ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

INTERIM RESPONSE TO THE GOVERNMENT WHITE PAPER ON COMMUNITY CARE- "CARING FOR PEOPLE: COMMUNITY CARE IN THE NEXT DECADE AND BEYOND"

The Government's White Paper on Community Care* sets out a commitment to "enable people to live as normal a life as possible in their own homes or in a homely environment in the local community"(1.8), with sufficient support and care to achieve their full potential and maximum possible independence through a greater individual say in how they live their lives. The White Paper, however, leaves many questions unanswered: it does not elucidate sufficiently user-centred guidelines for the assessment of individuals' and their carers' needs; and it does not set out procedures for the monitoring and inspection of services in the community that adequately incorporate the clients' perspective. Most importantly, it does not state the extent of resources that will be made available to local authorities to facilitate their new role as lead agencies in the management of community care. Nevertheless, the restatement of commitment by the Government to the principle of care in the community is to be welcomed.

1. Funding Arrangements

1.1 "Caring for People" introduces a new funding structure for care in the community. Local authorities are given the responsibility, in collaboration with medical, nursing and other interests, for "assessing individual need, designing care arrangements and securing their delivery within available resources"(1.12) The Government proposes to transfer resources from the social security budget to local authorities, so that there is a single budget covering care costs for all people receiving residential or domestic care. This transfer is intended to eliminate the anomaly whereby local authorities have a "perverse incentive" to send their clients to private homes, as benefit claimants are entitled to social security benefits to cover board and lodging and care. In future the care element of the social security payments will be transferred to the local authorities.

1.2 Without the necessary resources to implement its policy on community care, the Government's written and spoken commitments will become empty rhetoric. There is considerable lack of detail over how the new system will be financed. There is no guarantee that there will be adequate resources or that they will be directed to the right place. The Government has failed to state exactly how much money will be transferred from the current £1 billion spent by social security on private and voluntary homes.

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* "Caring for People: Community Care in the Next Decade and Beyond" HMSO November 1989 £8.10.
(Numbers in brackets refer to the relevant paragraphs of the White Paper).

Indeed, local authorities will have to wait until next autumn's public expenditure round to find out what funds they will be allocated to support their lead role in the organisation of care. This has aroused doubts over whether the money eventually made available will be sufficient to organise adequate services.

1.3 ACHCEW also regrets that the Government has rejected Sir Roy Griffiths' recommendation to ring fence health authority and social security spending on community care and pay it to local authorities as a specific grant. The Government has decided instead to channel the extra funds through the Revenue Support Grant. ACHCEW supports the view that if the funds are not earmarked for specific key areas of care services there is no guarantee that extra resources will be directed to the areas of most need and that they may be subsumed in general budgets.

1.4 One of two approaches could be taken to ensure that resources are directed appropriately. The Government could either make it a statutory requirement that a defined amount of money was to be found from local authorities' general budgets to be used on community care, or it could allocate a specific grant to each local authority to be spent only on community care. Neither of these seems likely to be adopted.

1.5 One clarification made in the White Paper is that the only specific grant proposed is that for the care of mentally ill people, to be paid to social services via the regional health authority. This is extra Government money, but as yet there is no indication as to the size of the grant and whether it will be recurrent. It appears to be a "pump-priming" measure, because as Roger Freeman has stated, the Government does not want a "perpetual" commitment.

1.6 The White Paper states, "There will be no nationally set limits to the level of fees which may be met by local authorities; it will be for each authority to exercise its own purchasing power to achieve best value for money" (3.7.3). This seems to indicate that cost rather than quality will be the prime motivator for local authorities in arranging the provision of care, particularly when contracting-out care services to the voluntary and private sectors. Indeed, it can be argued that there is now a "perverse incentive" to use private residential homes, as local authorities will receive compensation for the care element, while they will have to meet the full costs for their own homes. This will diminish, not enhance, consumer choice.

1.7 At present, because of limits on the amount payable for residential places, social security fails to meet the full costs of private residential and nursing home care, leaving a shortfall between the subsidy and the actual cost. It is unclear whether the Government will top up the shortfall when it transfers resources to the local authorities or whether it will be left for the local authorities to fill the gap.

2. Quality

2.1 The White Paper states that the introduction of competitive tendering disciplines to the residential and nursing home field, in addition to the area of domiciliary and home care services, will "enhance the ability of social services authorities to obtain best value for public money" (3.7.3). The Government assumes that local authorities' "new found purchasing power " will "ensure high quality care for those people who really need it" (3.7.5). But without any nationally laid down guidelines on, or minimum standards set for, the level and quality of provision, the contracting out of residential care for the elderly to private and voluntary organisations could lead to sub-standard care.

2.2 There is a fear that the profit margins in the provision of domiciliary and home help services will not be as attractive to the independent sector as those in the provision of residential care. This may well lead to corners being cut in the provision of care and the development of a poorer pay structure. Higher staff turnover as a result will not be able to deliver what is required in terms of continuity of care to clients.

2.3 Monitoring of community care services is vital to ensure adequate levels and quality of provision. With regard to the inspection of residential care and nursing homes, the White Paper proposes that local authorities should set up independent inspection units, under the Director of Social Services, charged with inspecting and reporting on both local authority and registerable independent residential care homes. These units are to be "independent of the day to day management of local authority homes" (5.19), but are nevertheless not external and impartial monitoring bodies. The composition of the units should include, for example, former owners or managers in the independent sector or former public sector staff experienced in residential care. There is no indication of direct lay involvement in such units.

2.4 However, the Paper goes on to say that "There will need to be provision for representatives of the private and voluntary sectors, and residents of homes, to have a voice in the organisation, management and operation of registration and inspection units" (5.23) and a consultation document will be produced on this matter.

2.5 There is no strong commitment from the Government for consistent user involvement in the evaluation and monitoring process. For example, referring to the drawing up of contracts for the provision of residential and nursing home care, the White Paper states that specifications in the contract "might usefully require service providers to set up and operate systems for evaluating their own performance" (3.7.4). Self-evaluation by service providers which lacks any input from the users of services is far from being sufficient to ensure quality of provision.

3. User-orientated services?

3.1 The White Paper states, "Assessments should take account of the wishes of the individual and his or her carer, and of the carer's ability to continue to provide care, and where possible should include their active participation" (3.2.6). There is also to be a "case manager" to take responsibility for ensuring that individuals' needs are regularly reviewed, resources are managed effectively and that each service user has a single point of contact. This concern for the needs of the individual client may be offset, however, by the Government's statement that, "Decisions on service provision will have to take account of what is available and affordable" (3.2.12).

3.2 In addition, Government assurances on clients' needs and wishes do not constitute an entitlement on the behalf of patients to such considerations; the concept of entitlement, which lay behind the Disabled Persons Act 1986, is not made explicit.

3.3 The White Paper exhorts local authorities to "offer flexible services which enable individuals and carers to make choices" (3.2.6), and states that "subject to the availability of resources, people should be able to exercise the maximum possible choice" (3.7.8) about the residential or nursing home they enter. But there is no indication that each user and carer will have access to an independent source of information and advice to enable her/him to exercise choice. Moreover, the concept of advocacy, as proposed in Sections 1 and 2 of the Disabled Persons Act 1986, is not mentioned in this context.

3.4 One of the priorities for care of elderly and disabled people is stated as being "ensuring improved access to information about local and national facilities including respite care, and a greater involvement of patients, clients and carers in the development of services" (2.12). Authorities "should also consult with, and take account of the views of, private and voluntary sector services providers and representatives of service users and carers in drawing up their plans" (5.7). As representatives of service users, CHCs should be involved in the planning process. Local authorities will also be required to publish and make public annual plans for community care for annual review, thus achieving a level of accountability.

3.5 "Caring for People" also states, "Where these do not already exist, authorities should establish procedures for receiving comments and complaints from users of services. Procedures should be publicised. This will be an essential safeguard for users and will also act as an important monitoring and management instrument for social services authorities and service providers alike" (3.4.10). These complaints procedures will be a key channel for users' views and CHCs should ensure that they are properly established.

3.6 With regard to services for ethnic minorities, the Government states, "Good community care will take account of the circumstances of minority communities and will be planned in consultation with them" (2.9). Again, mechanisms for how this is to be done are not spelt out.

3.7 The Government rightly recognises the vital role of carers in the provision of community care services and states that "a key role of statutory service providers should be to do all they can to assist and support carers" (2.3). Such help, the White Paper suggests, could take the form of advice and support as well as practical services such as day, domiciliary and respite care. However, there is no indication that there will be an obligation on the part of local authorities to provide such support for carers, neither is there any mention of extra resources to cater for this additional and crucial service. At its 1988 AGM ACHCEW passed a resolution calling on the Government "to ensure that a full range of support services are provided for carers"; this should be made a requirement of local authorities and not a suggestion to them which they may or may not take up.

3.8 The National Council for Voluntary Organisations has produced a useful set of "Criteria for Community Care Services" (attached) and those planning services would do well to consider them.

4. Services for mentally ill people

4.1 The section devoted to services for the mentally ill is limited and demonstrates the need for further work. As already mentioned, the Governmment has proposed a specific grant to social services from 1991/2 for people with a mental illness, although the amount is not yet known. The White Paper fails to guarantee even the current levels of spending on mental health services and this funding could be eroded still further as the NHS is reorganised. The hidden costs, such as support for relatives and carers, have not been addressed and are therefore not included in proposed expenditure levels.

4.2 With regard to health care, the Department of Health will shortly issue guidance to health authorities on care programmes, which, taken in conjunction with the statement of good practice by the Royal College of Psychiatrists, will offer clearer guidance on good practice in the treatment of the mentally ill.

4.3 The Government has explicitly rejected demands to implement Section 7 of the Disabled Persons Act 1986, which would impose statutory obligations on health and social services in respect of those leaving hospital after six months or more as in-patients. This part of the Act, if implemented, would help to ensure that patients would not be discharged from hospital without adequate assessment of their needs in the community and without the necessary arrangements to meet those needs.

4.4 Moreover, ACHCEW regrets that only four clauses of the Disabled Persons Act have so far been implemented. If the Government is to illustrate in practice its commitment to put the needs of clients paramount it is essential that the remaining clauses of the Act are brought into effect.

4.5 The Government recognises criticisms that in the past some patients have been discharged without adequate planning to meet their needs in the community and makes a commitment that, "Ministers will not approve the closure of any mental hospital unless it can be demonstrated that adequate alternatives have been developed" (7.5). This will only benefit patients, however, if more money is injected into services in the community and it remains to be seen whether the specific grant proposed will prove adequate for this purpose.

5. The Role of Community Health Councils

5.1 Community Health Councils are not mentioned in the White Paper, but as already noted there is a lack of proper monitoring of community care services from the patients' perspective. There is clearly a need for a watchdog to take on the role of representing the users of all care in the community services provided and be involved in monitoring the quality of that provision.

5.2 CHCs have, of course, a track record of protecting the interests of people in residential institutions. They have also over the years promoted concerns about the so-called "cinderella" services and the needs of mentally ill people, elderly people, people with learning difficulties etc. and their carers. ACHCEW's Panel of Inquiry recommended that, with an appropriate level of resourcing, CHCs should be given the role of representing the interests of all users of community care services.

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CRITERIA FOR COMMUNITY CARE SERVICES

Any system established to provide community care should ensure that:

1. there is one point of access to community care services for people who may require support.

2. there is a named person responsible for ensuring that the needs of each individual are assessed, and for co-ordinating subsequent services.

3. services are comprehensive enough to cater for all degrees of illness, dependency and disability, and financed at a level to enable all those who require it to be supported in the community.

4. community care services support and enhance existing informal community support networks and improve access to ordinary mainstream services (eg primary health care, public transport, educational facilities).

5. the services available provide a sufficiently wide range of options to enable the needs of people from black and ethnic minorities and from the full range of cultural and social groups to be appropriately met.

6. each user and carer has access to an independent source of information, advice and advocacy to enable him/her to exercise choice.

7. services are designed around the needs, circumstances and choices of each individual, and are not pre-packaged into a fixed set of 'take it or leave it' options.

8. the needs of people who may require support are assessed and periodically reassessed in the light of changing needs.

9. carers' needs are assessed and periodically reassessed independently of those of the person they are supporting and are fully taken into account in deciding what services are required.

10. assessment includes consideration of income, housing, access to employment and occupation, mobility and other inter-related factors, as well as personal and practical support in daily living.

11. there is an appeal system and a right to a second opinion in the assessment process.

12. users and carers are automatically involved and represented at all levels in the planning, running and evaluation of services in order to promote high quality and sensitivity in service provision.