The Community Revolution:
Personal Social Services and Community Care

The Audit Commission for Local Authorities and the National Health Service in England and Wales

SOC 1
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Preface

The Audit Commission oversees the external audit of local authorities and the National Health Service (NHS) in England and Wales. As part of this function the Commission is charged with reviewing the value for money provided, and to this end undertakes studies and audits of selected topics each year.

For the past eighteen months the Commission has been reviewing arrangements for implementing community care. The policy of caring for people in the community in preference to hospital whenever it is feasible and sensible to do so has been supported by successive governments for many years. The Commission has maintained an interest in the implementation of this policy for some time. A report was published in 1986, entitled *Making a Reality of Community Care* (Ref.1), which identified a number of serious weaknesses in the way the policy is being pursued. The Government has subsequently introduced major change, with the NHS and Community Care Act 1990 providing the legislative framework.

This report looks at the problems which face local social services authorities as they prepare to implement these changes. The Department of Health has issued policy guidance to local social services and health authorities and the study takes this as the basis for implementation by social services. The report addresses the challenge to the traditional way in which social services have delivered care to vulnerable adults. It looks at the information and system requirements of the changes and at the recognised need to work more closely with other agencies in order to deliver a comprehensive service to people in the community.

To complement this paper the Commission has produced two other reports. The first *Managing the Cascade of Change* is an overview focusing on the interagency aspects of community care; the second *Homeward Bound* is a study of the role of the community health service. A further study, on the services provided by the Family Health Services Authorities (FHSAs), will be published later this year.

Under the direction of Dr Ross Tristem and David Browning, the social services study was undertaken by Claire Blackman, Dr Judy Renshaw and Graham Cuthbert with support from Jim Burden and Mark Davenport. Anthony Harrison acted as consultant to the team.
# Table of Contents

**SUMMARY**
- 1. Resistance to change: 1
- 2. Inadequate systems: 2
- 3. A fragmented service: 2

**INTRODUCTION**
- Background 5
- From 1993 onwards 8
  Transfer of social security income support 8

**1. PEOPLE, FINANCE AND ACTIVITIES**
- Elderly people 12
- Younger, physically disabled people 14
- People with learning disabilities 14
- People with mental health problems 15
- Carers – the fifth user group 17

**2. A CULTURAL REVOLUTION**
- Traditional social services & obstacles to change 19
  - 1. The changing role of social services 20
    The problems 20
    The solutions 22
  - 2. A new focus for policy decisions 26
    The problem 26
    The solution 26
  - 3. A challenge to power structures and vested interests 27
    The problems 27
    The solutions 27

**3. SYSTEMS REQUIREMENTS**
- Policy making in a vacuum 31
  The problems 31
- Informed policy making 33
  The solutions 33
- Inadequate operational systems 41
  The problems 41
Summary

The delivery of care and support to adults in the community will undergo a fundamental change in the 1990s. Firstly, implementation of the National Health Service and Community Care Act 1990 requires local social services authorities to move from being the suppliers of a range of services to adopting the lead agency role. From April 1993 they will be required to assess the needs of individual people, arrange with them individually tailored services to meet those needs and commission these services as appropriate. Innovative schemes which are sensitive to users’ needs can be found already in many authorities but they are often local projects and do not reach the majority of social services’ users: hence the need for more comprehensive change.

Secondly, from April 1993 the care element of social security income support for nursing and residential home care currently available to people through a means test will be paid instead to local social services authorities. The money will then be available to pay for care delivered in the home as well as for nursing and residential home care. At present this form of income support is paid to some 200,000 people. Their entitlement to it will be protected. But from April 1993 potential new claimants will need to approach social services for support. Demand for local authority support is, therefore, likely to increase significantly, particularly from elderly people.

Behind these changes there are two key aims from which others flow. The first aim is to empower the service users and their carers giving them choices about the support provided so that their needs can be met in ways and at times convenient to them. The second is to enable people to be cared for in their own home where appropriate, rather than in residential settings simply because that is where the resources lie. In addition, where more than one agency is involved in arranging for care to be delivered – eg, social services and health authorities – then service delivery should be co-ordinated so that the users and their carers experience a ‘seamless service’.

To implement the new legislation and deliver these objectives a revolution must take place over the next decade in the way social services operate. The Department of Health and Welsh Office have issued guidance on what is expected of authorities and how the desired results can be achieved. And most recently the requirements for April 1993 have been reiterated in a letter to directors of social services from the Department of Health. But the Audit Commission has identified major obstacles facing social services in implementing this guidance. Three stand out:

1. RESISTANCE TO CHANGE:
   — The new approach to community care focuses on the service user, not on the service. It therefore presents a challenge to the traditional role and culture of the social services department. Established power structures and vested interests, both within the department and in the authority as a whole, will be undermined. If positive steps are not taken, many – although by no means all – social services departments will experience significant resistance to the fundamental changes required by the implementation of the new legislation.
2. **INADEQUATE SYSTEMS:**

— As the role of social services is being changed from that of a service supplier to that of assessor and commissioner (with many services commissioned from within the local authority in the short term) the current systems for policy making and operations are inadequate for the future. Unfocused commissioning and uncontrolled budgets will result if the system requirements of the new role are not rigorously addressed.

3. **A FRAGMENTED SERVICE:**

— If the new approach is to work, the agencies involved in community care must work well together. Experience shows that this is often not the case, particularly between the key agencies of social services and health. Priorities, organisational styles and cultures are different, frequently producing uncomplimentary opinions of each other and a reluctance to work co-operatively. Arrangements for the discharge of people from acute hospital care who require continuing support are particularly difficult. From April 1993 a publicly funded place in a nursing home will not be available (unless paid for by the health service) without the agreement of social services. Acute hospital beds may become blocked and elective surgery cancelled if arrangements for support following discharge are not in place.

Solutions to these challenges are possible and authorities are beginning to find them. A basic requirement is commitment to the changes from local social services authority members and staff. Such commitment will not happen overnight and new responsibilities should not be programmed in the expectation that those involved will be automatically committed to them from the outset. A number of elements are required to start the process: a corporate approach, committed leadership in social services from someone with the authority and time to devote to the task, clear philosophy and goals and above all involvement, training and education for both members and staff at all levels. Changes should be introduced incrementally to allow staff to gain experience and confidence and to enable new systems to be developed and tested.

Many authorities are beginning to focus on these system requirements. ‘Need’ within the community must be rigorously defined and then measured – necessarily rather crudely in the first year or two. A stocktake of current resources is necessary. Priorities and targets between and within user groups must be set together with eligibility criteria for receipt of care. Budgets must then be allocated which attempt to square the circle between needs, targets and resources. These decisions will not be easy but unless council members take them they will have failed to give the necessary lead and policy decisions will be made by front line staff by default.

A lack of financial and management information is the rock on which community care will founder if devolved budgets and a split between the commissioner and provider functions are implemented ahead of the necessary support systems. Attention must be paid to developing two elements: management structures that appropriately support care management, devolved budget holding and the split between the roles of commissioning and provision; and financial and management information geared to the needs of the staff operating these new functions. The first priorities are to have an assessment procedure in place by April 1993 to cope with the increased number of potential users, together with a system to handle the changes in charging mechanisms brought in by the transfer of the care element of income support to local authorities from that date.
Working with other agencies will be an important aspect of community care. Where relationships have not been productive in the past such working arrangements will need to be handled sensitively. There are indications that authorities are making an increased effort to work together. The new legislation requires consultation between agencies. This should be interpreted as involvement in policy decisions in order to get joint agreements particularly on needs, goals, priorities and targets, and on the boundaries of responsibility between agencies, especially health and social care. Where possible, a joint plan should be agreed for the development of community care that uses combined resources in a cost effective manner avoiding duplication and gaps in services. Operationally there must be co-operation between the agencies, in particular around the discharge of patients from acute care. A promising model for collaboration could involve a local care manager responsible for co-ordinating the delivery of both social and health care.

Local authorities are at different stages in developing solutions to the problems highlighted. Some are well advanced; others require more help in tackling the obstacles they face. Over the next twelve months the Commission's auditors will be working with social services inspectors from the Department of Health and the Welsh Office to monitor and advise local social services authorities on ways of overcoming such difficulties to implement this important legislation.
Introduction

BACKGROUND

1. 'Community Care' is not a new concept but it is undergoing a number of major changes which will continue throughout the 1990s. Following the Audit Commission's report in 1986 (Ref. 1) which detailed a number of financial, organisational and cultural problems, the Government asked Sir Roy Griffiths for a review of the issues (Ref. 2). This resulted in legislation under the National Health Service and Community Care Act 1990 which places the needs of users and their carers before those of service providers. Local social services authorities will cease to be merely suppliers of services and instead take the lead role in assessing the social care needs of individual people and commissioning services. The main elements of these reforms are:

(i). to arrange services based on the assessment of needs,
(ii). to set up a care management system for commissioning care,
(iii). to devolve budgets as close to the user as possible to allow flexible, local purchasing,
(iv). to encourage a 'mixed economy of care' in which voluntary, private and statutory providers operate enabling more flexible choice of services to users and carers,
(v). to transfer to local social services authorities the care element of social security income support currently paid to residents of private and voluntary residential and nursing homes.

2. The timetable for the legislative changes is short (Exhibit 1) but much is being left to the discretion of local social services authorities as to how they organise themselves to achieve the policy objectives. The Department of Health (DoH) and the Welsh Office are following the brief requirements of the Act with a wealth of guidance. Policy Guidance (Ref. 3) explaining what is expected of authorities has been published and practice guidance papers are being issued outlining how the policy objectives might be realised.

Exhibit 1

ACTION ON COMMUNITY CARE
The timetable for the legislative changes

![Timetable Diagram]

- April 1991: Inspection Unit, Complaints Procedure, Specific Grants for Mental Illness, Drug and Alcohol Abuse
- April 1992: First Community Care Plan
- April 1993: New Assessment Procedures, Social Security Income Support transferred to social services authorities
- Onwards: Development of Care Management and new service patterns based on assessment of individual needs
3. The Policy Guidance emphasises that support for individuals should help sustain as normal and independent a life as possible, using ordinary services whenever feasible, building upon each person's own relationships and life style. Users and carers should be given choice in the support provided and the times they receive it. So, for example, an elderly or physically disabled person relying on the local authority for social care should not have to be helped to bed by 7pm, because of inflexible staffing conditions. Nor should someone with mental health problems find social support impossible to find at weekends or on Christmas day because staffing arrangements mean facilities are closed. For people with learning disabilities the increased emphasis on independence and choice should mean individual care plans are implemented to help each person lead as ordinary a life as possible using community facilities available to everyone. For carers there should be more information, choice, and better access to respite care. Carers, who have been largely neglected by statutory services in the past, have a range of needs which are sometimes quite simple and straightforward.

4. The reforms are not expected to be fully operational by April 1993, as indicated by the Policy Guidance: 'organisational structures, procedures, practices and attitudes will need to be adapted over time to achieve a (user) needs-led approach to assessment and the delivery of service'. Existing service patterns which do not respond to people's needs will have to adapt or face eventual closure with their budgets used to commission new service patterns which give more appropriate support. However, authorities should set a timetable for the development of the reforms. The first priority is to ensure that current budgets buy those new services that are wanted (Exhibit 2). Any future growth money can then be used to target areas of unmet need identified by comprehensive assessment.

Exhibit 2

CHANGING SERVICE PATTERNS

Authorities should ensure that budgets buy new services that are wanted

5. In implementing the 1990 Act and DoH Guidance local authorities must pay increasing attention to their links with other agencies – particularly the NHS. Many of social services' most dependent users are also clients of the community health service or have recently been discharged from hospital. Indeed the NHS is a major source of referral to social services. For users of both health and social care the DoH Policy Guidance requires that 'the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective
of the service user'. In other words district health authorities (DHAs), family health services authorities (FHSAs) and Local Authorities must between them provide a 'seamless service' to users. The 1990 Act requires local authorities to consult their respective health authorities both at the strategic planning stage and in the local assessment of individual people. And, although it has not been made mandatory for English authorities, it is hoped that many Community Care Plans will be jointly produced by local and health authorities; in Wales this is a mandatory requirement.

6. Indeed, developments in joint working, backed by Welsh Office funding, have been pursued in Wales for a number of years. Strategies have been developed for people with learning difficulties and mental health problems which are distinctly different from their English counterparts. The *All Wales Strategy for People with Mental Handicaps*, published in 1983, set out a ten year plan for new services. It stated three principles:

— people with 'mental handicaps' should have a right to normal patterns of life within the community

— people with 'mental handicaps' should have a right to be treated as individuals

— people with 'mental handicaps' require additional help from the communities in which they live and from professional services if they are to develop their maximum potential as individuals.

Additional funding was made available by the Welsh Office for services planned locally, on the basis of local need, which were required to fulfil the principles of the Strategy. Primary responsibility was given to social services authorities, which had to consult with health and other bodies. Representatives of users and their families were to be involved in the planning and management of services. Monitoring and evaluation of the new services was commissioned throughout the Strategy period. Some marked improvements have been noted since 1983, although overall progress has inevitably been uneven. Many people have left institutions and more support has been received by families. The development of suitable measures for evaluating the impact and cost-effectiveness of the new services is being carried out jointly by the Welsh Office, local authorities in Wales and the Audit Commission. Proposals for continuing the Strategy for a further period are being considered. The Strategy document *Mental Illness Services: a Strategy for Wales* was issued in 1989 following a consultation document the previous year, to which a wide variety of organisations and individuals had responded. A broad pattern of service development was described and ear-marked funding was made available for plans approved by the Welsh Office. Bids were required to be jointly developed between health, social services and the voluntary sector. The impact and costs of this Strategy will also be evaluated by research commissioned by the Welsh Office.

7. Health authorities are not the only bodies with which authorities must consult and co-operate. Housing agencies and voluntary bodies – both providing services and those representing users and carers – must also be consulted when local social services authorities are preparing their Community Care Plans. Other providers must also be involved. Between them these disparate agencies have to deliver care to many different users. The four main groups are:

— elderly people

— people with physical and sensory disabilities
— people with learning disabilities
— people with mental health problems

The user numbers, expenditure and activities for each of these groups are outlined in the next chapter.

FROM 1993 ONWARDS

8. Against this background local social services authorities face an uphill task. They are already grappling with the requirements of the Children Act 1989 and Criminal Justice Act 1991; and pressure is growing on them to arrange support in the community for increasing numbers of adults. Hospital stays are reducing, long stay NHS facilities are closing and demand for support for very vulnerable people and carers is increasing. In addition social services user numbers will rise sharply following the transfer of social security funds in 1993.

TRANSFER OF SOCIAL SECURITY INCOME SUPPORT

9. It is not yet known what proportion of the income support finance will be identified as the 'care element' to be transferred to local authorities, nor how much will be passed over year by year. The DoH expects social services budgets for adult services to rise by at least a third in real terms in three years. The number of claimants receiving income support for residential and nursing home care is large – 189,000 in 1990. The finance eventually transferred will represent the cost of care for these people whose successors – many of whom are likely to be highly dependent – will rely on social services for their support. (Those already in private or voluntary homes on 1 April 1993 will continue to receive income support direct as at present).

10. The financial transfer to local authorities will be made through the revenue support grant. There is no guarantee that all the transferred funds will be allocated by authorities to social services – although the amount transferred to authorities will be identifiable. Indeed, there is a genuine concern that some authorities – particularly those that are in greatest financial difficulties – may use the new funds to reduce financial pressure within other departments. If this happens the results could be adverse, not only for vulnerable people and their carers but also for the NHS. People in hospital whose needs outside the hospital environment must be assessed and met through social services may be kept waiting, blocking beds for other patients with a corresponding effect on the waiting lists for elective surgery. One solution, which varies a proposal by Sir Roy Griffiths, would be to ringfence the finance during the transition period to ensure that local authorities allocate the financial transfer to social services. Once the capacity to arrange services for the increased number of users has been developed, the risk that a significant portion of this transfer would be allocated to other departments would reduce. Ringfencing could then cease.

11. The transfer of the 'care' element of income support is intended to encourage the growth of care in people's own homes. In consequence, a substantial reduction in nursing and residential home placements could well result, causing under-utilisation and premature closure of homes with residents still living in them. If remaining residents are not to suffer a reducing quality of care and increasing level of anxiety the decline in the number of homes must be managed. Discussions will also be needed with health purchasers and providers to ensure provision to meet any increased requirement for community nursing. Nursing home places may well be used only
when 24 hour nursing care is required. Any increased demand for nurse visits to residential homes and people's own homes for those who might previously have gone into nursing homes must be met by health authorities. Social services will be able to pay for nursing home care but not for an NHS nurse in someone's own home.

12. The new legislation and proposed transfer of income support go some way towards addressing the issues raised by the Commission in 1986. However, significant problems remain. Although social services authorities have been given lead responsibility for assessing and purchasing social care there is still organisational and financial fragmentation between agencies with some confusion over the boundary between social and health care. Local health and social services authorities are exhorted to work together but incentives for this are still lacking, particularly in England. The DoH is issuing both policy and practice guidance to authorities on what is expected of them and how to set about achieving it. The following four chapters highlight areas which the Commission believes present difficulties for local authorities and significant problems in carrying out that guidance. Suggestions for addressing those problems are made.

Chapter One – summarises the scale of the challenge facing local authorities in terms of user groups, levels of current expenditure and activities and likely trends in demand.

Chapter Two – explains the problems effecting the cultural revolution needed to turn a service-driven organisation into one that is focused on the needs of individuals, and suggests some solutions.

Chapter Three – examines the information and systems required to help identify needs, resources and the control of finances where budgets have been devolved to care managers.

Chapter Four – explores how social services can co-operate with the other agencies involved in community care and the users of services.
13. Expenditure on community care has almost doubled in real terms over the last decade (Exhibit 3). These broad brush figures show that during this period local government expenditure has risen by 40%, but has declined from 34% to 28% of the total. Expenditure on services for elderly people is more than twice that on the other three user groups put together (Exhibit 4, overleaf). The main components of local government expenditure are residential, day and domiciliary care.

Exhibit 3
EXPENDITURE ON MAJOR USER GROUPS
Expenditure has almost doubled in real terms over the last decade

Note: ‘Social Security Other’ includes mobility, invalid care, severe disability and attendance allowances.

Source: Department of Social Security, England.

14. Particularly noteworthy is the growing importance of social security provision such as mobility or invalid care allowances which are not tied to residential care but which go to users of community care and their carers. These payments far outweigh those from social security to people in residential and nursing home care, but it is not known how much of this finance is turned into domiciliary care, enabling people to stay in their own homes. Such evidence as there is, from small-scale surveys of the use people make of the extra income, tends to suggest its impact on care received is minor. Rather it is used as an addition to general income. Although some of these surveys and the Commission's study have identified that some public sector care schemes specifically rely on the attendance allowance for their finance.
15. The Independent Living Fund (ILF) provided £46 million in 1991/92 to support people in their own homes. The awards, averaging £90 a week, are based on an assessment of the care needs of the individual and are means-tested. A recent survey of nearly 500 recipients for a report by the ILF (Ref.4) found that 82% were aged between 16 and 74 but 12% were over 74 years of age. The disabled people interviewed ‘ranged from the articulate and competent to those who could not speak for themselves and were very dependent’. The awards are used to finance care directly and the report concluded that despite high levels of dependency, people were able to exercise choice and control over their care arrangements.

16. Appendix 1 provides a more detailed analysis of user numbers, expenditure and activities for the four main user groups. The results of the analyses are summarised below together with services to carers, who can be considered a user group in their own right. The analyses demonstrate some of the difficulties social services will face in the 1990s including growing demand, the inappropriateness of some current services, and unmet needs.

**ELDERLY PEOPLE**

17. The growth in numbers of very elderly people will continue during the 1990s (Exhibit 5). Potential users requiring social services' support are also likely to grow because of a number of other factors:

— the increase in number of elderly people living alone,

— the likely reduction in available informal care resulting from a combination of an increase in paid employment amongst women and a continuing decrease in the numbers of younger retired people,

— the shortening lengths of stay in geriatric and acute hospital beds, which may place extra pressures on community services to support convalescence previously undertaken in hospital,
— from April 1993, the redirection of elderly people to social services who previously would have gone directly into nursing or residential care funded by social security benefits.

Exhibit 5
ELDERLY PEOPLE IN ENGLAND
The growth in numbers of very elderly people will continue

Note: Expenditure figure of £2bn.

18. Following the transfer of the care element of social security income support from 1993 local authorities will assume responsibility for many more elderly people. They will need to be prepared for this growth which could amount to an extra 200,000 people within two to five years. There has been an increase in services in the last decade but this has not kept pace with the growing numbers of elderly people (Exhibit 6). The beneficiaries of this increased provision have

Exhibit 6
CHANGE IN RATES OF SERVICE PROVISION TO ELDERLY PEOPLE 1979 – 1989
The increase in services has been mainly benefited younger elderly people

Source: Department of Health.
mainly been younger elderly people aged 65 to 74 who are likely to be less frail than those aged over 75.

19. Meanwhile figures from Social Trends 1990 (Ref.5) show that there has been a substantial decrease in new sheltered housing for elderly people built by housing associations and local authorities. As a result there has been an overall slow down in new completions despite a rise in such dwellings built for the private market. But for those people who stay put, housing agency services projects are providing valuable help to elderly and disabled people, enabling them to get their homes repaired and adapted and avoid admission to a residential home.

YOUNGER, PHYSICALLY DISABLED PEOPLE

20. Physically disabled people share with many frail elderly people the requirements for domiciliary support and adapted housing but their needs do not always attract the same attention, resulting in scarce and sometimes inappropriate services. Their numbers are substantial (Table 1) and many are well able to exercise choice and take charge of their affairs if support is available to enable them to do so. Many could act as their own care managers as demonstrated by the recent ILF report, although legislation prevents their being given cash direct by local authorities at present. This, however, should not be a bar to people devising their own packages of services within a given budget.

Table 1
PREVALENCE RATES OF PEOPLE WITH DISABILITIES PER 1000 POPULATION
The numbers are substantial

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>16-64</th>
<th>65-74</th>
<th>75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Severe and Severe</td>
<td>6</td>
<td>34</td>
<td>91</td>
</tr>
<tr>
<td>Appreciable</td>
<td>7</td>
<td>53</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>87</td>
<td>168</td>
</tr>
</tbody>
</table>

Source: V Beardshaw, Last on the List, King’s Fund Institute

21. The prevalence rate for severe and very severe physical disability of six per 1000 population aged 16 to 64 if compared to a prevalence rate of three per 1000 adult population for severe learning disability may suggest that expenditure on the former is low compared with the latter (Exhibit 7). (The ILF awards may make up some difference but these are also granted to people with a learning disability).

22. If community care is to be a reality for physically disabled people wider initiatives are also required on such aspects as access to indoor shopping centres, other buildings, public toilets, transport and the suitability of pavements and crossings for disabled people. Whilst these aspects are beyond the scope of social services they can help by providing information to users, and to other local government departments who do have wider responsibilities.

PEOPLE WITH LEARNING DISABILITIES

23. Community care for people with learning disabilities should provide each person with individually-tailored support to enable them to live as normal a life as possible within the
PEOPLE WITH A PHYSICAL OR LEARNING DISABILITY IN ENGLAND

Local authority spending on the former is low compared to the latter

Hospital provision still dominates, however, partly due to the slowness of health and local authorities in agreeing the transfer of funds to local authorities for resettled residents. In 1989 the Commission also reported (Ref.6) that only 3% of local authorities had individual programme plans for this user group. Meanwhile, alternative services have not kept pace with the reduction in hospital beds resulting in a lack of adequate support in the community – particularly respite and day care for young adults who are severely disabled, and services for those older people whose carer can no longer provide support at home.

PEOPLE WITH MENTAL HEALTH PROBLEMS

24. It is difficult to estimate the numbers of people with serious, long term mental health problems. The number of hospital beds is reducing and inpatient stays shortening significantly
although the vast bulk of expenditure for this user group is still spent on inpatient care (Exhibit 8). Alternative provision is needed in the community and mental health centres are being developed. Research indicates, however, that authorities may not be targeting services for those with chronic illnesses requiring continuing care (Ref.7). The changing pattern of services, with patients mobile in the community also requires systems to keep track of such individuals where necessary. These systems have been slow to develop. A survey carried out by Research and Development in Psychiatry in 1988 found few such systems in place (Ref.8) (Table 2). The new specific grant is designed to increase social care provision but social services in their lead agency role will also need to take a lead on coordinating housing previously dealt with independently by health authorities.

Exhibit 8
PEOPLE WITH A MENTAL ILLNESS IN ENGLAND
The vast bulk of expenditure for this user group is on inpatient care.

Table 2
CONTINUING CARE SYSTEMS
Few such systems were in place in 1988

<table>
<thead>
<tr>
<th></th>
<th>DHAs</th>
<th>LAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care management</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Case registers</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Keyworkers</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>More than one of the above</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Other systems</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>No system</td>
<td>51</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: Research and Development in Psychiatry.
The prevalence of mental health problems among homeless people (estimated at 40%) has given rise to recent public concern. Although this is not a new phenomenon, the increase in number and visibility of homeless people has led some commentators to advocate a return to the institutions. Few mental health professionals would agree with such a move, however.

Most people with mental health problems prefer to live in the community, and those re-settled from long-stay hospitals rarely wish to return, even when care provided is far from ideal. The current problem is at least as much a consequence of housing policies as it is of community care. Good community care can be considerably better than hospital if it is properly resourced and well co-ordinated as Hoult & Reynolds described in 1983 (Ref.9) although a need for short-term 'asylum' will remain. From April 1991 health authorities have been required to develop 'care programmes' for everyone who is to be discharged from psychiatric hospital, which should ensure that a suitable package of care is provided by health, social services and other agencies, with someone clearly responsible for monitoring the circumstances of vulnerable individuals. A small number of care management projects for people in need of long term care have now been developed in different parts of the country (Ref.10).

CARERS – THE FIFTH USER GROUP

Without informal care – unpaid assistance given by relatives, friends and neighbours – no policy for care in the community would be feasible. In terms of numbers of carers and numbers of people being supported informal care is considerably more important than formal care. The 1985 OPCS survey (Ref. 11) suggested that there were about six million carers in Great Britain, of whom about a quarter were spending 20 or more hours a week in caring. Looking after a dependent person imposes several costs – particularly loss of income. Financial loss is only part of the costs of caring, however, as the stress involved is just as significant. The task of caring can be continuous, allowing neither holidays nor normal weekend breaks. Many carers suffer ill health themselves, which further limits their activities (Table 3). An age breakdown of elderly carers is not available but work by the Personal Social Services Research Unit (PSSRU) indicates that very aged carers are often left with little help (Ref.12).

Table 3

<table>
<thead>
<tr>
<th>THE BURDEN ON CARERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many carers suffer ill health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carers devoting 20 hours or more per week to caring</th>
<th>Age of Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-standing illness last 12 months</td>
<td>16 - 29</td>
</tr>
<tr>
<td>Limiting longstanding illness</td>
<td>%</td>
</tr>
<tr>
<td>Longstanding illness (either limiting or non-limiting)</td>
<td>17</td>
</tr>
</tbody>
</table>


Few services are aimed directly at carers. The main beneficiaries of social services are elderly people who live alone. Care attendant schemes such as Crossroads Care and other services that offer respite provide exceptions. The ILF report (Ref.4) reflects the value carers have found
in the type of assistance the fund has provided. The DoH has funded experiments in the support of carers which reveal (in keeping with other studies) the inadequacies from the carer's viewpoint of the services that are provided (Box A).

**Box A**

**SERVICES FOR CARERS**

Inadequacies from the Carer's Viewpoint

- 'the lack of information about likely prognosis and appropriate care of their dependants or about other services in the locality that might have made the caring task easier,
- unreliability of the service (e.g. late arrival of transport services to take their dependant to day centre meant that carers couldn't plan their own activities round these),
- services provided too infrequently (e.g. a weekly incontinence service allowed a build up of soiled bedclothes in the home),
- services that did not meet the needs of the dependant (e.g., meals on wheels that didn't take into account differing cultural tastes), and
- services that led to the distress of their dependent or a deterioration in their condition, through poor levels of care, disruption of regular routines and resulting disorientation (e.g. some forms of day care).

Source: Department of Health

Additionally, there was insufficient foresight in care planning with the result that services tended to be too reactive. These inadequacies must be addressed by social services. The needs of carers are given a high profile in the DoH Guidance and local authorities are expected to set out in their community care plans how these needs are to be met.

29. These trends will undoubtedly place pressure on social services departments as they take on their new responsibilities. But demand for community care services is always likely to outstrip supply. The task for local authorities will be to set up structures which allow difficult choices to be made in a sensitive, reasonable way.
2. A Cultural Revolution

TRADITIONAL SOCIAL SERVICES & OBSTACLES TO CHANGE

30. The traditional role of local social services authorities has been to provide and maintain a range of support services for vulnerable adults. These services have included residential care, day centres, home helps to do household chores within normal working hours and 'meals on wheels' often delivered by voluntary groups. The chief occupation of adult social services has been the smooth and efficient running of these often standardised services. Council Members have often concentrated mainly on occupancy rates and details of services' expenditure. Budgets have been committed to running 'bricks and mortar' services (e.g. residential homes, hostels and day centres), with slightly more flexibility for home helps. In 1991/2 about half of all social services expenditure for adults could be attributed to services provided in council-owned buildings (CIPFA 1991/2 estimates). More recently there has also been a growth in payments for residential places provided by private or voluntary groups for people with a learning disability. The organisational structure to support these operations has usually been centralised. Such an approach can be run with budgets committed to fixed levels of prescribed services and centrally-determined staffing arrangements.

31. In recent years there has been a recognition within many social services departments that a change of approach is needed introducing greater flexibility. As a result a number of experiments in service development have been established aimed at making support for people more responsive to their needs. Some residential homes, for example, are providing a laundry service or bathing for people in the local community for whom these activities are difficult or impossible without help. Learning disability services are aiming to provide more individually-tailored support. Home help/care services are sometimes becoming more flexible with working hours more suited to the needs of their clients and targeted on the most dependent people, providing personal care such as washing, dressing and feeding. However, these attempts by home help services have not always been successful; and experimental projects have rarely been translated into mainline services for the majority of users. As a result, their 'user responsiveness' has touched only a few people. Hence the need for a more radical approach to effect wide-spread change.

32. Changing from the traditional role requires a cultural revolution; and any failure to grasp the extent of the changes needed can be in itself a considerable obstacle to progress. Major changes in attitude are needed. The next sections deal with these in more detail.

33. The concept of user needs-led support for people in their own homes is widely held by local social services authorities. But the consequences of this philosophy are less well accepted. If implementation of the 1990 Act and guidance from the Department of Health and Welsh Office is to be successful, traditional behaviour patterns in social services must be changed affecting council members, central management, local management and staff working directly with service users alike. There are three main areas of potential conflict between the old culture and the new requirements.
1. THE CHANGING ROLE OF SOCIAL SERVICES

34. The change in emphasis presents authorities with some immediate challenges: to widen the choice to users and carers, to clarify priorities, and to make services more responsive to users' and carers' needs, but there are several problems to be overcome.

THE PROBLEMS
(a) The Mixed Economy of Care

35. A number of authorities are hesitant about the notion of a mixed economy of care. They often have a justified pride in the priority given to services for their more vulnerable citizens. Some consider that their duty is to continue to be the main provider of support: a review of 31 social services authorities for the study indicated that a third of them wished to remain the main provider of services. But exclusive provision denies choice to users and carers.

(b) Targeting Services

36. Local authorities may hold the view that services should not be targeted or prioritised according to users' dependencies and they may be concerned that such measures will require them to introduce rationing. Without unlimited resources, however, services have always been rationed (although not necessarily targeted). The rationing may not have been explicit but left, along with decisions on admission criteria for services, to staff responsible for making these admissions.

(c) Separating Commissioning and Providing

37. Some authorities accept the division between commissioning and providing without any noticeable difficulty but the concept is a problem for others. It is seen as 'privatisation' by another name. This is a misinterpretation, since the local authority can continue to act as both the commissioner and the provider – provided that they also offer the choice and flexibility of the mixed economy of care. Nor does the term imply a prescribed organisational model such as that required for the NHS. The term describes the role of care managers who act as commissioners of care packages from a variety of sources but who have no responsibilities for providing or managing services themselves. They can then concentrate on and listen to the user without the pressure to favour their own service provision.

(d) Inflexible Operational Style

38. The range of traditional services based largely on buildings can be an obstacle to innovation. Because of high fixed costs, it is difficult to adapt and change them. Admissions procedures measure people for prescribed services and the operational structure discourages flexibility and change:
   — budgets are allocated centrally over fixed heads of expenditure,
   — staffing establishments are fixed centrally,
   — conditions of service are inflexible,
   — recruitment is run centrally and often takes a long time,
   — unit managers are given little room for manoeuvre.
This rigid style of operation militates against a responsive service especially if care has to be provided for large groups of people. The emphasis is on efficient routines with little space, or budget flexibility, for creativity. Without a catalyst there are unlikely to be substantial new services developing as traditional budgets are fully allocated to support established services.

(e) Insufficient Attention to the Needs of Staff

39. A lack of good communication and training for front line staff and their managers also prevents changes to inflexible services. The attitudinal shifts and new ways of working which are required are considerable. Many staff are already having to cope with changes brought in by the implementation of the Children Act 1989. The Commission found that front line staff and their immediate managers were not always aware of changes in central policy affecting the role of social services for adults, introducing new ways of working. There is a danger that both the numbers of staff needing education and training for these changes and the amount of education and training needed are being under estimated. These requirements are not always being addressed strategically. As a result, there are indications that senior managements are planning organisational and operational changes without ensuring that the right staff, with the right skills will be in the right places. On the other hand, newly-enlarged training sections are programming training paid for by the DoH training support grant without linking this to the new organisational needs of the social services departments.

40. If the staff are not involved in and committed to the changes, implementation will be difficult. A publication by the Institute of Health Services Management on Change and Innovation in the NHS (Ref.13) describes the logical approach to change as:
   — devise a strategy
   — turn the strategy into a plan
   — seek sanction from those in authority
   — implement the plan

It then goes on to say:

'This process wrongly assumes that man is entirely a rational creature, who will therefore accept a well reasoned, well presented argument: if he resists, opposition can be overcome by use of authority, pressure from on high. Again wrongly, the assumption is often made that the existing organisation has the competence and capacity to work up the new arrangements.

Experience shows, however, that such straightforward, linear processes rarely work. The strategy setting and planning process take time, induce suspicion in those not involved and then generate a workload that feels overwhelming. This produces the maximum resistance. The concrete plan all too often allows minimal opportunity to generate commitment which would result from involvement in decision making.... In order to make progress, compliance is sought by manipulation, persuasion, barter or naked pressure from those with power. Delay sets in and is often fatal.'

41. Local social services authorities are faced with this challenge in their implementation of community care. A review by the study team indicated that nearly a third of authorities lacked member and staff commitment to the changes necessary to make user needs-led care a success.
This evidence was gathered at the planning stage. However some of those authorities registering the necessary commitment may find that they have been over-optimistic when implementation begins in earnest. In reality they may have given insufficient time and attention to the needs of the staff to gain their commitment to new ways of working. Suggestions on how to gain this commitment and begin the process of implementation are outlined below.

THE SOLUTIONS

42. Winning the hearts and minds of social services members and staff to a different role for social services is key to the success of community care. However, changing people's perceptions of the role of social services, is a task of some magnitude. Three elements are required to start the process: strong and committed leadership, clear values and goals, and appropriate training and involvement of staff (Exhibit 9). All three can help to change attitudes, enabling budgets to be devolved and flexible services to be developed.

Exhibit 9
THE TASK OF CHANGING THE ROLE OF SOCIAL SERVICES
Three elements are needed to start the process

(a) Strong, Committed Leadership

43. The task of co-ordinating and managing the development of a plan for implementing user centred community care should be full-time in most authorities. The officer appointed to carry out the task must be able to devote sufficient time and commitment to it. It is very difficult for someone who already has responsibilities for running existing services to find the time, or commitment to develop major new initiatives; and their original responsibilities may give them a vested interest in maintaining the status quo. Forty four per cent of authorities reviewed have no-one spending more than 50% of their time managing the implementation of community care. This will cause problems. The post must also be sufficiently senior to carry the necessary authority in setting up task groups, seconding staff and in providing leadership to start the process of change.

44. Further down the organisation, care managers can provide the catalyst for change. The logic of the decision to listen more to users and carers and provide user centred services requires
care managers with budgets to concentrate solely on users and carers, assessing their needs and
arranging with them the most appropriate services from the most appropriate sources. (Indeed,
some argue that the logic leads to users being helped to become their own care managers).

45. The DoH Policy Guidance (Ref.3) advises that care management
'will have its greatest impact where most of the processes involved are carried out by a single care
manager who has some measure of responsibility for a devolved budget.' The DoH considers that
'such a devolution of responsibility brings decision making closer to service users and this makes
it more responsive to their needs'.

Research indicates that care managers with other responsibilities are unlikely to perform their
care manager tasks for the most dependent users and carers with sufficient thoroughness. One
care manager in a pilot project who had previously been involved in home care said that 'one of
the luxuries of being a care manager is you don't have any staff to manage; you can step back and
do an assessment.' (Ref. 14). Research also indicates that assessors who do not have budgets to
purchase services lack influence with those responsible for holding the budgets. Without the
power of the purse, care management is usually ineffectual (Ref.12).

(b) Clear Values and Goals

46. Authorities must be clear about their intentions. The development of a 'mission
statement' is clearly a valuable starting point. But to be useful it must set out the aims and priorities
of the authority. Devon County Council involved practitioners, managers and members to draft
such a statement. It contained three priority risk groups for services which were sent to staff,
voluntary and statutory bodies, users and carers for comments. Over 200 were received before a
final statement was agreed by members and published as the authority's declared principles and
aims for the delivery of community care.

(c) Staff Training and Involvement

47. Managing change successfully on such a large scale, involving a significant shift in
culture, is not a straightforward task. Those responsible for managing this transition must receive
training. To begin with, senior management – at least within social services – could usefully attend
training courses on how to manage change. This should help them to win over their staff to the
changes. It is essential that the principal training officer is involved in planning and implement-
ing the changes. Further down the organisation, both care managers and service managers need
training (Exhibit 10, overleaf). Care managers will need training to carry out assessments,
develop care packages and handle budgets. Service managers, separately, will also need training
to cope with greater responsibility and accountability. Their staff will need to be informed,
re-assured, involved and trained in new ways of working if the necessary commitment is to be
won. The Joint Initiative for Community Care is working with the Local Government Training
Board and NALGO Education to provide flexible training modules for both care managers and
service managers. Management will also need to be trained to support and monitor the activities
of care managers and service providers. Joint training initiatives provided for and provided by
health and social services will also be both essential and valuable.

48. Introductory education about the changes will be needed by most, if not all staff within
social services. Those concerned with adult services will need more than a day's introductory
Exhibit 10

TRAINING NEEDS
Both care managers and service managers need training

Source: Joint Initiative for Community Care

...
49. Staff must be involved in planning for change. Many authorities have set up task groups of staff to research and advise on different topics such as assessment procedures, quality standards and information needs. This is good practice. These task groups involve a variety of staff which not only utilises a wealth of relevant experience but is also useful in securing commitment to the changes.

50. If they are not to be alienated, all social services staff must be kept well informed throughout the whole process of planning and implementation. Not only must they receive education to understand the issues involved but they must be updated regularly on what is (or is not) happening.

(d) Flexible Services

51. Care managers are likely to be commissioning significant levels of services from their local authority, at least in the short term, but also in the long term where services cannot easily be provided by others. It is essential that these services become more adaptable and responsive to individual needs agreed between care managers and users and carers. Services which are unable to provide a flexible response are likely to find themselves unattractive to care managers.

52. Services must therefore have the capacity to become innovative (Box B). This means that managers must have more control over their budgets with appropriate and timely information to support them. Staffing arrangements must allow for evening and weekend work and enable care to be provided quickly during crises. Recruitment should be run locally with the managers’ requirements taking priority. The need to attract users and carers – and therefore secure income to finance their budgets – will give service managers the incentive to be innovative, providing that budgetary and staffing systems do not prevent this by their inflexibility.

Box B
FLEXIBLE SERVICES
Services must have the capacity to become innovative.

- Members, senior management committed to change
- Unit manager committed to change
- Flexibility of spend within overall budget
- Flexible staff conditions and local recruitment within overall budget
- Timely, appropriate management information
- Freedom for manager to be innovative
- Staff informed, involved
- Adequate training
- Monitoring of outcomes
- Time to develop initiatives
- Senior management support
53. But it is not enough for social services staff alone to make this cultural shift; it is equally necessary for others in the authority – both members and officers – to be fully committed to the changes. Problems and possible solutions are discussed in the next four sections beginning with members' commitment to community care.

2. A NEW FOCUS FOR POLICY DECISIONS

THE PROBLEM

Services, Not People

54. Members' commitment to user-centred community care is vital. Research shows that they and senior management need to change the focus for policy decisions. All but one of the authorities visited by the Social Services Inspectorate (SSI) for a report on homecare (Ref.15) intended their home care services to be better targeted and more flexible, supporting very dependent people at home. Policies, however, were not specific. They lacked practical guidance to staff on criteria and processes for resource allocation. Decisions on targeting were left to home care organisers or other field staff. In consequence, very limited progress had been made on targeting resources on clearly defined priority groups. According to SSI, 'Goals being pursued were too vague' to allow performance to be monitored.

55. This example illustrates the problems facing policy makers in local authorities and is endorsed by the Commission's findings. Traditionally, members have issued broad policy statements indicating in general terms the direction in which service developments are aimed. Plans have often been tied to items of capital expenditure – the building of a social education centre, for example, or alterations to a hostel. Budgetary decisions have usually been based on historical spending levels and been service-centred. Members have often been protective towards facilities provided in their wards. Their traditional focus has been on the details of the services they have been providing – not the priorities and dependencies amongst the people they have been serving.

THE SOLUTION

People First

56. Council members are now being asked to consider and take decisions along different, and difficult lines. Policies must become specific. Division of the budget should be based on estimations of need between user groups. Members must decide on competing priorities between dependency levels and user groups, setting criteria for different levels of assessment, care management and services. They must indicate how much can be spent on individual users with different dependencies. Authorities are beginning to tackle these issues. Some will find decisions uncomfortable but unless they are taken, very limited progress will be made. Social services employees will be confused about what is expected of them. In the absence of guidance from members front line staff will be forced to make policy decisions by default and members will have failed to give the necessary lead in implementing user-centred care.

57. Information and study seminars on the issues involved in community care are needed for members – and there may well be key members in addition to those on the social services committee whose commitment and support will be vital. Workshops for members are one way of achieving awareness of and commitment to the changes required. A director of social services visited by the study team has found such workshops invaluable.
3. A CHALLENGE TO POWER STRUCTURES AND VESTED INTERESTS

THE PROBLEMS

(a) Rigid, Centralised Approach

58. Moving to a user-centred approach to social care means that a number of vested interests and established power structures will have to confront change. Besides social services, other departments within the local authority will also be involved with a myriad of individuals and groups caught up in the community care changes. Some of them – at least to begin with – may not be aware of this. The co-operation of most, if not all, must be won if the developments are to succeed. Community care delivery involves power sharing – often difficult for someone who already has power or a vested interest in the status quo. Planners, care managers and service providers must share their power with service users, but for them to be in a position to do so, colleagues, council members and trades unions must be prepared to relinquish and share power with them.

59. However, finance departments are used to controlling the budgetary process with little delegation and with financial information designed to serve their needs rather than those of the social services department. In the past the idea of 'giving social workers cheque books' has not always been a favourite with finance directors. Procedures for arranging virement between budget heads are often cumbersome. Personnel departments and trades unions are used to working conditions that are inflexible and recruitment policies that are centrally run.

(b) Vested, Professional Interests

60. Social work professionals also have vested interests and some regard the concept of the care manager as commissioner and not provider with grave misgivings. There may be an assumption that 'care manager' equals 'social worker' and as social workers they wish both to run with the hare and ride with the hounds. But as indicated, where care managers have other duties to perform the management of their most important cases is not thorough enough. Other professionals such as occupational therapists, nurses, as well as home care organisers should also be well placed to take on the role of care manager. Concern is also expressed in some authorities that where the line management of field social work has been integrated with that of day and residential units with a consequent improvement in morale and effectiveness, the removal of the social workers to act as commissioners could damage that improvement. Social work however is a provision in its own right, to be commissioned by the care manager, although the role of care manager may well encompass a degree of counselling and support.

THE SOLUTIONS

(a) Promote Decentralisation

61. These professional interests will need to be challenged if more than mere lip service is to be paid to the proposed changes. A more dynamic approach will be required (Exhibit 11, overleaf). Finance directors must agree to devolve budgets together with responsibility for spending them and accountability for their control and must provide appropriate and timely information systems to carry out these functions efficiently. Social services will need financial assistance within their departments to manage new financial systems, providing information and securing probity. Personnel departments and trades unions must agree to flexible working
conditions and recruitment procedures, operated locally. Members will need to re-focus their agendas. These are all significant requirements and will need sensitive handling if success is to be achieved. There is a realisation that this flexibility is required. For example, the Association of Directors of Social Services (ADSS) and the Chartered Institute of Public Finance and Accountants (CIPFA) have held joint initiatives to raise awareness of the finance department implications in the changes and to help with the necessary financial systems.

(b) Involve Other LA Departments

62. Other community aspects besides social services are also important to users and carers. For example, is public transport accessible to physically disabled people? Can they use pavement crossings and pedestrian areas? Can they open doors to shopping precincts? Can people in wheelchairs gain access to shops and other public buildings? Do libraries provide material for those who are sensorily impaired? Is adult education available to people with mental and physical disabilities and is there access to appropriate housing or adaptations for all user groups? Many departments should be involved in making community care a total reality and in some authorities this is happening. Leicestershire County Council for example, has developed a joint community care project which involves the departments of social services, education, planning and transport, libraries and information services, museums, arts and records services together with the chief executive and the director of property.
(c) Adopt Corporate Approach

63. The implementation of community care should not, therefore, be seen as merely a social services matter. There must be a corporate approach with the chief executive taking a lead. One authority visited had found two methods particularly useful in getting senior management – including chief officers of other departments – involved in community care, promoting their understanding and support for the issues. One involved staff, for example, sleeping in an old person's home, experiencing the realities of life in that home. The second linked involvement in community care to chief officers' performance related pay. As a result, chief officers previously unused to much contact with social services clients became more involved with users and carers and supportive of the user-centred approach to service delivery.

(d) Target Key People

64. There will be other key employees whose support will be crucial to the success of implementation. Some will be in particular positions of authority but others may be key because of their standing with their colleagues. Their opinions or leadership abilities will need to be harnessed in support of the changes. Training in the management of change could well prove useful in enabling this to be handled sensitively and well.
3. Systems Requirements

65. From April 1992 each local social services authority will be required to produce and publish a Community Care Plan (CCP) which should be revised annually. A great deal of information will be needed to complete the CCP; and each area of activity reflected within it will need support systems. Most will need to be developed. The main challenges facing authorities in this work can be divided into two: those to be overcome in the development of policy and those facing the implementation of operational arrangements. These are outlined in turn below, together with suggested solutions.

POLICY MAKING IN A VACUUM

66. Social services have been good at formulating general policy statements but less good at developing specific, targeted plans that describe how the values and outcomes expressed in these statements are to be achieved in practice. This shortfall has not been helped by a scarcity of data in several areas.

THE PROBLEMS

(a) Resources not deployed according to 'need'

67. Finance in the past has been allocated historically with last year's budget adjusted for inflation. Budgets for services are rarely determined by a systematic appraisal of needs and resources (including resources available from other agencies). There is a surprising lack of knowledge about the resources available within community care, which even includes ignorance of the authority's own contribution. Many Commission auditors found it difficult in 1988 to identify all the resources deployed by individual social services departments for people with a learning disability. Authorities often have not had an overview of the services they were providing, for whom, at what unit cost.

(b) Ill-defined needs, priorities and targets

68. With very little financial or managerial scope to change services substantially it is understandable that not much has been done in the past by social services to assess 'need' within their local communities. Need has often been defined as 'demand', i.e. the number of people asking for support. However, even demand is not well documented and, one authority visited by the study team would not monitor the uptake of services by its significant ethnic population as a matter of policy.

69. The definition of 'need' depends on priorities. One important aim of the community care legislation is to provide people who are at risk of undesired residential care with support in their own homes; and a major priority expressed by the DoH Guidance is that the most dependent people should be targeted first. (These are also the aims of many evolving home help/home care schemes). A number of case (care) management projects in the USA are also aimed at preventing entry into residential care. However, an evaluation of ten of them – the 'channelling demonstra-
tion' sites – found that all but one had failed in this aim because the wrong group of people had been targeted despite 'state of the art' screening and assessment procedures (Ref.16). The risk indicators used were incorrect. PSSRU has also found similar evidence in this country and has concluded that:

— disability as such is frequently not the major cause of a person's entry into residential care,
— domiciliary care can successfully support people who have 'very considerable disability' including incontinence,
— social services do not cope well with a vulnerable person's collapsing support network (for instance a relative who is the main carer becoming unable to continue caring),
— and that it is 'this situation (i.e. collapsing informal care) rather than severity of disability, which is most likely to result in entry to institutional care'. (Ref.12).

70. The difficulty in targeting the people most at risk of entry into inappropriate residential care is also illustrated by a survey conducted by Avon social services department highlighted by the National Institute for Social Work. This showed that only 50% of residents in their homes for elderly people had received support from home helps prior to entry into residential homes (Ref.17).

71. Targeting is a key issue for policy makers. Severe rationing of resources may occur if authorities fail to get it right as the number of expensive residential care placements will not decline if the wrong risk indicators are used in assessments, and if social services response in a crisis such as a carer's illness, is not quick enough.

(c) Service-led assessments

72. In the past, assessment for support by social services has frequently been linked to specific services. A person requiring more than one service received more than one assessment. Joint work between social services staff was rare. (Joint work with health authority or housing staff has been even less common. This will be discussed in more detail below). Attempts have been made more recently to improve this situation by linking home help assessment with that for meals on wheels. But this is still assessment for services rather than an attempt to look at an individual's overall needs in the context of their life style and current support networks. As a result, an Asian Moslem woman, for example, may be assessed as 'needing' meals-on-wheels (the actual 'need' is likely to be help with cooking – meals-on-wheels is the services' response). The cultural and religious aspects in connection with this service provision may not be addressed. Criteria for service provision have also been weak, which together with inflexible conditions of service have sometimes led to 'inverse dependency': where the more dependent a person is the less likely they are to get a service. Examples include:

— users needing more home help hours, support in the evening and weekends or more care of a personal nature than 'allowed' by the system;
— elderly people who are incontinent and may be considered unsuitable for a residential home. (One social services department recently surveyed its Part III residents and found them less dependent than many people supported in their own homes). Private residential homes are even less likely to have very dependent people in them – particularly elderly people who are confused (Exhibit 12).
73. The introduction of care management poses perhaps the biggest challenge. It is the lynch pin of the new system of community care. Yet aspects of it are hedged about with cultural, organisational and management problems. As indicated above, some authorities and social work professionals do not like the concept of care managers who are commissioners but not providers. Even where it is accepted there are significant decisions to take in developing care management (Exhibit 13, overleaf). In addition to such questions there are other issues concerning the collaboration between social services and other agencies – notably health – in assessment and care provision. These are raised in chapter three.

INFORMED POLICY MAKING

74. Many of the solutions to the forgoing problems are being identified and authorities are beginning to take steps to provide better systems for policy making.

THE SOLUTIONS:

(a) Plan the Changes

75. Local social services authorities need to undertake a significant amount of planning to implement the community care changes. DoH guidance on the CCP outlines where social services need to plan. Authorities are setting up task groups to work out the details of what needs to be done under the guidance of steering groups which pass on recommendations to members. This approach is a sensible one as there are many areas requiring review: needs, priorities and criteria, assessment and care management structures, resources (financial and human), management and financial information, personnel policies, organisational implications, monitoring and evaluation. No one person could, or should do all this, although, as outlined in the previous chapter someone needs to lead and co-ordinate the work. The steering group should include the
There are significant decisions to take in developing care management. The chief executive and finance director, senior representatives from other departments, the NHS and the voluntary sector in addition to the social services director and lead community care officer. At least one director of social services has found it valuable to have member representation too.

76. The Commission found that 75% of authorities reviewed have developed a 'critical path' through the various tasks and decisions in order to provide a robust timetable for action. The complexity of the work involved makes network analysis a valuable tool for enabling an authority to meet its target.

(b) Take Stock of Resources

77. Development plans must balance 'needs' against resources. Authorities will have to know precisely what services are available currently, including what is available within the authority but external to social services, and what exists outside the authority itself. Unit costs should be calculated. It is also important to know the dependency levels of the people currently receiving care in each authority's area. Many authorities realise work is required to establish these data. Over 90% of authorities reviewed in late spring 1991 were undertaking a stocktake of resources. This stocktake represents an early step in the planning process.
(c) Define And Measure Need

78. The CCP will be expected to identify the care needs of the authority's population on which its plans will be based. This presupposes a knowledge of what they are. At the crudest level information is required on the make-up of the adult population – its age profile, spread and density by age and ethnic group, deprivation factors, incidence of handicapping conditions such as physical or mental disability or HIV/AIDS. The DoH has provided a 'key-indicators package' to help with some of this. Authorities should seek to use research from Britain and elsewhere on methods of estimating need. Estimates of need should also indicate the incidence of relative dependency levels. Future CCPs will rely increasingly on information from care managers on needs identified by them at the local level.

79. Before assessing need within the community, what is meant by 'need' must be rigorously defined. Devon social services has been assessing need annually over the last three years (Box C) and an important lesson learnt in the first year was the necessity of defining need far more rigorously than had been realised. The definition depends on an authority's priorities for support and the people it intends to target, which in turn depends, in part, on the resources available.

**Box C**

**ASSESSING NEED WITHIN THE COMMUNITY**

The Procedure in Devon Social Services

- Each local district (34) within the county is required to estimate needs and unmet needs. In order to aggregate these for the county as a whole a proforma has been devised.
- Three priority groups have been defined for those people entitled to support. (These definitions were developed through a consultative process throughout the authority and with other agencies, users and carers.
- The three priority groups can be determined from a standard core assessment used for all users. Referral registers have led to fairly accurate information now becoming available.
- Data from referrals can be validated and projections made from national population statistics.
- The proforma for estimated numbers also requires a statement of the degree of confidence in each figure in order to indicate likely accuracy.
- The results may lead to some reallocation of resources between districts.

(d) Decide on Priorities and Targets

80. Most authorities will probably accord a high priority to support for people in their own homes and the prevention of inappropriate admission to residential care. Other priorities include supporting carers and arranging housing and support for people leaving long-stay institutions. Four target groups which seem to the Commission to be a sound selection are as follows (although it is for authorities to decide their own priorities):

- people in the community at high risk of institutionalisation such as dependent elderly people discharged from acute care, people whose informal care network has collapsed and people with mental health problems needing long-term continuing care;
— informal carers with high burdens such as those caring for people with severe learning disability or mentally confused elderly people;
— people requiring support following resettlement from a long-stay institution;
— people requiring intensive short-term support following illness or injury.

81. Having decided (with others) on its priority groups each authority must then identify how to target the people within them. This will be critical given the difficulties in identifying correctly those people in danger of inappropriate institutional care and the poor record of authorities in coping with collapsing support networks. Choice of appropriate risk indicators will be key in developing a system which accurately identifies people within target groups. For some target groups guideline indicators only can be provided, in order to allow care managers flexibility. Their effectiveness will need to be monitored by statistical analyses and reviews with care managers of individual cases.

82. If more than one group of people within a user group is targeted, then a decision will be needed on how to allocate the budget between them. This is likely to be difficult as in the past budgets have not necessarily been allocated according to target groups – it may mean service reductions for some people who do not fall within those groups. Decisions must also be taken on which groups, or which people within the groups, will not be eligible for care management.

(e) Introduce Needs-led Assessment and Care Management

83. Assessment of the needs and priorities of individual people is a key activity in implementing the new approach to community care. It is where users, carers and professionals first meet on an individual basis and will be the test of whether all the rhetoric and planning of user needs-led care actually mean anything for the people needing support. DoH guidance on assessment and care management has been issued to help authorities with the professional complexities of these issues.

84. Authorities are aware that assessment systems must centre on the needs of users and carers rather than the requirements of services. Eligibility criteria for different levels of service and care management are required. Most authorities started development of procedures and criteria for these purposes over a year ago (Exhibit 14). A balance must be struck between an authority's priorities, target groups and the resources available. It is important, therefore, that the council's policy guidance on priorities and target groups has been issued before progress is made on developing assessment instruments.

85. One of the most important guidelines will be on the screening process which will determine whether a fuller assessment is required or whether an individual's needs can be met more simply. Unless an authority has decided that its resources will stretch to only very dependent people needing complex packages of care, services can be available to suit different requirements (Exhibit 15).

(f) Develop Assessment and Care Management – Criteria and Budgets

86. Social services should decide on the criteria for care management. Arranging and co-ordinating packages of support which involve more than one agency is an obvious role for care managers but many authorities may decide that care managers should also deal with less complex
PREPARATION FOR CARE MANAGEMENT
Most authorities started developing care management procedures and eligibility criteria over a year ago

Source: Study survey (early summer 1991)

A SPECTRUM OF SUPPORT
Services can be available to suit different requirements

situations. Decisions on whether or not services will be available for people who do not meet the criteria for care management will affect how the budget is divided and devolved. If such services are to be made available, then there are likely to be two funding methods employed:

— care managers’ budgets which should be used to purchase services both internal and external to the authority. Services within the authority should be run as cost centres attracting funds directly from care managers for the services provided,
— locally or centrally arranged contracts for services for those people who do not need a care manager.

87. The amount each care manager is allowed to spend on each user will depend partly on the presenting problems. If people with different levels of need are eligible for care management then guidance on the amount of money appropriate for each may be necessary, as in Devon. In another authority which limited support to high-dependency users only, a level of two thirds of the cost of a residential place was fixed as the ceiling. Users could only be supported in their own homes above this limit if the care manager obtained senior management sanction to do so.

88. Some care management projects provide care managers with only a small budget of a few thousand pounds a year with which to buy minor items – an electric kettle or support from a neighbour for example. Other services are funded and used in the normal way. Whilst such budgets have proved useful, the traditional, service-driven approach to providing support is unlikely to be challenged significantly if care managers cannot eventually exercise the real choice on major service items that comes by holding the purse strings. Such small budgets should therefore be used as part of a transitional arrangement leading to a phased devolvement of a major portion of the budget. A partnership formed by the ADSS and CIPFA has published a guide, part of which leads authorities through the strategic management process of separating commissioning and providing, and of devolving budgets.

89. Charging people who can afford some payment for services obviously increases the budget available. One authority visited required a contribution from any attendance allowance received in part payment for services arranged by care managers. Most of the users at this authority were in receipt of attendance allowances and social services helped users to obtain the allowance where they were not already getting it. This social services department intends in 1993 to make its care managers responsible for collecting charges, including payments for residential care. They will then be able to use these payments to help fund the support they arrange for others: the more income they collect, the more they can provide. Authorities which make no charges to users will be restricting the number of people they can support and the amount of care they can give.

90. There will also be individuals and families who do not seek a subsidised service but who would welcome help in putting together a package of care. In the event of a sudden crisis – which can happen in any family – when support is urgently required, those involved may be unaware of the services available. They need professional help and advice – particularly where care is required quickly – even though they then pay for the care themselves.

(g) Assessment and Care Management – Organisation

91. Authorities must decide how to organise and deploy care management – whether care managers are to specialise on particular user groups, and over what geographical area. Once again PSSRU research gives an indication of the way forward: the impact of services is greater where care managers specialise. Indeed, it is difficult to see how a care manager could be sufficiently knowledgeable over such a wide field to be effective for all user groups. Specialist care managers may need to be organised on different geographical areas for different user groups. For example, the numbers of frail elderly people and people with learning disabilities will be different, requiring different numbers of care managers. For some groups multi-disciplinary teams of care managers
may be more suitable – for people with a learning disability or those with mental health problems, for example.

92. The 'job description' of a care manager, therefore, may vary with the model of care management chosen but certain aspects are likely to be common. The attributes the holder of the post brings to the job will be of key importance. It is unlikely that care managers will be drawn from any one professional group but those appointed should have both good interpersonal skills and imagination (Exhibit 16).

Exhibit 16
ATTRIBUTES OF CARE MANAGERS
Care managers should have good interpersonal skills and imagination

93. Care managers will need to translate these skills into hard practical decisions on service provision. In order to do so they must be able to handle a good deal of information efficiently: knowledge of local resources, costs, and the likely demands from other users. Care managers must also become skilled at using financial systems and information technology. They will need to negotiate with providers, influence the contract-making process and commission local providers. They will also need to monitor services effectively, making changes where necessary; and they must be able to take decisions which could prove unpopular with providers.
94. Organisational decisions based on need within the population will have an impact on how budgets are allocated. Care management projects currently running should give an indication of how many care managers are needed for a population of a given size. Several interesting projects are basing care managers for elderly and physically-disabled people in GP practices or in locations that cover one or more GP practices. Where such arrangements do not warrant more than one care manager both professional isolation and a lack of choice for users become risks. Careful consideration must be given to ways of providing professional and managerial support to care managers in dispersed settings, and of allowing users to exercise some choice of care manager.

(h) Develop Assessment and Care Management – Transitional Arrangements

95. Care managers – either singly or in multi-disciplinary teams – need to be given the authority to exercise real choice on behalf of users. But there may need to be a transitional period: they will need to gain expertise in handling their budgets and in exercising choice. If care managers were to be given complete freedom from day one then some council services could quickly find themselves 'bankrupt' through paying for unused services as well as those bought by care managers.

96. Unpopular services will either have to be reduced or given the chance to adapt into the kind of services users want. One possible method of providing gradual but increasing budgetary authority to care managers is to support current users as they are now; but from April 1993 new users will pass – with the transferred social security money – to care managers. Another option would be to give limited budgetary flexibility to care managers in the first year, increasing it yearly. Care managers should in any case be involved in the planning cycle, feeding in users’ unmet needs so that contracts, service agreements and service development arrangements can be adjusted accordingly.

97. The Independent Living Fund (ILF) report (Ref.4) on the care people buy with their awards from the fund provides some pointers to what users (and their carers) choose when they can act as their own care managers. From 1988 the ILF has enabled around 10,000 severely disabled people to live in their own homes. For some, an ILF award has given a chance to leave institutional care. For others it has removed the threat of admission to such care – sometimes by preventing a breakdown in informal care. The report contains useful lessons for local authorities as they plan their approach to care management and service provision:

— Disabled people – even those who are very dependent – are capable of exercising effective choice and control of their care arrangements (sometimes through relatives, friends and informal carers).

— As important as the amount of resources available are: choice of care assistant (finding someone with whom they could relate), consistency (the same care assistant coming on each occasion), and flexibility and control over tasks and times. The report states: 'The choice and control they (carers and users) valued so highly could not in their experience be provided by the statutory authorities.'

— The majority of people used private individuals as paid care assistants. Although some use was made of private agency staff the same criticisms were made of them as of the statutory authorities i.e. a lack of choice of care assistant, a lack of consistency with different people sent as care assistants, inflexibility and a lack of user/carer control over tasks and times.
— Only 5% of people had difficulty recruiting care assistants. The majority recruited through family, friends and other local networks rather than by advertising.

— Some people would have valued help and advice when recruiting care assistants. One reason given for not advertising for recruits was anxiety over the unknown trustworthiness of complete strangers who answered an advertisement.

98. These illustrate both the priorities of users and carers and the apparent ease with which appropriate people within the local community could be recruited to undertake what, in some cases, were very personal care tasks. At the same time, some help in recruiting would be appreciated. The cost of private care assistants was often lower than formal agency rates. (The cost of formal agencies was a criticism cited). If the new community care legislation is to provide greater choice and control in reality for users and carers, these timely findings by the ILF should be reflected in local authority arrangements for care management.

INADEQUATE OPERATIONAL SYSTEMS

99. The operational systems currently running are designed to support the service-driven approach to providing care. The social services’ budget is committed, within each user group, across residential, day, domiciliary and ‘field work’ (i.e. social work) services. The money follows the service – not the individual user. The shift of emphasis to the user demands considerable changes to current systems as they are most unlikely to meet the requirements of the new approach.

THE PROBLEMS
(a) Premature Devolution of Budgets

100. Even authorities opposed to a split between the roles of commissioner and provider recognise that the social services budget must be devolved to a level that is closer to the users (although there is an indication that some budgets might be constrained politically to purchase local authority services only). In anticipation of care management, authorities are beginning to devolve budgets to area or locality level. But in some cases insufficient attention is being given to the financial information and management arrangements required to support these arrangements. Budgets previously centralised have also been split and devolved without reference to past under or overspends and without realistic estimations of local needs.

101. Authorities which do not address these issues sufficiently rigorously are courting disaster. The Commission has learnt of several authorities where budgets have been devolved prematurely without proper regard for both management and financial systems in support. Financial and management responsibilities have not been aligned so that budgetary accountability may not rest with the person who spends the money; or the person who spends the money may be unaware of the state of the budget, or how much others have taken from it. A review for this report suggests a lack of investment in information systems by a number of authorities (Exhibit 17, overleaf). More recent enquiries by auditors show that authorities have not yet estimated the probable total development and capital costs. From a selection of those that have done so it would seem that expenditure of between £1 million and £3 million can be expected, depending on the size of the authority. The timetable for this development is likely to be between three and five years.
Exhibit 17
DEVELOPMENT OF FINANCIAL AND MANAGEMENT INFORMATION
There has been a lack of investment in information systems by many authorities

Source: Study survey of sample authorities

(b) Inadequate Data on Resources and Users

102. At present, financial and management information within adult social services is service-led and patchy. Monthly expenditure figures are often produced but a common complaint is that they arrive too late to be of practical use to the unit manager and commitments may not be recorded. User records may be in the form of card indexes with no aggregation of information across the authority. The cost of services to individual users is unlikely to be known. Eighty five percent of social services directors (and auditors) consider the current systems to be inadequate for the future.

(c) Inadequate Monitoring and Evaluation

103. Systems for monitoring the quality, outcomes or cost effectiveness of services have been patchy. Occupancy rates for homes and day centres are produced; and average home help hours per user may be provided quarterly or at the year end. However, standards and norms of good practice for measuring the quality of services, of assessing outcomes for users, and for determining the cost effectiveness of services are often missing. PSSRU has done a considerable amount of research into the outcomes and cost effectiveness of current services to elderly people (Ref.12). It points to a lack of sound criteria for services with a resulting 'inverse dependency' with less dependent people better served than those with greater needs (Box D).

(d) Inadequate Public Information

104. Information for users and carers must be intrinsic to the services. Public information is patchy and often piecemeal, and provided to different degrees by different authorities for different user groups. It may also consist of general statements of values and intent and lack practical guidance. Lack of good information is a common complaint from users and carers alike. Authorities have major problems keeping the information up to date; and they may be concerned
that by making information widely available they will generate a demand for services which they cannot meet.

**Box D**

**QUALITY, OUTCOMES AND COST EFFECTIVENESS**

Results of PSSRU research are mixed

<table>
<thead>
<tr>
<th><strong>on quality</strong></th>
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<tr>
<td>— there was an absence of guidance on good practice which could be used for improving performance,</td>
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<table>
<thead>
<tr>
<th><strong>on outcomes</strong></th>
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<tr>
<td>— people allocating services had at best vague criteria for judging successful outcomes making it difficult for them to decide whether services should continue,</td>
</tr>
<tr>
<td>— services provided the greatest benefit to those people who lacked informal support,</td>
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<tr>
<td>— social work ‘does not serve effectively to reduce fears of vulnerability’ amongst users,</td>
</tr>
<tr>
<td>— 24% of the users who were still alive when the projects were evaluated had not benefited greatly from services, but there had been no re-assessments of their circumstances,</td>
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<table>
<thead>
<tr>
<th><strong>users' views</strong></th>
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<tr>
<td>— users' views and providers' views about effectiveness of services did not necessarily correspond,</td>
</tr>
<tr>
<td>— greatest satisfaction with services occurred amongst those users who were less disabled or who had good informal care,</td>
</tr>
<tr>
<td>— least satisfaction was recorded amongst those users who were severely disabled and who had some informal care,</td>
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<table>
<thead>
<tr>
<th><strong>cost effectiveness</strong></th>
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<tbody>
<tr>
<td>— day care for elderly people was not cost effective as few people who were allocated places made use of them.</td>
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**INFORMED OPERATIONAL ARRANGEMENTS**

**THE SOLUTIONS**

**(a) Appropriate Support Systems for Devolved Budgets**

105. Financial and management information is crucial to community care developments.

One social services department, well organised and far advanced in its preparations for 1993, told the study team that the development of financial and management information systems was proving to be the factor that determined the speed of implementation of care management, devolved budgets and service commissioning. The Commission's own paper 'Better Financial Management' (Ref. 19) gives sound advice to authorities engaged in devolving budgets. When budgets are devolved it is essential to ensure that:

— financial and management responsibilities are aligned, so that managers who make decisions are responsible for the financial consequences with more senior managers supervising the results,
— each manager's responsibilities are made clear and incentives are given to manage efficiently,
— clear, up-to-date information is made available to the right people,
— financial advice is improved and brought closer to line managers.

In addition, the accuracy of budgets can be improved by a careful review of past performance, the setting of clear priorities, enforcement of cash limits and careful costing of new initiatives. The ADSS/CIPFA partnership guide could help authorities determine their needs for financial management information (Ref.20).

106. The need to monitor devolved budgets closely is commonly overlooked. In a centralised system there is usually a mixture of overspends and underspends, with the latter used to balance out the former. With dispersed budgets there are rarely any underspends but overspends have a habit of continuing – particularly if patterns of over and underspends have not been reviewed and adjusted before budgets are devolved. Financial regulations will also need amending when devolved budgetary arrangements are introduced.

(b) Data on Resources and Users

107. There are four main areas where information systems are required:
— Care managers as commissioners will need regular, up-to-date budgetary information – possibly weekly – showing their spend and commitments. They will also need information about clients and an up-to-date list of services available with unit prices.
— Service managers will need budgetary and management information provided in a frequent, timely and useful form.
— Senior managers will need management information to enable them to monitor both the budgetary and activity performances of those reporting to them, and also information on unmet need for planning purposes.
— On 1 April 1993 it will be essential for authorities to have systems capable of assessing users' finances, paying residential and nursing homes and charging and collecting any element of the current income support finance due.

108. The government recognises that there is a continuing need to develop information technology to support the implementation of community care. It has announced Supplementary Credit Approvals for 1992/93 of £93,348 for each local authority for community care information technology. This is to be welcomed. Supplementary Credit Approvals, however, can be used for capital expenditure only and authorities urgently need expertise for development work to help them decide on their exact information needs. This would normally count as revenue expenditure. There are indications that some authorities are purchasing software and hardware in order to take up their Supplementary Credit Approvals before they have thought through their information requirements. Some of these purchases may well prove inadequate for the tasks eventually expected of them.

(c) Standards and Techniques for Monitoring and Evaluation

109. Authorities will need both to monitor the efficiency of care managers and service providers and evaluate the quality, cost effectiveness and outcomes of services – including that of care management. There are a number of techniques available but they all require the setting
of standards: norms or criteria against which quality, outcomes and cost effectiveness can be measured. The DoH is also providing guidance. Users and carers – and potential users – must be consulted as part of any measurement of outcomes but this needs to be skilfully handled if the results are to be meaningful. Research indicates that user surveys show that users are satisfied – but users are a self-selected group as those who do not like the services drop out or refuse the service. There is also the likelihood that users and carers are unaware of what is available and are therefore unable to make informed choices. They may have low expectations, may not realise the support they could be given and they may not like to complain.

110. Some social services practitioners and commentators have expressed concern that resources for community care may not be sufficient in some authorities (Ref.21). Indeed, authorities will have to prioritise their budgets. Such targeting does not preclude the need to ensure that the funds spent on individual care packages are well spent and cost effective. Rather it enhances it. Care managers are eventually likely to have two sources of provision:

— a menu of services at unit costs provided under contracts let by others in the department,

— individually-tailored services negotiated locally by themselves.

Those responsible for letting contracts will need to become skilled at specifications and contract negotiations to ensure that value for money is obtained – high quality at the right price. Contracts must then be monitored to see that the desired outcomes are achieved for users.

111. Where care managers negotiate local services for individuals, both line and central management should monitor the results for cost effectiveness and outcomes. Some authorities may choose to set a ceiling on the costs of individual packages above which a care manager must seek approval to spend.

112. According to a study by Anthea Tinker, intensive home based care for moderately frail or dependent people seems to compare favourably with residential care in terms of both cost (Exhibit 18) and satisfaction although generalisation to very highly dependent people should be

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Exhibit 18

**COSTS OF CARE FOR DEPENDENT ELDERLY PEOPLE**

Very sheltered housing compares favourably with residential care

![Costs of Care Graph](source: A. Tinker – An Evaluation of Very Sheltered Housing)
treated with caution (Ref.22). The study showed that individuals who had moved from residential homes to very sheltered accommodation were amongst the most satisfied.

113. Experimental schemes in Darlington and Gateshead have demonstrated that it is possible to support very frail elderly people in their own homes with a carefully designed mix of care and services. A matched control group in each case received the usual combination of hospital, health care and social services available locally. Both schemes achieved significantly better outcomes for the experimental group, in terms of morale, reduction in loneliness, perceived ability to cope and life satisfaction. There were corresponding reductions in the perceived problems and burdens on informal carers.

114. The average costs for the Gateshead Scheme did not show significant differences between the experimental and control groups (experimental £5,159, control £5,070 at 1981 prices which included total NHS and social services costs, case management, capital discounted at a 5% rate, housing and personal consumption such as fuel) (Ref.23).

115. The average costs for the Darlington scheme were markedly lower for the experimental group (Table 4). Total costs to society were worked out on a similar basis to Gateshead (Ref.24).

116. Since the Darlington scheme was aimed specifically at helping people in hospital to leave, many of the individuals in the control group spent considerably longer as in-patients – possibly accounting for the large difference in comparative costs. The discharge of people from hospital and their continuing care in the community is an issue of particular concern discussed later in this report.

Table 4
COSTS IN COMMUNITY CARE PROJECT
Markedly lower for the experimental group

<table>
<thead>
<tr>
<th>Project Base</th>
<th>1986/87 prices</th>
<th>Cost (per week alive)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Experimental</td>
<td>Control</td>
</tr>
<tr>
<td>District Hospital</td>
<td>13,208</td>
<td>22,048</td>
</tr>
<tr>
<td>Geriatric Hospital</td>
<td>12,584</td>
<td>14,404</td>
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</tbody>
</table>

117. Average costs tend to mask wide variations (Table 5) and consequently should be treated with some caution. For example, the costs of residential and nursing home care vary markedly with location, ownership, size and staffing ratios as shown by a survey (Ref.25) of over 700 private and voluntary residential and nursing homes (Appendix 2). Capital costs also varied considerably, with upper and lower quartiles for these (excluding profit) being 45% and 3% respectively compared to an average of 28%. Different requirements by different registration authorities can have a significant effect on staffing ratios.

118. Cost comparisons of mental health care in different settings are complex. The most comprehensive evidence in England comes from the reprovision of two large north London hospitals which are running down towards closure. Average data mask large variations, particularly in the community (Table 6). The community cost of those who actually left hospital reflects the typical policy of resettling those who are less dependent first (and therefore less costly).
The costs of community care depend on both individual characteristics and service use. For example, people demonstrating improvement in certain 'psychotic' symptoms or overall high anxiety were associated with higher costs; as was general broadening of social networks. Costs were lower both for the most dependent and the most independent, who appear to receive less support in the community than others (Ref.26).

### Table 5
**AVERAGE COSTS IN PRIVATE AND VOLUNTARY HOMES**
Costs vary markedly

| National costs per bed per week (90% occupancy) | Median | Mean | Lower Quartile | Upper Quartile |
| Running costs and Capital costs and Profit (£) | 203 | 232 | 148 | 273 |
| Staff costs included (£) | 88 | 89 | 56 | 135 |


### Table 6
**COSTS OF COMMUNITY CARE FOR PEOPLE WITH A MENTAL ILLNESS**
Average data mask large variations.

| Hospital 1 (beds) | £16,959 | £17,702 | £18,822 | £19,958 |
| Hospital 2 (beds) | £19,036 | £18,607 | £23,506 | £22,570 |

Average community cost for resettled individuals = £13,913
Average predicted community cost for total hospital population = £16,676


These limited data point to the need for careful monitoring of unit costs both within and between authorities. While care managers must always give top priority to finding the right placement they will be a more effective purchasers armed with a good knowledge of different costs. The Commission will seek to develop such information as the policy moves forward.

### (d) Public Information

Authorities often argue that greater publicity could lead to a flood of new applicants, and use this as an excuse for not publicising their services more widely. They suggest that the new method of assessing will create demands that will be disappointed through a lack of resources. However, representatives of users and carers together with senior, experienced practitioners often view this as unlikely. Users and carers are often underrated; they want to know where they stand, but they can understand that services, or support cannot always be provided in the way they would ideally like. But they find it hard to cope with a lack of information, and uncertainty; and they object to being told that they need – and might get – a service but that it is not that particular
member of staff’s responsibility to arrange for it to be provided. Information about services and the criteria for assessment and care management will help to improve the quality of service given to users and carers without necessarily increasing the volume. Outlets for information must also be appropriate. An obvious choice among others would be GPs’ surgeries. This would require collaboration between the GPs, the local authority and other providers.

122. In order to provide a seamless service for users and carers, local social services authorities will need to work in close collaboration with others. The problems and potential remedies involved are explored in the next chapter.
4. Working With Others

123. Under the terms of the 1990 Act local social services authorities must 'consult' a variety of bodies when preparing their CCPs. Health and housing agencies, and voluntary bodies – both those providing services and those representing users or carers – are listed as are other providers. In addition, health and housing agencies must be invited to take part, where appropriate, in individual assessments. Local authorities, then, are obliged to work with other agencies. 'Consultation', however, can take many forms from a letter enclosing an almost-finalised draft CCP for comment, to involvement of others from the earliest stages of the Plan. Early, rather than late involvement, embodies the spirit of the new legislation. This chapter reviews the problems authorities face in developing constructive relationships with each other. Some solutions are suggested but they depend for their success on good relations with the other parties.

A FRAGMENTED SERVICE: DIFFERENT PRIORITIES, ORGANISATIONS AND CULTURES

124. The problems facing social services' authorities in developing a co-ordinated approach to care are of two kinds: different priorities and cultures between agencies; and a lack of incentives to collaborate and work together.

THE PROBLEMS
(a) Lack of Common Ground with the NHS

125. The biggest organisation with which local social services authorities must work is the NHS. The NHS spends more on long-term and community care than does local government (Exhibit 3). Many of the more dependent users will require both health and social care and research indicates that a high proportion of users and carers initially approach their GP when they require either form of care. If assessment procedures are to dovetail and inter-agency support for individuals is to be complementary, well organised, of good quality, and convenient to users and carers with no waste of resources then agencies must collaborate and co-ordinate their working practices. However, the NHS is itself fragmented consisting of different agencies which relate separately with social services authorities (Exhibit 19, overleaf).

126. The problem is exacerbated in many areas of England where social services and health authority areas are not co-terminous. A local authority therefore may have to relate to several health purchasers as well as many providers. This multiplicity complicates collaboration. Some additional confusion has occurred during the last year because of the NHS reforms. The picture should now become clearer as the various NHS components sort out their own futures.

127. The NHS, in its various parts, has different priorities from social services; including sometimes adopting a 'medical' rather than a 'social' model of care, focusing on short-term acute intervention rather than long-term support, and a short rather than long time scale.
128. The two types of authority have also developed different organisational and management styles which can make harmonious working relationships difficult to achieve:

— elected vs unelected members (LA/DHA),
— different committee and planning cycles,
— different management structures with more delegated authority given to NHS managers,
— different levels at which purchasing occurs,
— clinicians with greater power and authority within their place of work compared to social work practitioners leading to:
— SSD/NHS practitioners' uncomplimentary stereotypical views of each other.

129. The resultant lack of collaboration is evident throughout all user groups. Contact between social services and NHS has been sparse despite the fact that many referrals are from health to social services. For example, out of 177 elderly users receiving services from both agencies in one review, in only 7% of cases did the two agencies regularly liaise (Exhibit 20).

130. Surveys carried out on physical disability in the last decade for the Royal College of Physicians (Refs. 27 and 28) identified a lack of co-ordination between health and social services. Virginia Beardshaw, in an extensive review, commented that 'no specific arrangements for co-ordinating the health and social care services received by disabled people presently exist' (Ref. 29). She also noted significantly that professionals from different backgrounds seem unable to understand each others' perspective, roles and methods of working'. Audit Commission publications in 1986 and 1989 have documented the failure in collaboration for people with learning
disabilities and those with mental health problems. In recognition of public concern for the latter user group the Government now requires joint agreements between health and social services on care for people with mental health problems. For England a specific grant has been provided for social care for this group. Plans for this grant must be jointly agreed by health and social services authorities.

(b) Insufficient Liaison with Housing Agencies

131. Housing is an important element in community care. People with mental health problems or with a learning disability often need a home before community care can be contemplated. Sheltered housing and repairs and adaptations are vital elements in helping elderly or disabled people to remain in homes of their own. The provision of new sheltered housing units built by public agencies, however, has declined over the last decade by over 40%. Research by Anthea Tinker for the Department of the Environment shows that very sheltered housing for highly dependent people can be more cost-effective than residential care, although less so than supporting such people in their own homes (Ref.22).

132. Adaptations to their own homes are also important to elderly and disabled people. The School for Advanced Urban Studies evaluated 50 housing agency services projects aimed at repairing and adapting property. Of the 11,000 clients 90% were aged over 65, 40% aged over 75 and 57% had health or disability problems (Ref.30). However, seventy three percent of social services reviewed by the Commission for this report said there were problems getting adaptations done. The procedure for obtaining grants and the lack of occupational therapists (OTs) to assess
requirements were cited as causes of difficulty. Social services need the co-operation of housing agencies if repair work is to be done at public expense. Housing, however, has been on the margin of joint planning in the past and frequently unrepresented on joint care planning teams. There are now new areas of housing agency activity (e.g. alarm schemes and mobile wardens) which overlap with social services but which may not be co-ordinated or addressed at strategic level without the necessary liaison with social services.

133. Although London boroughs and metropolitan districts are both social services and housing authorities, county councils have to relate separately to each district housing authority within their borders. This multiplicity of agencies makes successful working relationships more difficult to achieve, particularly where there are different political priorities. The contraction of council housing stock also means that in areas of high demand for social housing it can be difficult to get agreement on the allocation of units for people with special needs. Indeed, housing authorities sometimes complain that social services ask for special needs housing and then expect the housing authority to provide the support as well. A recent survey by 'Shelter' found that 75% of housing authorities had no policy on allocations of units to disabled people and no policy on adaptations; and almost as many had no formal liaison with social services (Ref.31). These findings indicate a lack of common ground and shared priorities between social services and housing authorities.

134. Housing associations are playing an increasingly important role as local authority housing stocks decline, although the number of new sheltered housing units built by housing associations reduced from 1981 to 1988 by 19%. Social services departments therefore need to develop relationships with the associations in their area. Uncertainties about funding for special needs housing due to the changes in financing arrangements for housing associations have been a recent added complication.

(c) Different Viewpoints and the Independent Sector

135. The independent sector, with which social services must both consult and contract, provides support services to people within the community. This support is likely to increase. There are problems, however, which result in patchy services from this group of providers.

136. The independent sector consists of voluntary groups, 'not-for-profit' organisations and private providers. The 'voluntary sector' is not homogeneous although it is sometimes referred to as though it were. Groups may be established for different purposes:

— to provide services (sometimes those which are perceived as needed but not provided by social services),

— to provide advocacy for users,

— to represent the view of users or carers,

— to raise funds,

— to form a pressure group aimed at getting provider agencies to improve or create services.
They may also be large, national bodies with staff able to take on the consulting and contracting roles. Or small, local groups formed to fill a specific niche with people less used to influencing the bureaucratic process and few resources and limited expertise for negotiating contracts.

137. Many voluntary organisations delivering services have not been accustomed to the 'contract culture' and are viewing it with some misgivings. Some are also concerned that social services, in awarding contracts, may seek to constrain the independent voice of the voluntary organisation. Small, local groups providing innovative and valuable support to users and carers are also in danger if authorities seek to restrict service provision to large providers who offer economies of scale, but possibly less flexible support to users or carers. Services to ethnic minorities in particular might be adversely affected. Not only may services from statutory bodies lack sufficient sensitivity to ethnic differences but some ethnic groups may culturally prefer a self-help model of care.

138. Social services in many areas are seeking budget reductions and grants to voluntary bodies make an easy target (Exhibit 21). Voluntary organisations, can however, be providing essential services at less cost to the local authority than if the authority provided them itself. Cuts in grant and the uncertainty of future funding from local government mean that voluntary bodies are finding it difficult to plan, develop and improve their services.

*Exhibit 21*

**GRANTS TO VOLUNTARY BODIES**

An easy target to cut

Source: Study survey

139. Some local social service authorities are also ideologically opposed to using the private sector. This may well limit the number of service providers and service types from which care managers, users and carers can choose.

140. The picture may appear bleak representing as it does a lack of common aims that can sometimes even border on hostility between social services and other agencies. Solutions need to be identified to create a climate more conducive to co-operation. Good collaboration is possible and some authorities are achieving it.
A SEAMLESS SERVICE

141. Many users and carers are largely indifferent to the funding sources of their community support as long as it is reliable and comes at times and in ways convenient to them. Information should be readily accessible and entry into the system for support should be simple especially for those requiring multi-agency care. Users and carers should experience a 'seamless service' when support is needed from different agencies. Just as bringing about a cultural revolution within the local authority itself can be difficult so too can securing collaboration with other agencies. It involves working with different cultures, securing trust and sharing power and therefore needs to be handled by local authorities with sensitivity as well as persistence.

142. Local authorities already have experience of working with health authorities on Joint Consultative Committees (JCCs). Much of the work focused on the use of Joint Finance and planning, with the help of HA funds, for the resettlement of people with learning disabilities. These collaborative ventures have achieved some success although it has been uneven, as reported in previous Commission reports (Refs. 1 and 6). Where the outcomes have been successful it has often been due to the development of good relationships.

THE SOLUTIONS
(a) Joint Working with the NHS

143. The keys to progress on collaboration with the NHS are shared commitment and good relationships. The 'champions of change' identified by the 1986 Audit Commission report are still needed. Where they flourish progress is often evident. Where commitment and good relationships do not flourish action is required to establish them. It is necessary to achieve shared commitment to common goals. The 'Rubber Windmill' exercise in East Anglia (a workshop which included a simulation of the first three years of the new contracting arrangements in the NHS) concluded that 'negotiation of health and quality outcome objectives with local authorities and GPs is not simply a desirable objective, it is absolutely essential' (Ref.32). Joint statements of philosophy, goals and priorities should therefore be agreed to underpin future actions.

144. DoH guidance encourages a joint assessment of need within the community and joint plans produced by local social services and district health authorities. (In Wales this is mandatory). The 1990 Act makes 'consultation' on CCPs a legal requirement. Early, direct involvement in the production of the Plan itself should be the way forward, with health representatives (management, medical and nursing) playing a full part in social services development of community care. Task groups should all include appropriate NHS personnel – especially those researching needs, goals and priorities, resources, assessment and care management models, information requirements, criteria for service eligibility and evaluation of quality. Social services should also ensure that both NHS purchasers and providers are involved appropriately to reflect the NHS reforms.

145. Local social services authorities will need to reach agreements with both purchasers and providers in the NHS (Exhibit 22). Strategic level agreements on overall population 'needs' for example will be made with health purchasers, although providers will have some input whilst issues relating to the delivery of care will need to be agreed primarily, although not exclusively, with health providers.
Exhibit 22
JOINT AGREEMENTS WITH THE NHS
Agreements must be reached with both commissioners and providers.

146. GP fundholders are also health purchasers. At present they buy mainly elective surgery on behalf of their patients. They are not able yet to purchase either community health or social care. Although the extent to which their practice nurses perform such functions must be borne in mind. If, in future, GP fundholders are able to purchase these community services then they will become major participants with whom social services will need to negotiate. GPs also have a role in assessment. The British Medical Association believes that assessment should be separate from service provision and therefore a patient's own GP should not be involved. The assessment should be performed instead by another doctor.

147. The recent Commission report Managing the Cascade of Change (Ref.33) draws attention to the crucial importance of collaborative approaches between local authorities, health authorities and FHSA in drawing up joint agreements. The list of difficulties in para 128 above is by no means insurmountable. Good will, commitment to the best interests of users and carers and making best use of finite joint resources can achieve the positive gains of collaboration and joint agreements. Authorities are recognising this fact and are seeking to work more collaboratively. The Welsh Office and some regional health authorities (RHAs) are active in their support for joint working between social services and district health authorities. Yorkshire RHA, for example, is facilitating joint working groups. South East Thames RHA has issued advice to district health authorities on community care and strongly encourages a joint commissioning approach (Ref.34). In Cornwall the social services director, district general manager and FHSA general manager have adopted a joint approach to the development of community care. Indeed, in Wales the departmental guidance requires Social Care Plans to be fully joint.

148. It is important that agreements include guidelines on what is regarded as health care (and thus free at the point of delivery) and what is social care (and therefore potentially chargeable) as this could become a source of friction when local packages of support are being arranged for individual people. It is equally important that joint agreements and collaboration at one level between organisations are mirrored at the other levels. The Commission has found
indications that this is not always the case. Collaborative ventures then become frustrated as joint strategic level agreements fail to affect working practices. Alternatively local joint working practices may not be formally sanctioned and extended by senior management. Staff at all levels within an authority must therefore get together with their counterparts in other authorities.

(b) Closer Liaison with Housing

149. The same arguments for establishing good relationships apply also to social services' involvement with housing agencies. The 1990 Act requires social services to 'consult' housing agencies when preparing the CCP; and housing agencies must be invited to assist in individual assessments if housing is thought to be an issue. Once again 'consultation' should be interpreted as involvement. Social services are already involved with housing associations in providing homes for people with learning disabilities. As well as appointing housing representatives to appropriate task groups, social services could engage in some joint working:

— joint reviews of dependency levels in housing agency accommodation, particularly sheltered housing,

— establishment of policies and practices for supporting residents of special needs housing (a team of home carers, for example, servicing residents within a particular unit),

— agreements on other support activities provided from sheltered housing units – for example day activities in the common room, particularly where it is under-used; or meals for frail residents in the local community prepared in a communal kitchen,

— provision of resources for housing agency service projects and training for care managers in the importance of housing issues.

150. There are also innovative housing schemes that can be encouraged such as those developed by Retirement Security Limited as very sheltered housing in which social care to whatever intensity needed is provided by the private domiciliary help included in the scheme.

(c) Greater Understanding and Support for the Roles of the Independent Sector

151. Social services should involve representatives of voluntary organisations from the start when drawing up the CCP, and not just consult them after the event. Discussions should also be held with private providers of housing or community care services.

152. Secondly, each social services department needs to review the nature and make up of the voluntary bodies within its area, understanding where their strengths and interests lie and how best to ensure they can play their full part in support of users or carers. For some, core funding may be required on a more secure footing than an annually negotiated grant. Others may need assistance to take part in the contracting process. Appropriate voluntary groups that provide services can be encouraged to adopt a marketing approach. The study team visited such an organisation in the north east of England which provided services to physically disabled people. It was seeking to sell services to various social services and health authorities and act as a 'shop front' for manufacturers of aids for disabled people.
153. Thirdly, if local authority financial circumstances require cuts in grants to voluntary bodies then grants should be strategically reviewed. Arbitrary cuts could increase pressure on the authority's direct services if vital support from a voluntary body to some users is ended.

154. User groups and voluntary bodies can be useful channels for reviewing unmet need within the community so a constant dialogue between them, social services, and other local authority departments should be productive.

155. In some areas where independently provided services are patchy the social services authority may need to stimulate the supply. Areas of need should be identified, for example: a lack of advocacy services or meals for ethnic or religious minorities. Stimulation may take different forms, including the provision of start-up costs; or advice, time and support may be provided by a social services officer on how to organise and set up self-help groups.

(d) Consultation with Users and Carers

156. Local authorities should develop ways of consulting users and carers directly in the planning process. Some authorities have already begun to do this. Surveys can play a valuable role as can locally arranged meetings in community centres and village halls. Contact can also be made through such organisations as the Women's Institutes, residents' associations and parish councils as well as through users' and carers' groups.

LACK OF INCENTIVES
PROBLEM
Social Services and NHS Protecting their Separate Budgets

157. There has been little incentive for the NHS to collaborate with LAs. Discharging people to social services from long-term NHS institutions could require DHAs to hand over precious finance to the local authority, whilst social services could view such collaboration as the receipt from NHS of more people to support when finances were already tight. Such perceptions do not encourage either agency. There have been few incentives to act co-operatively within the acute or community sectors either. In fact, incentives have been perverse from the user's perspective. If one community agency unilaterally withdraws a service (for example continence pads or bathing at home) there may be a hope – but no guarantee – that the other will pick up the need and pay for provision. In addition social services may be reluctant to provide support for people leaving acute hospital on the basis that whilst in hospital those people are being looked after by the NHS budget but in the community it is the social services budget that will be used.

158. The discharge of patients from acute hospital beds is an area of particular concern. Twenty four percent of hospital patients are elderly (43% of acute beds are occupied by patients aged over 65). Many who are discharged require continuing support. This is an old problem, but will become critical unless social services and hospitals can agree – and operate – proper procedures on discharge. At present hospitals can by-pass the problem by arranging for patients to be discharged to nursing homes supported by social security payments – not always a desirable outcome from the patient's point of view. But from April 1993 this option will no longer be available to them. Lack of community support for discharged patients was a major cause of the collapse in the 'Rubber Windmill' exercise in East Anglia. Neglect of this issue could bring a crisis in the acute hospital sector in the future. The Commission found that a high proportion of social
ARRANGEMENTS FOR DISCHARGE FROM ACUTE CARE: THE DIFFICULTIES

Social Services felt insufficiently involved

Source: Study survey

services departments reported difficulties with collaboration with health authorities or hospitals over the discharge of patients from acute care (Exhibit 23, overleaf) PSSRU also registered problems of communications, particularly with hospital social workers. Co-ordination of services was worst for people coming out of acute care yet as PSSRU says:

'this is a group which contains a disproportionate number of persons at high risk of unnecessary admission to institutional care and admission to hospitals. It is precisely this group for which case (care) management must be best performed.'

159. A recent Audit Commission publication on the use of medical beds in acute hospitals (Ref .35) describes the current situation in more detail; for example:

— patients receiving less than 12 hours' notice of discharge,
— poor co-ordination between the hospital, GPs, community health and local authorities,
— lack of incentives for social workers to facilitate prompt discharge.

160. The report on the use of medical beds indicates the social security changes in 1993 and the crucial role social services will have in facilitating effective discharge from hospital. It highlights the concern felt that close co-operation between hospital and local authority staff will become essential.

WORKING TOGETHER
THE SOLUTIONS

(a) Joint Budgets and Local Purchasing with the NHS

161. The problem of how to develop complementary community health and social care that makes best use of joint resources without gaps or duplication in services or bureaucracy has
been an apparently intractable one in the past. Joint strategic agreements between the macro level purchasers from both organisations is a vital first step but that will not be sufficient. The purchaser/provider split within the NHS is different from that proposed in the care management models for social services. The split in the NHS is at a macro level with the DHA as purchaser contracting for the global health care needs of its population. In social services the split is at a micro level with a care manager commissioning individual elements of care for a person on his/her list. Local social services authorities will therefore need to reach agreements with both health purchasers and providers.

162. Several authorities are initiating projects co-ordinating health and social services budgets at a local level to be spent by care managers when assembling packages of care for individuals (Exhibit 24). In some cases these care managers are located in the GP practice, or practice locality for several GPs, which can make good sense when many people wanting social care approach their GP first. Combining budgets for care managers at a GP practice level also provides the DHA with a local health purchaser acting as an agent for the macro purchaser. It can be a useful model for a seamless service to those users and carers requiring multi-agency packages of care. There is no doubt that a 'one stop shop' is attractive to users and carers. The care manager becomes a single point of contact and co-ordinates care across the agencies. Locating a social services care manager within the surgery may also be attractive to GP fundholders if, in future, they can use their funds to purchase community care.

Exhibit 24
A MODEL FOR COLLABORATION
Several authorities are co-ordinating health and social services budgets

(b) Agreement with Hospitals on Acute Discharges

163. A local care manager acting for both agencies, however, will not solve difficulties experienced in supporting people discharged from acute care. As social services will be respon-
sible, from April 1993, for assessing people for nursing home care there should be an incentive for hospitals and healthcare purchasers to reach agreement with social services on proper discharge arrangements. Social services must be involved in the design of procedures for discharge. Their key requirement will be adequate notification prior to discharge and referrals based on an assessment of need – possibly a joint assessment – not just a request for services.

164. Guidance on this issue already exists. The Audit Commission report on the management of acute medical beds quotes the DoH circular LAC(89)7: ‘where continuing domiciliary care is needed social services staff should be involved in assessing the patients' social care needs and home circumstances at an early stage before discharge’. The report also urges hospital management and staff to liaise with local authorities to ensure effective discharge arrangements.
5. The Audit Commission's Role

165. Over the next six months the Commission's auditors will continue their review of the process for implementing community care changes in most social services authorities. In undertaking these reviews the auditors will have the professional advice and assistance of the Social Services Inspectorate.

166. Arrangements in health and local authorities for both purchasers and providers will be audited to ensure that authorities are addressing the changes systematically. An overview summarising the degree of co-ordination between local, district health and family health services authorities will be produced in each area during 1992 together with more detailed reviews of arrangements within local authorities and district health authorities.

167. The audits focus on three key areas:
— policy,
— operational arrangements,
— interagency co-ordination.

Each of these areas is subdivided into a number of 'modules' within the overall audit framework.

POLICY

168. Each authority will need to establish its own policy framework. Auditors will be reviewing authorities' approaches to needs assessment, combining demographic data with data collected locally. The process of setting objectives, calculating resource implications and adjusting priorities will be examined. Auditors will also review arrangements for producing forward plans and consulting with others.

OPERATIONAL ARRANGEMENTS

169. Plans must also set out how authorities intend to manage their policies in practice. Local authorities will be experimenting with care management; and assessment arrangements will be crucial if co-ordinated care packages are to result. Auditors will therefore review authorities' plans and intentions.

170. The form of the relationship between commissioners and providers will also be crucial. Auditors will check that arrangements are positive, that the full potential for creative use of funds is being seized, and that funds are not locked up in contracts that constrain rather than enable.

171. Considerable attention will be given by auditors to information systems – particularly financial information systems where funds are being devolved to care managers. Sound financial controls and commitment accounting for both care managers and providers are essential if the new arrangements are not to disintegrate. And with social services expecting injections of new
cash transferred as the 'care' element from social security from 1993, good systems will be essential. Auditors are particularly well placed to advise on these matters.

172. Finally auditors will be commenting on arrangements for ensuring that users and carers receive a quality service. Care managers will need new methods of approach to ensure that what is being provided is of high quality.

CO-ORDINATING CARE

173. All of the policy and operational issues must be co-ordinated between authorities. There are real potential benefits for authorities to pool their individual knowledge about needs; and it will be essential for them to co-ordinate their policies, objectives and priorities. Simply going through the motions of consulting on each other's plans after decisions have been taken will not be good enough. At the operational level it will be necessary to set in place linked arrangements for co-ordinating care and assessment, and for ensuring that packages of care involving components from different agencies are properly co-ordinated.

174. As auditors check through both policy and operational arrangements in each authority they will ask questions about how the authority is linking at every level with others. Reviews will also be undertaken of the machinery in place for promoting joint working – whether it is limited to a rather infrequent formal contact through joint consultative committees or whether there is everyday contact between officers at every level. In this way auditors will build a picture of the degree of co-operation between authorities.

REPORTING

175. The outcome of each audit will be an individual report to each authority setting out the key issues to be addressed within the authority. But in addition, the intention is to produce an overview summarising the degree of co-operation between authorities, setting out where authorities need to work together to improve co-operation. To this end issues raised in each authority which have implications for other authorities will be drawn together to ensure that collaborative arrangements are appropriate.
Summary of Recommendations

If implementation of community care changes is to be successful local social services authorities need to pay particular attention to three key areas: gaining the commitment of members and staff, developing systems to support strategic and operational aspects of implementation and achieving good collaboration with other agencies.

1. A CULTURAL REVOLUTION
   (i) Hearts and Minds
       (a) Provide strong, committed leadership in social services with sufficient time to devote to masterminding the changes and authority to co-opt and influence staff.
       (b) Establish clear values and goals with a 'mission statement' drawn up with the agreement of staff.
       (c) Involve, inform and train staff in the issues.
       (d) Enable local authority services to be innovative in order to respond to user needs-led demands.
   (ii) Member Commitment
       (a) Provide information and study seminars for members.
   (iii) Power Sharing
       (a) Foster agreement to devolved budgeting and flexible working arrangements between professional and trades groupings within the authority must agree .
       (b) Increase awareness the needs of infirm and handicapped people in other local authority departments.
       (c) Tackle community care as a corporate issue.
       (d) Target key individuals whose commitment to community care will be particularly beneficial to its development.
       (e) Consult users and carers directly in the planning process.

2. SYSTEMS REQUIREMENTS
   (i) Informed Policy Making
       (a) Set up task groups to research key developmental areas and working to a steering group.
       (b) Take stock of resources both within and external to the local authority. Calculate unit costs and establish dependency levels currently served.
(c) Rigorously define, then measure need within the community.

(d) Decide priorities for support amongst user groups and dependency levels. Choose risk indicators to help target priorities.

(e) Develop assessment process after the council has agreed its priorities and target groups.

(f) Divide budget according to decisions on priorities and dependency levels serviced by care management. Establish changes for services from those able to afford a contribution.

(g) Decide the organisation for assessment and care management.

(h) Arrange for transitional arrangements to allow staff and systems to be developed.

(ii) Informed Operational Arrangements

(a) Match financial and management information to the needs of the system's users. Increased attention to development is needed. Do not devolve budgets until appropriate information is available.

(b) Improve data on users and services.

(c) Set measurable standards for monitoring outcomes and cost effectiveness of services. Evaluation techniques must also be developed.

(d) Provide and update information to users.

3. WORKING WITH OTHERS

(i) A Seamless Service

(a) Interpret 'consultation' with NHS as 'involvement'. Develop working agreements with both purchasers and providers. Agree distinction and responsibilities between health and social care.

(b) Develop closer liaison with housing agencies with joint reviews of dependencies and agreements on support in sheltered housing.

(c) Involve independent organisations in the planning process. Understand and make appropriate responses to the varied nature of the voluntary sector.

(d) Consult users and carers directly.

(ii) Working Together

(a) Work towards joint local budgets for the purchase of social and health care.

(b) Agree and implement arrangements for discharging patients from acute hospitals and for providing them with care in the community.
ELDERLY PEOPLE
TRENDS IN THE NUMBER OF POTENTIAL SERVICE USERS – ELDERLY PEOPLE.

The increase in the elderly population has been well publicised during the 1980s. In that decade the number of people aged over 85 went up by more than 50%, those aged 76 to 85 rose by 20% but the number between 65 and 75 fell. The number of very elderly people is projected to continue rising during the 1990s but less steeply than recently (Exhibit 25).

Exhibit 25
CHANGES IN THE ELDERLY POPULATION
The number of very elderly people will continue to rise

Source: OPCS

So how should these general projections be interpreted for planning local authority activities? Although most elderly people do not need long-term care it is known that disability of some form or other does increase rapidly with age. The Office of Population Censuses and Surveys (OPCS) General Household Survey (GHS) of the mid 1980s shows that the proportion of people aged over 80 with very severe disability is more than twice that for those people aged between 70 and 79 (Ref. 36).

The GHS also shows a sharp age related increase in the use of health and social services. What is not known, however, is whether the onset of dependency is delayed as life expectancy increases. Virtually no health monitoring is done on a regular basis in the UK. Bebbington of PSSRU, suggests, based on the GHS, that whilst the onset of disability is being delayed the length of life then spent disabled may be lengthening. If this is so, longer life is bringing with it extra need.
As the projected increase in the numbers of very elderly people later this decade is lower than that experienced recently it could be assumed that social services would need to plan for a correspondingly smaller increase in service levels. However, this is to ignore four critical factors:

— the rise in the number of elderly people, particularly women, who live alone,
— other social trends resulting in a reduction in informal care,
— shortening lengths of stay in NHS facilities,
— changes in arrangements for social security income support for residential and nursing home residents in 1993.

These are outlined in turn below.

ELDERLY PEOPLE LIVING ALONE

The numbers of elderly people living alone is rising although not quickly: from 47% to 50% between 1983 and 1988. This group is also a major user of social services support (Exhibit 26).

Exhibit 26

ELDERLY PEOPLE AT HOME ALONE

Major users of social services

![Chart showing the percentage of the population aged 75 or over living alone or with a spouse.]

Source: OPCS

This is not surprising since the lack of informal carers clearly increases the likelihood of needing support from some other source.

SOCIAL TRENDS

Although men form a significant proportion of carers of elderly people, the bulk of informal care for people below retirement age is provided by women below the age of 60 (Ref. 11). Amongst women, however, participation rates in paid employment rose during the 1980s from 47.3% of the population in 1979 to 50.9% in 1988. With fewer young adults projected in the 1990s it is likely that this employment trend will not change significantly. This suggests that fewer women will be able to provide intensive informal care for elderly people (and others) than in the past.
In addition, the number of people aged 60-64 is projected to decline over the same period which means that there will be fewer younger retired people, many of whom have traditionally provided informal and voluntary support to the very old. Since it is collapsing informal support rather than disability itself which often results in an application for residential care (PSSRU), the allocation of local authority resources to reflect carers’ needs is crucial. Carers in effect become a user group in their own right and this is reflected in the priority given to them in the DoH community care guidance.

SHORTENING LENGTHS OF STAY

NHS provision of specialised geriatric beds has fallen relative to the number of elderly people but its activities in terms of cases treated within the hospital has risen, reducing lengths of stay.

Between 1979 and 1986 the average length of stay for elderly people in geriatric wards declined from 77.5 days to 44.8 days. There has also been a decline in the average length of stay for elderly people in acute medical and surgical wards (Ref.37). This has obvious implications for community care services. Projects researched by PSSRU confirmed this. They found that 48% of home help elderly users and 44% of those receiving day care or social work support had been NHS inpatients in the three months prior to applying to social services for care. A third of these people were then readmitted to acute care within nine months.

SOCIAL SECURITY INCOME SUPPORT FOR RESIDENTIAL AND NURSING HOME CARE

Not all elderly inpatients, however, return to be supported in their own homes. The decline in average length of stay of elderly people within NHS hospitals has been in part made possible by the growth in private nursing homes (Exhibit 27) and the concurrent closure of NHS long stay beds.

Exhibit 27
GROWTH IN PRIVATE NURSING HOMES
The growth has in part, made possible a declining length of stay in NHS hospitals.

*Before 1987 private and voluntary homes places not separately identified
Source: Department of Health
A sample survey by York Health Authority (Ref. 38) showed that 54% of admissions to nursing homes was from hospital. Further data on the movement of geriatric patients are described in a Commission paper on the use of acute hospital beds (Ref. 35) published in January 1992.

This movement from hospital to nursing home has largely been made possible by the availability of income support from the Department of Social Security (DSS) for nursing home care. This use of income support will cease for new applicants from April 1993 when the care element is progressively transferred to local social services authorities for them to spend on whatever social support is most appropriate for individual users. This change is causing anxiety in both the clinical and social camps. Hospital management and professionals fear they will be unable to move elderly people out of acute beds as social services will not be able to provide support. Social services on the other hand are afraid their new budgets made up of previous social security money will be largely preempted by the costly needs of mainly elderly people coming out of acute NHS care. Whatever the outcome, however, the need for social services support following acute hospital care will increase. From April 1993 local social services authorities will also need to assess the support needs of elderly people who previously would have gone into residential care financed by DSS income support. The 1986 Commission report amongst others pointed out the perverse incentive of social security income support for private or voluntary provided residential care when finance for domiciliary care was limited by additional conditions, thus encouraging the growth of residential homes instead of support for people in their own homes. The growth of private residential care has trebled in the last decade (Exhibit 28) and only part of this increase can be attributable to demographics. In 1985 the Commission said that 11 places only per 1000 people over the age of 65 were needed to support highly dependent people at that time (Ref. 39). By 1989 there were 31.1 places per 1000 people over the age of 65.

Exhibit 28
GROWTH OF PRIVATE RESIDENTIAL CARE
Trebling in the last decade

Note: Figures for Wales are not included
Source: Laing and Buisson
William Laing (the research specialist in private sector care) calculated that 29% more elderly people were in long-term residential care than would have been expected (Ref. 40). The Firth Committee (Ref. 41) reached a similar conclusion estimating that around half only of the actual increase in residential provision during the first half of the 1980s could be accounted for by a demographic rise in the elderly population.

Some research (Ref. 38) indicates that some elderly people in local authority residential care are inappropriately placed. In general, dependency levels in the private sector are lower than in local authority homes and hence by implication the chances of misplacement are higher. On this basis from April 1993 when social security no longer directly funds residential care proportionately more elderly people are likely to require care in their own homes.

In short, whilst the growth in numbers of very elderly people will be slower during the 1990s potential users of social services arranged support are likely to grow because of a number of factors:

— the increase in the number of elderly people living alone,
— the likely reduction in available informal care because of an increase in paid employment by women,
— and a decrease in the numbers of younger retired people,
— the shortening lengths of stay in NHS hospitals,
— from April 1993 the channelling of elderly people through social services who might previously have gone directly into social security funded nursing or residential care.

EXPENDITURE AND ACTIVITY

The previous sections have discussed how various factors are affecting the demands for services for elderly people. The financial resources devoted to meeting this demand are considerable since elderly people are by far the largest of the four main user groups and they absorb the lion's share of the total resources identified in Exhibit 3. The local authority spend on elderly people in 1988/89 was £1.4 million.

In the last decade there has been considerable growth in social services expenditure on services which support people in their own homes whilst residential care has not risen (Exhibit 29, overleaf).

If a policy of domiciliary support to people in their own homes is being pursued one would expect a rise in related expenditure. A corresponding decrease in spend on residential care has not occurred although there has been a small reduction in local authority 'Part III' residential home places. The increased spend on home based support has provided for a 25% increase in home helps and a 12% rise in meals on wheels. The increase in day care has been more modest with an extra 4000 places provided.

The expansion of services to people in their own homes has not been as fast, however, as the numbers of elderly people likely to be dependent on them. The main beneficiaries have been younger elderly people who have also been the largest age group entering private residential care.
There has been a growth in expenditure on domiciliary support

Source: Department of Health

HOUSING

Housing is an essential element of community care. If elderly people are to be supported in their own homes then those homes must provide a standard of accommodation that does not, because it is inadequate, add to the stress of living as housing problems undermine a person's ability to stay at home. Ensuring that elderly people live in homes that meet their needs can be achieved in two ways: by providing appropriate sheltered housing or by adaptations and repairs to a person's existing home. Social services departments have no powers to provide ordinary domestic houses so it is necessary for them to have links with local housing authorities, housing associations and private providers of homes for elderly people.

Figures from Social Trends 1990 (Ref 5) show that although there is an increasing elderly population the numbers of new specialised dwellings for them has declined in the last decade despite an increase in private building (Table 7). The total stock of specialised dwellings has, of course, risen by the number of new completions.

| Table 7 | COMPLETION OF NEW, SPECIALISED DWELLINGS FOR ELDERLY PEOPLE | Numbers of completions have declined |
|-----------------------------------------------|
| Sheltered Housing | | | | |
| Private | 130 | 850 | 1,912 | 2,189 |
| Housing Associations | 1,929 | 1,916 | 1,814 | 1,557 |
| Local Authorities/New Towns | 5,558 | 3,772 | 2,883 | 2,707 |
| Other Homes | | | | |
| Private | 62 | 193 | 285 | 520 |
| Housing Associations | 261 | 597 | 511 | 349 |
| Local Authorities/New Towns | 4,636 | 1,776 | 1,892 | 1,382 |
A high percentage of elderly people are owner occupiers. The spectrum ranges from 57% of those aged 60 to 69 to 46% of those people aged over 80. The 1986 English House Condition Survey (Ref. 42) highlighted the unsatisfactory conditions in which many of these owner occupiers lived. One third of dwellings lacking amenities and 16% of those which were unfit were lived in by households the heads of which were aged over 75. A study by the School for Advanced Urban Studies (SAUS) indicated that elderly households which needed expensive repair work done also had low incomes from which to finance it.

The Local Government and Housing Act 1989 has given local authorities the powers to finance home improvement agency services which give assistance to people who wish to repair or improve their homes. SAUS has evaluated 50 housing agency services projects aimed specifically at giving detailed advice to elderly people on repairing their homes (Ref. 30). SAUS looked in detail at the health and welfare role of these projects and suggested that 'social services departments need to give serious consideration to whether they should be helping to resource local projects'. Staying in their own homes can remain a viable option for frail people following successful assistance from a housing agency services project although with increasing workloads agencies will need to decide whether to target their resources on those in greatest immediate danger of institutionalisation.

To summarise, the numbers of frail elderly people likely to require support from social services will increase in the 1990s, in particular following transfer of income support from 1993. Local authorities will need to be prepared for this growth. There has been an increase in services but this has not kept pace with growing numbers of very elderly people. The beneficiaries of this increased provision have been younger elderly people aged 65 to 75 who are likely to be less frail than those aged over 75. Meanwhile the completions of new specialised dwellings for elderly people have decreased but housing agency service projects are providing valuable help to elderly and disabled people in getting their homes repaired and adapted thus enabling frail people to avoid institutionalisation. Social services should encourage and make use of such projects in their development of community care.

**YOUNGER PHYSICALLY DISABLED PEOPLE**
**POTENTIAL SERVICE USERS, EXPENDITURE AND ACTIVITIES**

This is the Cinderella group amongst the main community care users. In the last 20 years there has been only one national survey of those who might be described as physically disabled and data on facilities, expenditure and needs are very patchy.

The OPCS survey in 1986 identified 6.5 million disabled people of whom 4.2 million were over 60 years of age. Of the remainder just under two million people were in private households. Very few were in communal establishments. Thus disabled people are already 'in the community'. Other estimates have been made of those people with very severe, severe and appreciable disabilities and these numbers are substantial (Table 1).

Overall social services spend on people who are physically disabled has changed little over the last 10 years but the proportions have shifted. Residential care expenditure has declined by 21% whilst spend on day support has increased by 63% to £43 million and £44 million respectively.
The University of York survey of six districts (Ref 43) confirmed the low priority attached to younger disabled people with local authority per capita expenditure of only £3 and that of health authorities only £1 per head.

There are few national sources on the state of service provision for younger people who are physically disabled but Edwards and Warren produced a survey in 1990 (Ref. 28) which found large variations in the pattern of provision – in some cases local authorities in the lead, in others health authorities. This confirmed a previous survey by the Royal College of Physicians (Ref. 27) which also identified misplacement of young people in long term care wards for elderly people and in ‘Part III’ accommodation.

There has been an increase in the 1980s in services which can help disabled people lead a more normal life: occupational therapists (44%) and adaptations to houses (36%). The small decrease in residential provision could be regarded as a welcome change providing alternative living arrangements in people's own homes have been provided. There has been a marked decrease, however, in completions of houses built with special features to accommodate disability reflecting a similar decline for elderly people. Access to housing of a suitable kind is essential if disabled people are to be genuinely independent. A recent survey by Shelter (Ref. 31) found only a small minority of housing departments had a written policy for disabled provision and little evidence of links between housing and social services. A 1988 report from the Living Options project of the King’s Fund (Ref. 44) also concluded 'the response from statutory authorities to the project's initial request for information suggested that housing and support services for severely disabled people are scarce, patchily distributed and a low priority among service providers'.

With this picture, it is hardly surprising that the evidence given by disability groups to the 1990 Social Services Committee of the House of Commons (Ref. 45) reflected a negative view of local authorities: 'we would strenuously oppose any transfer of social security expenditure from central government to local government. Such a transfer would further weaken the position of a disabled person by further strengthening the control a local authority can exercise over his or her life' and 'disabled people will thus be defenceless if left solely dependent on local authorities'.

In short, although younger physically disabled people share with many frail elderly people the requirements for domiciliary support and adapted housing their needs do not receive the same priority, resulting in scarce and sometimes inappropriate services. If community care is to be a reality for physically disabled people other factors must also be taken into account such as access to buildings, public toilets, transport and the suitability of pavements and crossings for disabled people. Whilst these aspects are beyond the remit of social services they can help by providing information to users.

PEOPLE WITH LEARNING DISABILITIES

This is a small, relatively stable user group. Earlier Commission publications put the number of people with learning disability at between 120,000 and 130,000 in England and Wales. Unlike elderly people and more particularly people with mental health problems this user group is readily identifiable after initial diagnosis has taken place. There are particular pinch points, however, which are beginning to make themselves noticeably felt. The most urgent of these, identified by
the Commission's 1988 audits of social services departments' services for this user group are, firstly young adults with very severe disabilities which sometimes include challenging behaviour. These are people who previously might have been admitted to long term hospital care but they and their carers are now more often reliant on frequently inadequate levels of respite care available from social services or the NHS. Secondly, there is an urgent need for services for older people whose carers can no longer offer support at home.

The change in expenditure over the last decade indicates a rise in total resources deployed between local authorities and the NHS although the latter still spends nearly twice as much as local authorities (Exhibit 30).

Exhibit 30
EXPENDITURE ON PEOPLE WITH A LEARNING DISABILITY
The NHS spends almost twice as much as local authorities.

Source: Department of Health

The most significant change in services has been the 38% decrease in NHS beds and a doubling of places in homes and hostels (although the latter does not match the former). (Table 3). Wertheimer (Ref. 46) has shown that although there have been closures of larger NHS units most of their residents (68%) went into some other hospital, or into NHS hostels or community units (17%). Only 7% went into a near home environment.

Somewhere to live is an important factor in developing a normal life both for people leaving NHS institutions and for those already in the community. The Commission reported in 1989 (Ref. 6) that over 60% of local social services authorities surveyed were involved in development with housing associations. That, however, meant that nearly 40% of the survey authorities were not involved with housing associations and the major alternative source of housing, local authorities were not always generous with their allocations.

In summary, community care for people with learning disabilities should mean that each person should receive support to live as normal a life as possible within the community. Hospital provision still dominates, however, and in 1989 the Commission reported (Ref. 6) that only 3% of local authorities had individual programme plans for people with a learning disability for whom they were providing services. Meanwhile, alternative services have not kept pace with the
reduction in hospital beds which means that there is a lack of adequate support in the community, particularly respite and day care for young adults who are severely disabled.

PEOPLE WITH MENTAL HEALTH PROBLEMS
USERS, EXPENDITURE AND ACTIVITY

There are few data available on the total size of this user group. As a recent publication by the Royal College of Psychiatrists puts it: ’... an independent, readily accessible means of estimating the potential psychiatric demand would be useful’ (Ref. 47). In practice demand/need is measured by the caseload which presents itself to hospital based clinicians. Some very large figures are quoted in a recent Mental Health Foundation publication (Ref. 48) which draws on the most recent (1981) morbidity survey of GP practices. On this basis the ‘market’ amounts to some six million people a year. But how many of these are suffering chronic illness requiring long term support and how many are the ‘worried well’ is difficult to say. Although it is clear that the incidence of recorded mental illness increases with age and that the proportion of elderly admissions has been growing.

The vast bulk of expenditure continues to be spent on institutional care within the NHS (Exhibit 31). There are indications however that the form of that provision is altering from larger to smaller units.

Exhibit 31
EXPENDITURE ON MENTAL ILLNESS
The vast bulk of expenditure is on inpatient care.

Source: Department of Health

NHS beds (and occupancy) have declined slightly, and there has been some growth in community based services. But there is no way of telling how decline on the one hand relates to growth on the other. One interpretation of these scanty data is that for this user group, care in the community mainly represents a transformation of NHS provision from long-stay in large units to shorter – stays in smaller (acute) units.

Data assembled by the Department of Health (Ref. 49) show that local units increased bed capacity between 1975 and 1989 by two thirds, from 11,099 to 18,233, while beds in specialist
mental hospitals fell by over half: 86,967 to 40,637. This pattern is country wide. Current plans quoted by the DoH suggest little further decline in bed numbers but that local services will tend to replace the large mental hospital.

From work done by Research and Development in Psychiatry (RDP) there appears to have been a major development of community mental health centres (CMHC) within the NHS (Ref 50), which gathered momentum in the second half of the 1980s and is still continuing.

Meanwhile evidence from Good Practices in Mental Health (GPMH) indicates that the change in type of provision is leading to a shift in user served (Ref. 7). In particular, it would seem that the CMHCs are not looking after people needing continuing care – reflecting American experience of similar centres. The study team preparing this report also found that in some local authorities services were not aimed at people suffering from chronic illness.

Length of stay in hospital has tended to be shorter. Between 1967 and 1987 the percentage of people admitted to hospital who have stayed for under one month has risen from 45% to 63%.

This changing pattern of provision is clearly one which poses difficulties for services as tracking individuals and keeping contact with mobile patients becomes more difficult. The RDP survey suggests such continuing care systems are not in place.

Unsurprisingly, therefore, a number of studies which have traced patients discharged from hospitals have found that follow-up has been poor both from the viewpoint of the ex patient and of the carer. Concern has been growing that an increasing number of people discharged from hospital end up homeless, in prison or in temporary accommodation and without the continuing support they need.

New legislation is designed to improve the situation with the requirement that people leaving hospital or accepted by the specialist psychiatric services for community support must have a care programme and a designated person to ensure this programme is followed. In England the new specific grant is designed to increase the provisions in the community for social care for people with severe mental health problems who have been (or should be) referred to specialist psychiatric services.

As with learning disability, the availability of suitable housing is an important issue, particularly for those people leaving hospital. Health authorities have been involved with housing developments independently of social services. This should change with the requirement to involve social services in care plans and the specific grant.

To summarise, it is difficult to estimate how many people there are with serious, long-term mental health problems but the number of hospital beds is reducing and inpatient stays shortening significantly. Alternative provision is needed in the community and mental health centres are being developed but research indicates that they may not be providing services for those with chronic illnesses requiring continuing care. The new specific grant is designed to increase social care provision but social services in their new lead role will also need to become involved with housing issues previously dealt with independently by health authorities.
**Appendix 2**

Average costs of private and voluntary homes by location, ownership, size and staffing ratios.

### RUNNING COST PER BED PER WEEK

<table>
<thead>
<tr>
<th>Region</th>
<th>Residential</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sample Size</td>
<td>Running Costs &amp; Capital Costs &amp; Profit (£)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>median</td>
</tr>
<tr>
<td>Cumbria</td>
<td>median</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>57</td>
</tr>
<tr>
<td>Leeds</td>
<td>median</td>
<td>141</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>52</td>
</tr>
<tr>
<td>Lancashire</td>
<td>median</td>
<td>141</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>39</td>
</tr>
<tr>
<td>Hereford &amp; Worcester</td>
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<td></td>
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<tr>
<td>Northants</td>
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</tr>
<tr>
<td></td>
<td>mean</td>
<td>44</td>
</tr>
<tr>
<td>Suffolk</td>
<td>median</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>47</td>
</tr>
<tr>
<td>Inner London</td>
<td>median</td>
<td>259</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>28</td>
</tr>
<tr>
<td>Outer London</td>
<td>median</td>
<td>203</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>58</td>
</tr>
<tr>
<td>West Sussex</td>
<td>median</td>
<td>162</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>50</td>
</tr>
<tr>
<td>Somerset</td>
<td>median</td>
<td>252</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>31</td>
</tr>
<tr>
<td>Mid Glamorgan</td>
<td>median</td>
<td>284</td>
</tr>
<tr>
<td></td>
<td>mean</td>
<td>41</td>
</tr>
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</table>

### NATIONAL MEDIAN AND MEAN COSTS BY SECTOR (90% OCCUPANCY) PER BED PER WEEK

<table>
<thead>
<tr>
<th>Sector</th>
<th>Sample Size</th>
<th>Running Costs &amp; Capital Costs &amp; Profit (£)</th>
<th>Staff Costs (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential</td>
<td>Sample Size</td>
<td>Running Costs &amp; Capital Costs &amp; Profit (£)</td>
<td>Staff Costs (£)</td>
</tr>
<tr>
<td>Private</td>
<td>328</td>
<td>155 (158)</td>
<td>56 (59)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>182</td>
<td>256 (316)</td>
<td>134 (162)</td>
</tr>
<tr>
<td>Nursing</td>
<td>Sample Size</td>
<td>Running Costs &amp; Capital Costs &amp; Profit (£)</td>
<td>Staff Costs (£)</td>
</tr>
<tr>
<td>Private</td>
<td>99</td>
<td>260 (272)</td>
<td>126 (130)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>31</td>
<td>468 (505)</td>
<td>252 (284)</td>
</tr>
</tbody>
</table>
## NATIONAL MEDIAN AND MEAN COSTS BY SIZE (90% OCCUPANCY) PER BED PER WEEK

<table>
<thead>
<tr>
<th>Bed Size</th>
<th>Sample Size</th>
<th>Running Costs &amp; Capital Costs &amp; Profit (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10</td>
<td>163</td>
<td>160 (213)</td>
</tr>
<tr>
<td>11-20</td>
<td>303</td>
<td>182 (220)</td>
</tr>
<tr>
<td>21-30</td>
<td>148</td>
<td>229 (244)</td>
</tr>
<tr>
<td>31-40</td>
<td>56</td>
<td>244</td>
</tr>
<tr>
<td>41 - 50</td>
<td>31</td>
<td>237 (258)</td>
</tr>
<tr>
<td>OVER 50</td>
<td>31</td>
<td>297 (349)</td>
</tr>
</tbody>
</table>

## NATIONAL MEDIAN AND MEAN COSTS BY RESIDENT / STAFF RATIO PER BED PER WEEK

<table>
<thead>
<tr>
<th>Resident / Staff Ratio</th>
<th>Sample Size</th>
<th>Running Costs &amp; Capital Costs &amp; Profit (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.8</td>
<td>64</td>
<td>342 (438)</td>
</tr>
<tr>
<td>0.8 - 1.09</td>
<td>102</td>
<td>273 (301)</td>
</tr>
<tr>
<td>1.1-1.29</td>
<td>120</td>
<td>225 (238)</td>
</tr>
<tr>
<td>1.3 - 1.49</td>
<td>104</td>
<td>209 (220)</td>
</tr>
<tr>
<td>1.5 - 1.69</td>
<td>94</td>
<td>182 (210)</td>
</tr>
<tr>
<td>1.7-1.89</td>
<td>65</td>
<td>154 (165)</td>
</tr>
<tr>
<td>1.9-2.19</td>
<td>67</td>
<td>164 (180)</td>
</tr>
<tr>
<td>2.2 - 2.99</td>
<td>60</td>
<td>157 (168)</td>
</tr>
<tr>
<td>OVER 3.0</td>
<td>56</td>
<td>123 (140)</td>
</tr>
</tbody>
</table>
Appendix 3

SOME DATA SOURCES

Exhibit 4

Data have been extracted from Department of Health R03 summary for 1989/90 on local authority expenditure on Personal Social Services as follows.

<table>
<thead>
<tr>
<th>Service</th>
<th>R03 B</th>
<th>Lines</th>
<th>R03 C</th>
<th>Lines</th>
<th>R03 D</th>
<th>Line</th>
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</thead>
<tbody>
<tr>
<td>Residential care</td>
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<td>1, 7, 14</td>
<td></td>
<td>1, 5, 7, 10</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Day care</td>
<td>R03 B</td>
<td>Lines</td>
<td>3, 4, 8</td>
<td></td>
<td>3, 4, 9</td>
<td></td>
</tr>
<tr>
<td>Domiciliary care</td>
<td>R03 B</td>
<td>Lines</td>
<td>2, 5, 6</td>
<td></td>
<td>2, 8</td>
<td></td>
</tr>
</tbody>
</table>

Adaptations to homes and provision of various items of equipment have not been included, nor has expenditure described as 'other services'. Training and administration have been omitted for the purposes of this exhibit as the split over day and domiciliary care is not possible. To be internally consistent this also means omitting training and administration on residential care. Fieldwork has also been excluded.

Exhibits 29, 30, 31

Data have been derived from the programme budgets prepared by the Department of Health for NHS and Local Authority personal social services as published in Public Expenditure on Health Matters, House of Commons Health Committee, Session 1990/91, HC 408. For the NHS, the published tables distinguish expenditure as in- or out-patients on the special needs groups shown in exhibits 29, 30 and 31. In the case of elderly people only geriatric services and non-psychiatric day cases are specifically allocated to that group, although they do make use of acute services as well.

For local authority social services, the financial returns on which the programme budgets are based generally reflect expenditure on different categories of facility rather than user characteristics directly. In social services in particular, that means that some large blocks of expenditure such as social work cannot be identified readily for individual client groups. For expenditure on mental illness and learning disability, the amount spent on residential and day care facilities for each group has been attributed to them and no attempt has been made to allocate other items of expenditure.

In the case of social services expenditure on elderly people, some data are available on the age of users of particular services. For this user group, therefore, allocations of other services have been included – again drawing upon programme budget figures. The result is to allocate most of the expenditure on home helps and meals to elderly people, but only about a quarter of social work expenditure (the bulk of which involves work with children). The figures derived in this
way must be treated with caution since the allocation even on an age basis cannot be precise, but it seems likely that the broad picture which emerges is reasonably correct.
TRANSFER OF RESIDENTIAL HOMES

Whether or not to transfer local authority residential homes to the private or voluntary sector is a complex issue. A number of authorities have devised schemes and questions have been raised about the viability or legality of some of them. The Local Government Information Unit has issued a useful booklet on the subject called 'Transferring homes, opportunity or illusion? A guide to the issues.'

The booklet has been designed as a checklist for decision makers within local authorities. It is not prescriptive but 'acts as a guide through the complex issues and questions that need addressing'. It covers the following:

— Statistical and other information which are needed before considering any options.

— Questions to be answered before the viability of an option can be judged, which are grouped under the following topics:

  — how do the possible options affect the authority's overall strategy for care for elderly and disabled people?

  — have all possible options been considered?

  — how is the authority going to meet its own requirements for residential care in the future?

  — can the authority ensure quality of care following transfer?

  — are the arrangements for staffing satisfactory?

  — what are the assumptions about benefit entitlement?

  — what has been included in the financial projections?

  — What steps are being taken to consult with anyone affected by the proposals?

The Audit Commission has issued guidance to its auditors on the legal issues involved (Technical Release 25/91). Local authorities can obtain a copy of this guidance from their local auditor.
Appendix 5

The following people were members of an advisory group to the study. The Commission wishes to thank them for their help and advice to the project team.

Don Brand  Deputy Chief Inspector, Social Services Inspectorate
Ritchard Brazil  Deputy Director, Kings Fund College
Sally Greengross  Director, Age Concern
Tessa Harding  National Institute of Social Work
Adrianne Jones  Director, Birmingham Social Services
Tessa Jowell MP  Director, Community Care Programme, Joseph Rowntree Foundation
Lucille Lusk  representative, British Council for Organisations for Disabled People
David Peryer  former Director, Humberside Social Services
Jill Pitkeathly  Director, Carers' National Association
Brian Roycroft  Director, Newcastle-upon-Tyne Social Services
John Rea Price  former Director, Islington Social Services (to Dec. 1990)
Norman Warner  former Director, Kent Social Services
Gerald Wistow  Co-ordinator, Community Care Unit, Nuffield Institute for Health
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