'Making a Reality of Community Care' -

A Response to Sir Roy Griffiths and his Review Team

Produced by the King's Fund College
in consultation with senior managers
from the health service, local authorities
and voluntary organisations

May - July 1987

King's Fund College
2, Palace Court,
London W2 4HS.

"Making a Reality of Communtiy Care" - A Response to Sir Roy Griffiths and his Review Team.

At the invitation of the King's Fund College a group of 34 senior managers from the NHS, Social Services and the voluntary sector met over three days in May and July 1987 to review current organisational frameworks and processes for delivering community care.

Participants examined the current and future roles of contributing agencies in meeting the overall objective of providing comprehensive community services for elderly people and people with a mental handicap,illness, or physical disability.

We have sought to direct our comments on the general issues which relate to community services, taking care to ensure their relevance for all client groups.

This statement summarises the outcome of these deliberations and is offered as evidence to Sir Roy Griffiths and his review team.

The statement is organised in five sections;

- The diagnosis revisited.
- Requirements for informed change.
- Options for change.
- Enhancing quality and promoting learning and development.
- Conclusions.

(1) The diagnosis revisited

Our starting point is the conviction that the community care initiative should not be judged by the rate of run down and closure of existing institutions but rather the strength and continuity that can be established in building up appropriate frameworks of local community services. The ultimate goal of these services will be to sustain people with disabilities in the citizenship roles that they can play.

'Making a Reality of Community Care' points to major weaknesses in progress towards the intention which we have summarised in Figure 1.; managers working in existing services share the Audit Commission's views of current weaknesses and indeed would amplify the critique by pointing both to deficits in some of the replacement services which have been produced in recent years and by continuing failure to address needs arising in the community and represented for example, in reliance on excessive demands on unpaid carers.

We therefore accept the need for significant change in the framework of strategic policies, the funding arrangements and local organisational processes if these major deficiencies are to be corrected. Our focus, here, is on the latter, but it became clear in our discussions that fresh efforts locally need to be stimulated and supported by wider change and coherent national leadership.

Criteria for change.

Prior to considering options for change, pooled ideas to identify criteria against which proposed changes in current systems of service delivery might be assessed, produced the following concerns.

Will proposed changes:

* Enhance the eligibility of service users on an equitable basis (Current concentration on closing institutions as against building up local community services denies opportunities to people already living in the community.)

* Promote equal access

* Ensure services are tailored to the individual needs and wishes of consumers

* Improve the opportunities for user choice and control

* Ensure that services provide support to users based on the explicit objectives of promoting citizenship and partnership with the community

* Define specific responsibility for case management according to agreed individual plans

* Ensure local services are managed at the neighbourhood level (Yet still provide appropriate access to specialised services where these are required)

* Establish organisational arrangements which define clear roles in service provision and accountability arrangements

* Ensure coherent arrangements for programme co-ordination at an agreed (authority) level with control over the programme budget for each client group

* Include specific built in methods for safeguarding quality

* Encourage existing authorities to establish the policies required for effective programme management

(2) Key Requirements for Change

2.1 Generating commitment.

Providing high quality community care for all people with disabilities is an enormous challenge. Much goodwill exists for the broad thrust of the policy objective of running down and closing long stay institutions, replacing them with the appropriate range of local services and ensuring the build up of services for people who already live in the community. At this stage however, the scope of the task is probably too large to be undertaken without a further initiative from government designed to regenerate a national commitment to work towards the goals we are seeking. The pressures of conflicting priorities have ensured that there is an increasingly uneven response from the Health Service and Local Authorities in the move towards community care.

We do not believe that momentum can be created or sustained without a strong governmental lead._

We seek a recomendation that the Government should restate its commitment to community care and indicate firm targets and timescales for the build up of community services for people with disabilities, in addition to the run down and closure of institutions.

It is also recognised that the nature of individual need will vary across the country dependant on different understandings of what is meant by community, in rural or urban situations. Nevertheless while we welcome flexibility and diversity of provision related to local circumstances, there is an increasing tendency to design services based around expediency, purely financial considerations, and the retention of outdated models of provision.

We believe that a national committment to community care must clearly represent the values and principles that should underpin the development of local services. These principles should emphasise the need for services which

* Enhance individuals' presence in the community
* Encourage the development of relationships between disabled and non-disabled people

* Extend the variety and opportunities for choice
* Support the personal development and competence of individuals
* Value the citizenship roles of people with disabilities.

Whatever adjustments or changes that are made to the current system of planning community care services we consider that models do exist for strengthening the investment and energy that is available. The success of the All Wales Mental Handicap Strategy derives from the explicit commitment that was made by the Welsh Office, the willingness of component parts of the Welsh Office to co-ordinate the strategy, the specific planning guidelines that were implemented and the funding that has been made available.

The planning system must have the authority to demand local co-operation and should include a formal approval system for any plans that are produced.

2.2 Resourcing commitment.

In the provision of welfare services it is worthwhile remembering that the resources that are available to the state derive generally from the taxpayer and/or consumer. We are inexperienced in this country in tracing the connection between the rights of consumers as citizens and the provision of welfare services. Given that the funds that are available from various sources to support community care come from one original source - the people - we are concerned to ensure that the debate that takes place about the funding of community care starts from the broadest possible assumptions.

The Audit Commission outlines the approximate overall figure of £6 billion expenditure on community care of which £3 billion comes from the NHS, £2 billion from local authorities and £1 billion from the social security budget. As well as being subjected to the different policies of two government departments and sub-departments, services and resources are made available to users in a bewildering range of ways. The Audit Commission diagnosis that these fragmented spending patterns have not led to a properly co-ordinated or maximised use of funding designed to promote community care, is strongly supported.

We would wish to see the construction centrally, from all available sources, of a single national budget for community care. This would involve the recognised annual earmarking of proposed expenditure from all of the departmental budgets concerned. In order to carry out this activity we feel that central government may need to institute some form of interdepartmental community care policy and expenditure review group. This group would ensure adequate and equitable distribution of funding across the country.

We further consider that such an initiative may require legislation to establish the redistribution of budgets currently held by a variety of of different sources.

It is tempting to think that the growth of expenditure in the board and lodging elements of the social security budget has led to greater freedom of choice for the individual consumer. Again the Audit Commission indicates that this has not been the case and that much of the current board and lodging expenditure (approximately £500 million) is being used to expand the private and voluntary residential sector at the expense of integrated community care.

We would like to see proposals that would protect the current and future levels of national expenditure represented by the board and lodging budget, while at the same time ensuring its future use is secured through nationally and locally approved plans.

We further believe that in return for possibly reducing the notional control individuals have in 'purchasing' services through the use of the board and lodging element of the social security system - such power does not exist in reality - a new system should be instituted which extends the requirements for individual service plans which were developed for children with special needs under the 1981 Education Act and for people leaving hospital under the Disabled Persons (Services, Consultation and Representation) Act 1986. A new approach operating around the negotiation of individual service entitlements between service providers and users would back up the development of locally appropriate comprehensive services base on individual need.

We are also aware that one of the major blocks to comprehensive services is the current confusion over terms and conditions of service for staff working in community care services but employed by the NHS, local authorities or voluntary agencies.

We believe that urgent action is required to ensure that the plans that are being developed by CCETSW and UKCC for the social work and nursing professions take full account of the integrated nature of providing care in the community. There is also a need for a central initiative to sponsor arrangements which will facilitate staff transferring between different agencies while enabling them to retain pension rights and appropriate earned seniority.

2.3 Ensuring commitment.

We are concerned at an interpretation of the Audit Commission's report that the requirement for 'lead' or new agencies necessarily will involve existing agencies as the single managers of services. We do not intend to enter into the debate about which current agency would best provide for particular client groups. Rather, we wish to emphasise our view that the system of community care must ensure plurality of provision, encourage innovation and support creativity.

At local levels we can envisage partnerships developing which make the best and most appropriate use of inter agency professional skills. We believe it is too simplistic to assume that care for one particular client group can be the major responsibility of one authority. The nature of local circumstances and local political priorities is always likely to bias the impact of a national directive of this kind. However we do consider that some structural or organisational change may be worth contemplating.

3. Some Options for Organisational Change.

In making a judgement about whether structural or organisational change is indeed required we hope that it will be possible to retain and in turn sustain the strengths of the current system. The Audit Commission while providing us with a powerful critical diagnosis of the underlying weaknesses of our attempts to introduce community care for people with disabilities, at the same time pointed out examples (albeit isolated) of good services occuring in some areas. We would ask two questions. First if these services have common components which include;

* strong leadership
* calculated risk taking
* wider delegated authority
* services based on individual needs
* involving all relevant organisations
* consumer involvement
* explicit principles

how can these innovations be reproduced elsewhere ? Secondly, If our answer is based around the impact of local circumstances and personalities can we address solutions for areas which may not have so fortunate a combination ?

Our feeling for both questions is that good practice does not flourish unaided. Central government carries with it the responsibility for creating the conditions in which its policies can be implemented and we have outlined some areas where we feel action is required at that level. Additionally however, in promoting local responses which are effective and worthwhile, Government will have to decide the extent to which structural change may be necessary.

We do not believe that we should shy away from potential organisational change and our composite view is that such change, while it should be kept to a minimum, should be faced if the end result will ensure a vast improvement on the quality of community care that is currently being provided.

However we would like to envisage a future which allows for organisational frameworks which are varied to match local circumstances and able to work in flexible and innovative ways. Complementing the requirement for strong central leadership, we would like to see a system which builds from the individual service entitlements which might be established with users at a very local level. In aggregated form these entitlements, defined in contracts between service users and providers, would represent the outputs required to be provided in the service plans which agencies would need to construct. Central government - or its agent - would examine these plans prior to allocating resources and would evaluate the extent to which overall planning guidelines had been met in local circumstances.

Making judgements about the most appropriate organisational framework to activate this system effectively might best decided by the agencies involved. The structure for implementing the local plan need not be a central concern as long as effective checks were built into the system. These checks would require regular central reviews of local progress against objectives, prior to making available further funding.

Given this scenario we would only consider moving from the current organisational structure of community care if results indicate in local areas that progress is not being made. In this way, we assess three options for possibly changing the way community care is organised;

a) extending the joint planning system

b) establishing lead agencies

c) creating new agencies.

Starting from a), we envisage the three options to represent a continuum of change which would be required to respond to local failure to achieve results. In arguing for diversity we are neither promoting organisational change for its own sake nor identifying preferred options but rather indicating that the need and scope for change at local levels would be determined by local characteristics and ability to perform.

3.1 Extending the joint planning system.

In calling for changes in the overall nature of resource allocation and distribution,together with a much more structured requirement for strategic planning, existing methods of joint planning based on goodwill and common concern are still likely to produce weak responses.

As it currently operates, the process of joint planning between the NHS, local authorities and voluntary organisations tends to be led by the individual financial considerations and objectives of the participating agencies. Existing joint plans are often uneasy combinations, reflecting different priorities, of hospital closures and community service improvements. As, currently, most of the 'bridging' or pump priming finance is available from the NHS, planning imbalance is common. (A recent study by NAHA and NCVO - Partnerships for Health, NAHA, 1987 - has shown that only £10m has been made available nationally to voluntary organisations from health authorities for community care.)

The current joint planning system does not contain sufficient incentives or sanctions for true collaboration. Local authority elections and individual performance reviews for NHS managers are inadequate checks on the ability of agencies to make progress through partnership.

If joint planning is to remain the only focus of local response to community needs, we view with great importance the implementation of the Government's review of the operation of JCC's to make compulsory the widespread reporting and monitoring of work which is jointly planned.

3.2 `Lead Agencies'

Our concern about this aspect of the Audit Commission's report is that the suggestion that either the NHS or Social Services should take overall co-ordinating responsibility for mental handicap and mental illness services, does not reflect the diversity of success in providing services for both client groups and by both agencies on a national basis. We again emphasise the need to take local circumstances into account.

There is, furthermore, no guarantee that allocating responsibility for a client group to a particular authority would ensure that competing priorities within that organisation would still not prove to be a problem. We have in mind the possible conflict within a health authority between the resourcing of acute and priority care services; within a local authority the similar conflict that may exist between community care for a particular client group and other identified or pressing needs. Without explicit protection of community care funds, ratecapping or the force of argument for other political priorities, could easily lead to the skewing of patterns of service.

We would also be concerned that lead agency responsibility might work against the interests of plurality of provision. Joint planning is often at best a fragile activity forced on agencies by circumstances rather than choice and we would be concerned that some authorities without responsibility for leading services would prefer to take the opportunity to opt out altogether, perhaps taking with them important and irreplacable skills.

3.3 Establishing new agencies.

The Audit Commission suggested the possibility of setting up new agencies to co-ordinate the management of services for elderly people. We think it worthwhile to examine the implications of this idea in relation to all client groups.

We consider that the establishment of `joint boards', `community care authorities', `statutory consortia' or other such hybrids could in theory blend together the best of existing provision. We would envisage such bodies being set up by legislation and empowered to take responsibility for:

* long term strategic planning.

* budgeting and resource allocation.

* setting policy for individual case management.

* consumer involvement - by setting up accountability fora not unlike the role currently played by CHC's.

* service provision - by entering into contracts with existing agencies to ensure their provision of appropriate local services.

* monitoring and evaluation.

These new agencies might be sited at level similar to local authorities or health authorities with boundaries coterminous with one or the other (or in rare occasions with both). With statutory powers, we would envisage such an agency as properly competent to negotiate and pay for services from existing authorities around particular client group needs thus ensuring the most appropriate balance of local input. We do not envisage these new agencies being accountable to Regional Health Authorities but to possibly group themselves together on a regional basis and report directly to central government. The new authorities might be elected or alternatively contain appropriate representation from existing statutory and voluntary agencies and consumers.

Taking into account the concept of a unitary agency allows us to envisage such an authority negotiating with FPC's, education authorities and other possible contributors to a pattern of comprehensive community care that extends beyond accomodation and support.

Some parts of the country are already beginning to adopt local versions of unitary management and collaborative agencies. These organisations or consortia are developing out of the necessity for co-operation determined by local circumstances. Our view, given the substantial shifts that are required centrally to give impetus to community care, is that the possibility of new unitary collaborative responses is current on the agenda of existing authorities and may be one of the solutions which will make it possible to translate a new national commitment into progress at a local level.

We consider that the establishment of new agencies will be costly and disruptive during organisational change. We have outlined what we consider to be some significant advantages which could be gained if in the local view, retaining a reliance solely on joint planning would not work.

4. Ensuring Quality and Promoting Learning and Development.

In our comments on how to ensure national commitment to a new drive towards effective community care policies we previously emphasised (2.1) the need to establish services which are based on positive values and principles.In addition to national policy changes and any structural alterations that may be contemplated we feel it is important to emphasise the need for a national body to take on a role for licencing and/or certificating service agencies and monitoring the quality of services.

Given our view that there is likely to be diversity and therefore plurality in service provision in the future we feel that current functions such as the implementation of the Registered Homes Act 1984 by local authorities and the advising, guiding and developmental roles of the Health Advisory Service and the National Development Team for Mentally Handicapped People do not adequately cover the need to monitor and ensure the quality of services at a local level.

We envisage a system similar to that which operates in Canadian health care and is to be introduced in Victoria in Australia; access to funding would only be available to accredited bodies, whether statutory , voluntary or private. The need for a national accreditation body can be justified on the basis of pulling together all of the monitoring functions currently held by the agencies discussed above in a more coherent whole. In the related field of housing, the Housing Corporation provides a good example of a monitoring and accreditation body which on a national basis supervises the activities of over 3000 housing associations, large and small.

Monitoring and evaluation will not be sufficient to ensure quality in services. We envisage the need for much more investment in learning and development. Only from enhancing our capacity to profit from experience will we be able to equip people for the significant managerial challenges faced in delivering high quality services. We hope that a stronger central policy lead combined with central service monitoring can be supplemented by central dissemination of good practice.

5. Conclusion.

We have outlined in this statement our conclusion that there cannnot be a further effective drive towards the goals of providing high quality community services without a re-examination of the criteria that would in a general sense inform any changes that are made.

We believe that there is an urgent requirement for a new national commitment to community care which would be demonstrated by a tighter and more comprehensive approach to planning and resourcing community services.

In terms of organisational responses to the challenges of community care we have emphasised our view that structural change for its own sake is not welcomed. We are not sanguine about the current ability of the Health Service, Local Authorities and Voluntary Agencies to deliver the innovative provision that is required on a national scale. However, if local circumstances as they currently pertain, combined with the central lead that we are recommending, can prove sufficient to meet our objectives, then in some or many places, structural change will not be required. Some areas may still not be capable of responding positively to central direction and where this is the case we feel concerned that improving the joint planning system or establishing lead agencies might still not achieve the results we are seeking. In such cases we consider the possibility of new agencies to co-ordinate the development and management of services as a realistic alternative.

Overall however, we believe it is possible to envisage plurality and diversity of local provision, which in turn is built upon local strengths and supported and nurtured by strong central coherence and leadership.

CONTRIBUTORS TO THE RESPONSE

Mr D M Anderson	Unit General Manager (Mental Health) Northumberland HA
Mr T B Bennett	Assistant Director of Social Services Isle of Wight County Council
Mr R L Browning	Unit General Manager East Dorset HA
Mr D P Carter	Assistant Director (Care Services Division) Wandsworth Borough Council
Mr J Clark	Principal Officer/Resource & Management Cornwall County Council
Mr D Durham	Unit General Manager Paddington & North Kensington HA
Ms A Foster	Unit General Manager NW Surrey HA
Mr C P Hanvey	Area Manager & Co-ordinator of Services for Mental Handicapped People Coventry Social Services
Mr C J Heppenstall	Unit General Manager Mid-Downs HA
Miss E A Heyer	Unit General Manager (Mental Health/Mental Handicap Services) Harrow HA
Mrs R Hindley	Assistant Director of Social Services London Borough of Tower Hamlets
Mr J Hobden	Divisional Director North Yorkshire Social Services Dept
Mr L C Howell	Unit General Manager (Mental Health) East Yorkshire HA
Mr C Howgrave-Graham	General Manager (Community & Mental Health Services) Barking Havering & Brentwood HA
Mr A Jackman	Unit General Manager South Birmingham HA

Dr B John	Chairman (Psychiatric Division) Warrington HA
Mr K Johnson	Unit General Manager (Community Care) Burnley Pendle & Rossendale HA
Mr G Lake	Assistant Director (North West Area) Humberside County Council
Mr K E Long	Manager (Mental Illness) Norwich HA
Miss M Mowat	Unit General Manager (Primary Care Services) Hillingdon HA
Dr J E Munro	Unit General Manager Mental Handicap & Community Services) Salford Health Authority
Mr T S Neil	Management Handicap Norwich HA
Ms C O'Brien	Team Co-ordinator (Mental Handicap Unit) Bloomsbury HA
Mr N Orr	General Manager (Service Planning & Operations) Newcastle HA
Miss S Peters	Senior Area Manager MENCAP Homes Foundation
Miss Poupard	Deputy Director (Social Services) Wandsworth Borough Council
Mr J Prosser	Unit General Manager (Community & Priority Services) Tower Hamlets HA
Mrs E Richardson	Unit General Manager (Mental Handicap) NW Surrey HA
Mr M Shannon	Unit General Manager (Mental Illness) Warrington HA
Mr G J Shelton	Director (Mental Handicap) Norwich HA
Mr G Shepherd	Unit General Manager (Community & Continuing Care) Islington HA

Miss B Stephenson	Director (Social Services) London Borough of Redbridge
Mr C Stevens	UGM Mental Handicap Services Unit Solihull HA
Mr D J Taylor	Assistant UGM (Mental Illness/Mental Handicap Unit East Dorset HA
Mr R Taylor	Clinical Services Manager Warrington HA
Mr J Weston	Principal Officer West Sussex Social Services

Co-ordinated by:-

Ritchard Brazil
Fellow (Mental Handicap Strategies)
King's Fund College

Together with

Nan Carle
Director, Services for People
With a Mental Handicap
Lewisham and North Southwark HA

Sharon Collins
Senior Development Worker
Southwark Consortium for People
With Learning Difficulties

Robin Douglas
Fellow in Health and Social
Services Development
King's Fund College

Su Kingsley
Associate Consultant
King's Fund College

David Towell
Fellow in Health
Policy and Development
King's Fund College

Chris Heginbotham
National Director
MIND

David Hunter
Policy Analyst
King's Fund Institute