include those at the top of the needs pyramid (Exhibit 3). In practice, most authorities are not concentrating all of their resources at the top, but are providing supportive and preventive care at various levels throughout the pyramid. How should services be balanced in future, and how should eligibility criteria reflect the intended balance? But providing services is not the only way of meeting needs. Where someone has clear needs, but the authority cannot meet those needs, either because they do not qualify under the criteria, or there are inadequate resources, an alternative way of helping could be to provide advice and guidance on other ways of tackling the problems, using the private or independent sectors for example. All authorities should have information available on alternatives - possibly in the form of directories - and everyone should be entitled to good advice, counselling and sympathy at the very least, making assessment a service in its own right. Indeed, this sort of advice could become an important way of meeting needs further down the needs pyramid, broadening the base (and the appeal) of local authority activities, with services only provided in exceptional circumstances. A half-way solution would involve authorities organising service packages and then recharging the full cost to users. Authorities will need to work out their preferred strategies with some care.

22. None of this is easy, but progress is underway (Exhibit 4, overleaf). Some 84% of authorities claimed to have estimated needs for 1993/94 with 57% doing so for all client groups. However, 96% claimed to have defined eligibility criteria with 59% having done so for all client groups. It is difficult to see how more authorities can have set meaningful criteria than have estimated need. Furthermore, only 87% of authorities have had their criteria accepted by Committee, with less than two thirds publishing them in community care plans. It is worrying that well over a third of authorities have yet to set criteria for some groups - since how are assessors to judge the need for services without them? However, progress is being made, and auditors will be checking the detail of these arrangements for the 1994/95 community care plans in the Spring of 1994.
vulnerable. Smooth hospital discharge is essential if they are to regain their confidence in the community, and if scarce hospital resources are to be used to best effect. It has been recognised by many as a key indicator of progress with community care changes.

24. All local authorities had agreed arrangements for hospital discharge with health authorities by 31 December 1992 (and will need to do so again in 1993), identifying responsibilities for co-ordinating the discharge process and agreeing arrangements for making referrals, and resolving inter-agency disputes. But less than three quarters have agreed maximum times between notification and assessment, although more than three quarters are monitoring this time, and are helping to monitor delayed discharges.

25. However, in this first year, authorities have had little data with which to plan: fewer than half have been able to estimate the numbers of patients expected to need assessments and just over half have agreed contingency plans in the event of delayed discharges.

26. In practice, however, in spite of this early uncertainty, there are only isolated reports of serious difficulties with delayed discharge and blocked beds. So far health and social services authorities seem to have managed their responsibilities without difficulty. To ensure that this success continues, authorities should be strengthening their planning arrangements, making full use of information from hospitals as it becomes available, so that they can be confident that they are deploying sufficient staff to meet their obligation in an efficient manner.

MANAGING FINANCE AND RESOURCES

27. In support of the processes for evaluating need, setting criteria, carrying out assessments and drawing up care plans, authorities must put in place sound financial and organisational procedures for managing the delivery of care. As an early indicator of progress, the Commission has been paying particular attention to the special transitional grant (STG). The STG is made up of a number of components (Exhibit 5). The bulk of the money consists of funds transferred from social security which previously would have gone to individuals taking up residence in independent residential and nursing homes. 85% of this social security transfer must be used to purchase non-local authority services. Local authorities of all types must therefore set up arrangements for spending this grant, commissioning external services as necessary. As such, the management of the STG provides an early guide to the extent to which local authorities are adjusting to the new 'commissioning' approach, even if all their other services continue to be funded in the traditional way.
users and their carers it must be possible to use resources flexibly. This is best achieved if budgets are delegated.

29. Nearly all authorities have established purchasing budgets to some degree, with just under half having such budgets for all client groups. However, in just under a half (not the same half) the purchasing budget is limited to the STG at present. The degree of delegation varies, with more than a quarter still controlling the budget exclusively from the centre through a central contracting team, service manager, or 'third tier' officer (Exhibit 6).

Exhibit 5
THE SPECIAL TRANSITIONAL GRANT FOR ENGLAND (1993/94)
The STG is made up of a number of components

Exhibit 6
BUDGET DELEGATION
More than a quarter of authorities still control the budget exclusively from the centre

Source: Department of Health Memorandum EL(92)67

PLANNING, CONTROLLING AND MONITORING EXPENDITURE

30. This reluctance to delegate by some may in part be due to insufficient procedures for controlling delegated budgets. The Commission endorses this caution. Delegation must be matched with proper systems for planning, controlling and monitoring expenditure. Managing commissioning budgets calls for new skills, including cash-flow management.

31. Budget holders ought to start with a planned expenditure profile, setting out how much they expect to spend each month, based on assumptions about the expected pattern of demand. This pattern will generate accumulating commitments as people are provided with care that continues from week to week, and the expenditure profile will need to include these forward commitments.

32. Nearly all authorities reported having a budgetary control system that monitors full-year commitments. Four in five monitor actual expenditure against a planned financial profile, with just over half providing on-line access for those who approve expenditure. Three quarters provide regular exception reports to senior officers. Thus progress on financial control appears to be advancing well in most authorities.

33. But in spite of this progress, there are significant concerns with the management of the STG. Against all expectations, spending got off to a slow start during the first three months. For a smooth, even take-up, expenditure of about 6% of the grant would have been expected by 30th June. In reality, most authorities spent less than 2% (with a few exceptions in excess of 6%). Just a third believed themselves to be on-target, but Commission calculations suggest that many of these were being optimistic. Most of the rest were below target or were unsure of their positions. For those aware that they were off-target, the main reasons given were a pre-April rush for placements and undue delay in the assessment process (Exhibit 7).

34. Nine out of ten authorities have contingency plans in place to deal with an overspend in the budget. Few were expecting to be below target. But with hindsight, a slow start might have been predicted for several reasons:

- The tight conditions for the STG
- The likelihood of a cautious approach initially
- Delays in introducing new unfamiliar procedures
Taking Care
Progress with Care in the Community

Anticipated vacancy rate per annum
Source: Audit Commission checklist - 91 English authorities

It is very important that the flexibility and value of this effect is used to the full in the early years to set up a wide range of alternatives before the money becomes fully committed and the flexibility is reduced. At present, the constraints described above are hampering this process. Some way of freeing up the STG is required.

39. Modifying the 85% requirement would not necessarily be the right way forward as authorities might then divert the money to prop up existing services -


\[\text{Exhibit 8}\]
\text{ANTICIPATED TURN-OVER RATES}
Rates per annum appear to be relatively low

Residential Homes

Anticipated vacancy rate per annum
Source: Audit Commission checklist - 91 English authorities

impact, helping the smooth take-off of community care. It is very important that the flexibility and value of this effect is used to the full in the early years to set up a wide range of alternatives before the money becomes fully committed and the flexibility is reduced. At present, the constraints described above are hampering this process. Some way of freeing up the STG is required.

38. In the short term, however, additional funds that are not already committed can have a relatively big

\[\text{Exhibit 7}\]
\text{VARIANCE FROM STG SPENDING TARGET}
Most authorities not on-target were below target or were unsure of their positions (first quarter 1993/94)
perpetuating the service-driven approach. Carrying forward any underspend for use in future years would give considerable flexibility but is not likely to be feasible. Changing the pattern of demand is not within authorities’ control. This leaves increasing the ways in which the money is used - containing the full-year effects as necessary to maintain flexibility.

40. Any such increases would need to be within the spirit of the new grant - helping to establish and finance new, innovative services in the community, by funding initial costs such as training, rather than providing services directly, for example. Funds should not be used to promote low priority options simply to spend the money in time, giving poor value for money. A good test of appropriateness might be that options clearly contribute to authorities’ strategies for developing the market set out in their community care plans. Consideration should be given to promoting such options, allowing authorities to be more proactive in developing a wider range of choice reflecting the needs of their users and carers.

COMMISSIONING

41. All authorities, if they are to promote a mixed economy of care, must be commissioning non-local authority services. They have all done so to some degree for many years, but the new arrangements call for a much more substantial involvement with the independent sector. Authorities are receiving a major transfer of funds from the Department of Social Security (DSS) that previously would have gone to individuals in residential and nursing homes. They must spend 85% of these funds on non-local authority services and in the early months, they are likely to continue to go to residential and nursing homes. This situation could start to change once authorities have had a chance to consolidate assessment procedures and stimulate a wider range of independent sector options including home care. As a first step, authorities should be ‘mapping the market’, recording existing services of all types. Wherever possible, they should then be stimulating the development of new services, so that the overall pattern better reflects need.

Residential and nursing home care

42. In the early months following 1 April, the Commission has concentrated on monitoring arrangements for residential and nursing home care. The emphasis on choice, already reported, has had an effect on the type of contract employed by most authorities. Most are relying initially on ‘spot’ contracts, buying places individually to meet individual needs, and on ‘call-off contracts’, buying individual places as needed within an overall contract which specifies price, terms and conditions, but not numbers of places (Exhibit 9). Only one is relying solely on block contracts which specify prices, terms and conditions and numbers of places. One in five is using a mixture of contract types.

Prices paid tend to be at or above the former social security rates (Exhibits 10 and 11, overleaf), with average prices mostly above these rates (Table 1).

Exhibit 9

<table>
<thead>
<tr>
<th>TYPE OF CONTRACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spot contracts</td>
</tr>
<tr>
<td>Call-off contracts</td>
</tr>
<tr>
<td>Mixture of contract types</td>
</tr>
<tr>
<td>Block contracts</td>
</tr>
</tbody>
</table>

Source: Audit Commission checklist - 91 English authorities

Table 1

<table>
<thead>
<tr>
<th>AVERAGE (MEAN) COST OF HOMES PLACES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average prices are mostly above former social security rates</td>
</tr>
<tr>
<td>(Sample: 44 English authorities - resident weeks, first quarter 1993/94)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Nursing homes</th>
<th>Residential homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>former average rates</td>
<td>280</td>
<td>287</td>
</tr>
<tr>
<td>DSS (mean)</td>
<td>274</td>
<td>274</td>
</tr>
<tr>
<td>net prices</td>
<td>175</td>
<td>185</td>
</tr>
<tr>
<td>to LAs</td>
<td>185</td>
<td>201</td>
</tr>
<tr>
<td>costs</td>
<td>185</td>
<td>201</td>
</tr>
<tr>
<td>DSS (mean)</td>
<td>209</td>
<td>104</td>
</tr>
<tr>
<td>net prices</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>to LAs</td>
<td></td>
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</tr>
</tbody>
</table>

Counties (10)  | Metropolitan authorities (12) |
London boroughs (12) | 315 | 341 | 210 | 210 | 270 | 162 |

43. A number of patterns emerge from this analysis. First, nursing home prices are being held down to former social security rates more tightly than residential care rates, except in London. A few counties are paying nursing home care rates of around £180 - £210, no doubt for dual registration homes, bringing the overall average of £274 below the DSS rate of £280.
Exhibit 10
PRICES PAID AND NET COSTS TO LOCAL AUTHORITIES FOR INDEPENDENT NURSING HOMES

Nursing home prices are being held down to former social security rates, except in London

Source: Audit Commission checklist - 44 English authorities

Taking Care
Progress with Care in the Community
Exhibit 11
PRICES PAID AND NET COSTS TO LOCAL AUTHORITIES FOR INDEPENDENT RESIDENTIAL HOMES
The spread of prices paid for residential care is wider

Source: Audit Commission checklist - 44 English authorities
44. The spread of prices paid for residential care is wider. Some are reporting that this is because authorities are placing people who previously would have been placed in nursing homes in residential homes, and paying a price mid-way between DSS nursing and residential home rates. There is as yet no direct evidence to support this claim, but it seems possible. If true, this shift down from nursing home places to residential home places would represent a move to greater economy countering the apparent upward drift in prices above social security rates. Authorities should ensure that needs are met appropriately - in particular any needs requiring nursing care. The continuing improvement of assessment procedures (including measures of ‘frailty’) should allow them to do so with ever greater efficiency. And health purchasers should ensure that appropriate nursing care is provided.

45. When the allocation of STG to authorities is also taken into account, the relative disadvantage of some authorities - particularly some London Boroughs - becomes apparent. Dividing STG per head of population aged over 75 by the average net cost to local authorities of independent residential care gives resident weeks available per person over 75 - a very crude estimate of the purchasing power of the STG for residential homes in different types of authority which shows it to be highest in metropolitan authorities and lowest in London in the sample (Exhibit 12). This calculation does not take account of the relative costs of independent sector nursing home costs or of home care services which are relatively under-developed as yet, but illustrates why some authorities may be finding it easier to meet targets than others. The spread is in part due to differences in prices and in part due to the methodology used this year for allocating the STG between authorities. Half of the grant is distributed to reflect the existing distribution of homes. Difficulties may be experienced next year by authorities receiving large grant settlements this year to pay for large numbers of independent homes in their areas, since the standard spending assessment adjustment for next year will not continue this premium. Such authorities will need to be particularly careful to keep full-year commitments within bounds if they are not to over commit themselves next year.

46. Independent sector residential care prices may also be lower than unit costs in local authority residential homes. This was found to be the case in some homes in a sample of county council-owned residential homes costed using CIPFA principles with overheads and market values for capital included (Exhibit 13). Such homes must be vulnerable in an increasingly competitive world. All but 5% on overheads are likely to be available for redeployment on closure with staff costs accounting for 70% (Exhibit 14). Furthermore, many local authority homes are still failing to meet registration standards. To raise standards will cost significant amounts of capital that local authorities often do not have available. Social
47. The prospect of closing or selling local authority homes is never popular, but should be considered where appropriate. Every home with unnecessarily high costs denies people in the community funds for their home care. Also, closures or sales could allow authorities to solve several other potential problems. First, a shift to the independent sector would allow authorities to ensure that they can use the 85% portion of the social security transfer to the full. Second, resources would be released, allowing authorities to expand and develop home care services. Third, the need for capital expenditure to bring homes up to registration standards would be avoided. Fourth, skilled staff would be released from homes for use in the community: demand is likely to be such that there is no need to contemplate redundancy for anyone prepared to make the switch to domiciliary care. For local authorities there is the added advantage of shifting costs from local authority to social security budgets for all new placements in the independent sector. This shift could lead to increases in public expenditure overall.

48. Authorities will need to consider their options carefully. Some have already transferred most of their homes to the independent sector; others have extensive plans for reducing numbers of places; yet others are resisting closures at the moment. But whatever course of action is taken, it is essential that the interests of existing residents are safeguarded. It is important to plan any closures with great care and sensitivity from the start. All authorities will need to be careful to ensure that their own supply is adequate to buffer against sharp rises in prices in future, and some are planning a much reduced but still significant number of homes to safeguard their own interests. The Commission will be investigating costs more extensively and monitoring prices over the next six to nine months, and will be presenting authorities with comparisons for their own individual areas to help them determine appropriate strategies which fit their own circumstances.

CONTRACTING

49. As part of the commissioning process, authorities must draw up contracts with the independent sector. While all have experience of contracting for ancillary services, contracting for care on a significant scale is new, and authorities are still working out the best way forward. Most will need to continue to improve their arrangements, further strengthening the regularity of their contracting process.

50. In addition to promoting choice (already described), authorities contracting with residential and nursing homes should also be:

- ensuring that homes are financially sound;
- putting in place an appropriate range of safeguards;
- monitoring arrangements;
- promoting further developments

These are considered in turn.

50. **Financial viability:** a service should only be selected - particularly a residential or nursing home - if it is going to be able to continue for the foreseeable future. Only just over half of authorities make any assessment of a home’s financial viability. Only a quarter review a home’s accounts and just 8% check credit references. A very small number (3%) do both, and it is these authorities that are best placed to protect the interests of users and ensure that quality care is maintained. Less than three quarters of authorities have contingency plans to deal with home closures. A quarter plan to relocate residents and only 8% have plans to support residents in the home until other arrangements can be sorted out. The plans of nearly half (42%) of authorities appeared to be unclear, with 29% having no plans at all. All authorities should develop a policy for dealing with the closure of independent sector homes, publishing it as part of their community care plan to open the issue for public consultation.

51. **Safeguards:** all authorities must introduce sound procedures for guarding against corruption as a matter of course. Most authorities have separated responsibility for letting contracts and placing clients between different officers. Relatively few are employing
competitive tendering, preferring to fix prices in advance. Of those that are, there appear to be clear
tendering and opening procedures, with half using
existing procedures employed by other departments.
Those fixing prices should consider tendering to explore
whether lower prices can be obtained.

52. Two thirds of authorities operate an approved list
of homes, with half inviting homes to join the list, while
40% rely on open advertisement (with some overlap
between the two groups). Less than half have criteria for
joining the list approved by Committee. All must ensure
that the list is open to all homes on merit with no
possibility of partiality.

53. Almost half of all authorities had a register of
interest for social services staff and over 40% for
members. Only 29% had a register for other local
authority staff, and just 4% had a register for GPs and
hospital consultants. Over a third had no register of any
sort. All authorities should be strengthening this area of
their activities. Three out of five authorities include
warnings about inducements in contract documentation,
with a third specifying penalties in the event of
inducements. But two out of every five authorities have
yet to take these basic precautions. The Commission will
be continuing to monitor contracting arrangements
actively, to ensure that sound procedures are introduced
in all authorities.

54. Monitoring: Nearly all authorities have some
arrangements in place for monitoring contracts. Nearly
two thirds make regular visits to homes, but only 13% ask
the residents for their views. Two authorities rely solely
on registration and inspection visits, and eight have yet
to finalise arrangements. All should actively monitor
quality and contract compliance, consulting users at
every opportunity. Only just over half of authorities
report on contracting issues regularly to Committee.
Members should be kept informed about important
contracting issues as part of a strategy for ensuring that
contracting is as open and fair as possible.

55. Further developments: As authorities start to
commission a wider range of services, they will need to
extend and develop the contracting process still further.
Arrangements appropriate for a contract with a major
supplier of residential care are unlikely to be suitable for
a service agreement with a neighbour to pop in daily to
help settle somebody at night, for example. Yet it is
essential that purchaser, neighbour and (above all) the
user are adequately protected by workable arrangements.

And there are likely to be many services in between these
two extremes requiring sound arrangements that are not
too onerous. Here again, there is a need for further
development, and the Commission intends to take a
major interest in this important area of activity.

CONCLUSION

Most authorities are putting in place the foundations
that will allow the new arrangements for community care
to flourish. However, some are rather slower than others,
and a few are in danger of lagging well behind. The
Commission intends to continue checking on progress
in association with the SSI to ensure that the good
progress to date continues, and that all authorities
achieve the standards of the best.
H Authorities must strike a balance, creating an environment in which flexibility and imagination can flourish within a framework of sound quality and financial controls.

H Assessments should be streamlined to be selective and progressive with particular lines of enquiry only pursued when initial checks have indicated a problem.

H While nearly all authorities offer choice to users and carers, the few that do not must introduce procedures as soon as possible.

H Authorities must introduce eligibility criteria for all client groups to provide guidance to assessors and to limit their own financial liability.

H They must identify need, and in particular, record shortfalls identified during assessments.

H They must introduce procedures for quantifying the resource implications of meeting needs, and set priorities and hence criteria that ensure the financial consequences do not exceed budgets.

H They should consider developing assessment as a service in its own right, providing advice even to those who do not fulfil the eligibility criteria where necessary.

H They should back agreements on hospital discharge with sound planning and resource commitments as information becomes available.

H They should delegate budgets but only when proper systems are in place for planning, controlling and monitoring expenditure.

H Consideration should be given to increasing the ways in which the 85% portion of the STG social security transfer is used.

H Authorities will need to monitor and control forward commitments and vacancy rates to ensure they have a steady flow of vacancies and do not become over-committed.

H They need to review the costs of their own residential care, ensuring that they are getting best value for money, within an overall strategy.

H They need to ensure that contracting procedures continue to develop, and take into account financial viability of contractors. They should also include safeguards against irregular conduct, and arrangements for monitoring.

H All need to continue to build on an encouraging start – particularly those authorities in danger of lagging behind.

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