

# THE FUTURE OF COMMUNITY CARE

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**THE FUTURE OF COMMUNITY CARE**

Adam Smith Institute  
London  
1985

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## THE FUTURE OF COMMUNITY CARE

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Thanks are due to all those who participated in this project. The report contains the edited summaries of the work of several different individuals, and none of its contents should be regarded as the definitive views of any one author.

Thanks go also to Jeanne Hill and Andrew Wallace for their help in the preparation of the final text.

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AN INTERNAL MARKET IN CARE PROVISION?

Dr Andrew Pirie

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It is a background of rising demand caused partly by an increase in the numbers of the elderly and partly by the rise in the elderly as a proportion of the total population. Those currently of retirement age are 16% of the population; but in a very few years, they are expected to amount for about a quarter of the electorate and shortly thereafter about a fifth of the population. Another cause is the reduction in mortality; medical advances have been reducing infant deaths and so raising the average age of the population, but more recent advances have actually started to prolong the life of the elderly, and we expect a further drop in mortality rates of about 25% over the

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## AN INTERNAL MARKET IN CARE PROVISION?

**Dr Madsen Pirie**

I will give some of the demographic background against which our interest in community care and indeed the interest of the government takes place.

It is a background of rising demand caused partly by an increase in the numbers of the elderly and partly by the rise in the elderly as a proportion of the total population. Those currently of retirement age are 16% of the population; but in a very few years, they are expected to account for about a quarter of the electorate and shortly thereafter about a fifth of the population. Another cause is the reduction in mortality; medical advances have been reducing infant deaths and so raising the average age of the population, but more recent advances have actually started to prolong the life of the elderly, and we expect a further drop in mortality rates of about 25% over the course of the next generation. Thus, over the next 25 years: we expect the number of people aged over 85 to increase by 90%. By the middle of the next century we expect those aged over 75 will count for 6.4 million persons in Britain, of whom 1.8 million will be over 85.

The problem for the health and social services budget is that older people cost more to look after. Those who are over 65 are only 15% of the population but they account for 42% of NHS spending; and those aged over 75 cost per head in the NHS 15 times the cost of a person from the 16-64 age group. Those aged over 75 are the group which is growing most rapidly and they are the ones who are going to cost most.

All of this means that we are going to encounter greatly increasing numbers who need help with daily living. Of those aged over 85, already 12% of men are in an institution of some kind and 21% of women. There are currently in Britain 1.5 million people needing some form of care, of whom 1 million come into the category of elderly and 500,000 are handicapped in some way. Already from public funds the cost of £6 million of which half is met through the National Health budget, £2 billion annually by local authorities, and £1 billion in social security payments.

Those who urge the family to look after elderly people as they did in the past are missing three quite important demographic factors. Firstly, families are very much smaller than they used to be. This is partly caused by the rising age of marriage and



the rising age at which people have children; and with that comes the fact that the houses themselves are smaller, and there very often simply isn't room for an elderly parent. Secondly, the distribution of families in Britain is such that distances involved are very much greater and it is quite likely these days that the children will live at the other end of the country. It is easy to look after an elderly parent in the next street, more difficult when it is the other side of the country. Thirdly, as the proportion of elderly people in the population grows, there are obviously fewer carers in the younger age groups to go round.

Against this picture of increasing demand there some good news, and that is of course that the doctors are not simply prolonging dependent and frail life; they are prolonging active life as well. Older people today are more likely to be healthy, fit, and active than their counterparts of a generation ago.

The other good news is that wealth is moving rapidly up the age-range as it did a generation earlier in the United States. Of those reaching retirement age in the next 15-20 years, 70% will own their own home (and we are usually speaking of a home already paid for rather than on a mortgage). Most of those reaching retirement age have an additional income and even more possess some kind of substantial asset. Some businesses have already responded to this increased effective demand -- firms such as Saga which pioneered holidays for the elderly; and the TV scientist Heinz Wolf is engaged with colleagues in developing a range of products specifically aimed at that newly affluent elderly market; while sheltered housing is the fastest sector for housing growth in Britain and sheltered housing has the highest development land value.

The UK, however, is behind the United States in one key factor of this demographics. We have an elderly population with substantial assets, but not yet one with substantial income. So when we come to provision of retirement care, we do not have in this country the incomes commanded by the elderly in the United States and therefore people look to schemes which involve some use of the assets. The situation is changing; of those retiring currently, the majority do have occupational pensions, and in due course we expect to see the development of substantial incomes amongst the elderly.

The upshot is, however, that the elderly are increasingly able to pay and are increasingly ready to pay for their own security in retirement. They see no need to conserve assets for their children as they did a generation ago. In the nature of things someone in their seventies has children probably in their fifties, and those children probably already own their homes and have substantial wealth and do not need an inheritance that would have been a sizeable lump sum in previous times but is less noticeable nowadays.

The implication from all this is that increasingly there will be



a demand for retirement care; increasingly, people will be able to pay for it themselves, or with their families; and the private sector will be able to provide a substantial part of that supply in the future. The emphasis for the state will be on those who need help, but the majority may well be able to pay for care directly.

We expect a variety of new private sector schemes launched, to provide different forms of retirement care. Sometimes the move to a care home will be financed by an annuity from the sale of a house no longer needed; sometimes we will see the universal life plan with a rider, now increasingly common in the United States, to pre-pay death benefits, if retirement care is needed (a typical scheme will pay 2% of the value of the Death Benefit per month for fifty months, giving over four years of retirement care as a substitute for a cash benefit on death). Most of the features of retirement care, home health care, day care, residential care, nursing care, home care are all, in the US, regarded as insurable benefits, and there are schemes provided to cover all of them.

The requirement in Britain would be for a very modest change in the regulations relating to occupational pensions and pension funds to allow them to provide residential care in the package; that is small change and one we can expect within the next two or three years. As demand starts to rise, there will be corresponding need to make it easier for people to provide for themselves, and a very modest change in pension law will suffice. We believe the private sector is well able to meet this challenge.

## DIFFICULT OPTIONS

Michael Forsyth MP  
Scottish Health Minister

Community care is a simple enough concept: the aim is to enable people, particularly those who are elderly, mentally or physically handicapped or mentally ill, to live as full and as independent a life as is possible for them in the community for as long as they wish to do so.

For many people the provision of services such as home help or seats on wheels will enable them to continue living at home. For others, more intensive care is needed. People who spend lengthy periods in hospital might require substantial support to enable them to re-establish their lives away from institutionalized settings.

Such simple concepts, as I certainly discovered during the time that we have **ASSESSMENT, PROVISION AND FUNDING** report, are not easily brought to practical reality and there is no denying there were a number of aspects of community care which were far from satisfactory. Community care is the responsibility of no single agency and many of the difficulties arise from the multiplicity of clients' needs and the way in which services require to be organized and co-ordinated to ensure that they are delivered in an effective and satisfactory fashion.

Elderly people with mental and physical handicaps, or people with mental health problems, require packages of health and non-health services: hospital treatment, medical treatment in the home or with the GP, help with meals, personal and domestic arrangements in the home, social support outside the home and residential care with special housing for those unable to stay at home are all required. These packages of care need to be suited to individual needs and preferences. One of the main areas of recent growth of community care expenditure and a major cause for concern is the support available through Supplementary Benefit - now income support - to help meet fees in independent residential care homes and nursing homes. That made this form of care artificially cheap to both eligible users and individual statutory agencies, and with public finance for other services quite rightly reflecting priorities, a perverse incentive towards residential care financed through post-ended social security benefits was created. And this has led, as Adam Smith himself would have anticipated, to a rapid growth in private-sector provision, dramatic increases in the number of claimants in homes, and an incentive for individuals and authorities to opt



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Such simple concepts, as I certainly discovered during the time that we have been considering the Griffiths Report, are not easily brought to practical reality and there is no denying there were a number of aspects of community care which were far from satisfactory. Community care is the responsibility of no single agency and many of the difficulties arise from the multiplicity of clients' needs and the way in which services require to be organized and co-ordinated to ensure that they are delivered in an effective and satisfactory fashion.

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for independent-sector residential care over domiciliary services irrespective of the precise care needs of the clients and the cost effectiveness of the service. Now I do not want to dwell on the problems of the present system, which have been well documented. Suffice it to say that community care was developing in an unstructured and uncontrolled fashion with the precise needs of individuals not necessarily being fully addressed -- creating very real doubts about the value and cost effectiveness of the expenditure involved.

Now whilst it is easy to criticize the existing system, the options for change certainly required very careful consideration in view of the possible repercussions and ramifications of any change. Ministers have undertaken the searching examination of all available courses. The major objectives for the future are clear enough -- we want to see better services for individuals, taking greater account of their preferences; more clearly defined responsibilities between public agencies with strong lines of accountability for all relevant expenditure; the removal of perverse incentives towards costly and not necessarily appropriate forms of care; acceptable consequences for the future level of public expenditure, and strengthened management of the public resources devoted to community care with scope for central government to influence implementation of national policy as necessary and as appropriate.

In deciding how community care should be organized (or more particularly who should have the primary responsibility for its delivery) we looked beyond the local authority model as suggested by Sir Roy Griffiths. We considered placing responsibility with health authorities, or alternatively with specially created community care authorities; we considered making the Department of Social Security at local level responsible; or giving the lead to Family Practitioner Committees; and finally we looked at the way in which joint boards might be able to respond to the demands of managing community care. Whichever model was chosen the prime duties of the care authority would have to be to identify and assess the need for community care in its area and plan for the arrangement of service delivery accordingly; to arrange to manage the delivery of budgeted packages of care in response to that need making best use of the available resources in a unified care budget and to manage a programme to enhance competition for care services; and to promote efficiency, diversity of suppliers and consumer choice.

We eventually ruled out the creation of a new community care authority. We would have had to have been convinced that there were very sound reasons for creating a new quango and that the task could not be carried out equally as well through existing authorities. We would have been faced with initial setting-up costs and potential transitional difficulties whilst in the period before the new organisation was fully effective. The new authority option and indeed the health option would have involved splitting social services departments, transferring community care responsibilities but leaving child care and family service



responsibilities within local government: but since community care is very much geared to the needs of families this was seen as a strong argument in favour of the local authority option. We looked at the possibility of Health Authorities taking on community care in its entirety: in effect that would have meant adding community care to existing responsibilities for acute services, non-acute hospital services and community health services. That would have involved health authorities increasingly in non-health care, and would have involved disruption both in the health service and in local authorities.

We concluded that, subject to appropriate safeguards, the local authority was the best option for the way forward.

Now the main difficulty with the present system is that people who are unable to support themselves and need help with social care look to two sources of statutory help -- to the social security system for payments towards the costs of places in residential care and to local authorities for help in relation to home care, day care, and residential care. But the system does not allow priority to be given towards supporting people at home where that is possible and desirable. So we are proposing now to introduce a new funding structure for those seeking help from public funds for the cost of care, and we believe that in future there should be a single budget to cover the costs of care whether in a person's own home or in residential or nursing homes.

Local authorities will hold the new budget and take on responsibility for assessment of need and arranging for the provision of care in collaboration with others including doctors and other caring professions. The aim will be to assess individuals' needs and thereafter to design and secure the delivery of suitable care arrangements. There is no question of local authorities providing a full range of services directly themselves. Let me repeat that -- there is no question of local authorities providing a full range of services directly themselves. We have made it quite clear that the maximum possible use should be made of the voluntary and commercial sectors so as to widen individuals' room for choice, to increase flexibility of service and to stimulate innovation.

Some fears, understandably, have been expressed that local authorities will find themselves in a very strong position having as they will a combination of assessment, provision, and regulation powers. However, we have made it very clear in our statements that local authorities should see themselves as enablers, not just as providers and I expect them to make full use of the facilities available from the voluntary and the private sector to ensure a mixed economy of care.

Thus, in community care, as in many other areas, the government are in effect creating the right environment to allow improved services to be delivered in a more cost effective manner and with increased regard to individual choice. In this it is little



different to the encouragement that we are giving to health authorities to improve their services by generating income through imaginative financial strategies. For example, health authorities can at present keep the receipts from selling surplus land and buildings as we move steadily away from large old-style institutions towards smaller units. Recently, new powers have been made available so that a range of income-generating potential in the NHS estate can be exploited, simultaneously benefiting patients by making money available to put back into patient care. As we encourage this, the face of the NHS is changing with hospital shops and hairdressers and banks becoming commonplace, and advertising space being leased; as a result patients are able to enjoy a growing range of extra services. With a bit of imagination we have shown in the NHS how liabilities can be turned into assets. In the Health Service we have been anxious to encourage the use of private-sector capital in the building programme and health authorities have been exploring with developers ways in which this might be achieved.

In Scotland a number of health boards are actively pursuing, with the private sector, the provision and running of purpose-built accommodation for elderly people who do not require the level of care provided in hospitals. We also recognize that selling mental hospital sites provides valuable capital for replacement facilities; but these facilities are needed before hospitals can be vacated, and in turn have to compete for resources with other priorities within capital programmes, which can hold up the whole process. One possibility is for health authorities to enter into agreements with developers to provide community facilities for the mentally ill in return for which they will receive all or part of a vacated site, and this is something that we certainly will wish to pursue further with authorities as a matter of urgency.

The same theme of increased choice and cost-effectiveness runs through our educational policies and in the ideas of self-governing schools and of extending opportunities for parents. I mention that because sometimes our policies are seen as being distinctive in particular areas, but they are linked by a common theme. In education we would like to see all parents, regardless of their circumstances, in a position to exercise some judgement and discretion about the schools their children attend. That is why we have introduced a open placement regime, which has been particularly successful and has stimulated parents to consider carefully the advantages and merits of individual schools. Indeed some schools by virtue of their high academic standards and emphasis on encouraging motivation have been very successful in attracting large numbers of parents and pupils. And so our interest in providing the opportunity of self governing status follows from that.

Now I do not know whether few or many schools will opt out of education authority control, what I do care about is that that option should be available and if the result is to stimulate local authorities to improve the attractiveness and



responsiveness of their own service to the point that nobody does opt out then the exercise would have justified itself on that alone. I do not suspect that that will be the conclusion.

So in health and education, as in other public services, the government are committed to widening personal choice and increasing effectiveness. These same overall objectives underlie the changes we've announced in the arrangements for community care.

The government's policy on community care has three important elements. First, is the clarification of responsibilities. We believe that clearly identifying the role of local authorities coupled with an appropriate transfer of resources will provide them with the incentive to develop better services for people at home and to make greater use of independent providers. Second is the importance of having regard to individual choice. We believe that the majority of people want to stay in their own homes and communities as long as they can, they want care arrangements which so far as possible take account of their preferences. The new proposals stress the importance of individual packages of care. And thirdly is the need to use resources effectively. The numbers of elderly people who need community care is growing; local authorities must use resources wisely and in particular must look to the voluntary and private sector as a means of doing this. We need a mixed economy of care with a stimulus to improving standards which that provides.

Our new arrangements for community care offer the basis for further progress to extending personal choice and effective provision of services.

#### QUESTIONS AND DISCUSSION

**Dr Colin Barron:** A key part of the government's proposal is that funding for clients and private residential and nursing homes is going to be handed over from the DSS to the local authorities. Does the minister not think there's a bit of a danger here? Many local authorities in Britain have quite openly stated that they would like to see the private sector suppressed. There is the danger that they might abuse this paymaster role by delaying payments, refusing to make payments or cutting the actual amount of payments down. It is a bit like having Ron Todd as the paymaster for the Conservative Party.

**Michael Forsyth:** Yes, there is an anxiety. But it is difficult to see that we could have reached any other conclusions given the necessity to ensure that the body making an assessment in terms of the delivery of care needs should also be responsible for the funding.

I think its essential to see the idea of local authorities as enablers, rather than providers, being reflected in the



incentives and the way in which funds are provided. It is also important that there should be some kind of procedure which enables decisions to be challenged if people feel that they have been unfairly treated. These are matters on which I am sure your organization will be putting forward a number of propositions to the government and I think we are very open to your suggestions.

But it should be in the interests of local authorities, because of the way the funding will be structured, to actually use the private sector just as it is in the interests of the patients and the people in receipt of care to ensure that the local authority are able to ensure the highest possible standards. The way forward is to involve the private sector and we will need to look very carefully at ensuring that any political initiatives work to produce the mixed economy of care I referred to.

**Peter Westland** (Association of Metropolitan Authorities): I wonder if the minister would agree that one of the problems is to ensure that the government actually transfers enough money to local authorities for us to support the level of care which both he and we want. At the moment the level of social security funding is not adequate to meet the costs being incurred.

**Michael Forsyth:** The local authorities know that there are people being placed in residential care who could be more effectively looked after at home and who would wish to be looked after at home, and who could be looked after at home for considerably less cost in some cases. We need to introduce mechanisms to ensure that the money which is available is spent wisely. On the one hand there is a lobby that says local government should be free to determine its priorities, then on the other hand there are very strong lobbies for specific grants -- which pre-empt the use of resources by local authorities. You can't have it both ways. The budget should take account of the demands facing the local authorities but it is for the local authorities to establish their own priorities. If local authorities face an incentive structure which makes them more concerned about getting value for money then they will be a lot more concerned to use the voluntary and private sector than they have been in the past. The days when local authorities have been able, through virtue of a monopoly, to argue that the service is bad because they haven't got enough resources are coming to an end.

I believe that the resources which will be provided through the revenue support grant will be adequate and I believe that the competition which will come through the private sector and the voluntary sector will enable a high quality of service to be delivered from the available resources.

It will be for the local authorities themselves to decide what is an appropriate level of community charge and to make the case to government for a particular level of revenue grant. There will be accountability in the system and it will be up to the local authorities to make the resources available if they sense a local demand for additional services. That discretion is what I thought



the local authorities had been arguing for and we have been happy to oblige.

**Keith Hawes:** I'm most concerned that you're putting all your eggs in the local authority basket. We've got over a hundred local authorities with a hundred different rules and regulations. Now unless we have some form of very strict guidelines that the local authority has to work to, unless we have some form of control over how the local authorities are going to be regulating the sector, then this country is going to be in a total mess.

**Michael Forsyth:** That's a very fair point and one which I hope you will make as part of your representations. We are determined to ensure that the local authorities' role reflects that of an enabler and clearly it is important that a regulatory regime does not act as a barrier to achieving our policy objectives. I will certainly see that this is considered in the period prior to the publication of the White Paper.

**Dr Black:** I'd like to ask the minister whether the government see any continuing role for long-stay or continuing care wards in NHS hospitals.

**Michael Forsyth:** Yes, we do see a role for long stay wards in NHS hospitals. In Scotland we have the absurd position of geriatric treatment being provided in acute wards and blocking acute beds, with elderly people being moved sometimes in the middle of the night because an acute case has come in, and where the costs of provision are very high indeed. A number of health boards have been able to get the private sector to offer to construct purpose-built units which will provide a very much better standard of care and where the capital costs will be zero to the health board and the revenue costs will be considerably less than would occur by continuing to provide treatment in an unsuitable way.

It is suggested that in England, the programme of decanting patients into the community has operated too rapidly and that there has not been sufficient support in the community in some cases. The government accepts that it is essential that, before patients are released into the community there should be proper and effective services to support them. There remain some patients for whom care in the community will not be a proper option and it's important that the support and services which are provided for those patients is at as high a standard as possible.

**Frederick Patterson:** I'd like to ask the minister if he would explain the similarity between the changes that are about to be made in the private care sector and what they are doing to the NHS.

**Michael Forsyth:** The NHS White Paper is about encouraging choice and competition in the provision of health care services. The mechanisms to achieve that are: giving the people who are taking the decisions about the care to be provided -- the general



practitioners -- the opportunity to have their own budget so the money follows the patient; and allowing hospitals to become self-governing so that they are able to manage their own affairs and to structure their services in a way which meets patients' needs.

The community care proposals in response to the Griffiths' Report are following a similar pattern insofar as they are about enabling local authorities to become the budget holders and are responsible for assessing the needs of the patient. Again, the money follows the patient to the provision which is determined for them. That will include provision in voluntary, private-sector, and indeed the local authorities' own homes.

I would like to think that the local authorities will see the advantage for them of pursuing a role as enablers and encouraging their own residential care provision to operate at an arm's length if not even on an independent basis. That would seem to me to be entirely consistent with carrying out an effective role as enablers and an effective role ensuring the best deal for the patient.

So there are very close parallels there, how close the white paper on community care will be to the white paper on the NHS will I suppose depend very much on some of the representations which are made in the intervening period.

As the case finds an increase in need is developing, there is a decrease in the number of carers. The number of women aged 40-49, who form the bulk of the involuntary carers, is declining, but the percentage of those working is increasing, so the numbers available to care at home, voluntarily, is falling fast. And there will be fewer skilled staff -- worth in the age group of 15-25 who form the new entry into the caring professions -- those numbers are also falling, and they have other new careers available to them today.

There will probably be another 200,000 places required in residential and nursing care homes by the end of the century. The belief is many quarters, and expressed by the minister, was that most of these are capable of being treated at home. But the survey by Bradshaw said that only about 15% of these could be treated at home. Another survey suggests that the numbers could be 15% provided that there was adequate community support. But there is not adequate community support and there could not be because the need is vastly increasing, because the skilled staff to provide that support is diminishing, and because the cost is very high if the patient has more than a limited degree of dependency. If patients have any high level of dependency at all, and require skilled staff, it is much more efficient to have the staff centrally, and bring the patients to the staff rather than decentralising the staff amongst people in their own homes. That may mean the provision of transport arrangements or it may mean an increase in the number of residential and nursing homes, probably both. In fact it is the finding of very many people that, rather than having too many people in residential



## USING THE INDEPENDENT SECTOR

**Anthony J Byrne**  
Chief Executive, IHA

I want to show the numbers who are at risk. Of those over sixty-five, there are three million who will be living alone. A portion of them will require some form of care and assistance which is not available to them from relatives living nearby. There are those with mobility disorders who are unable to get in and out of bed will therefore require additional care in dressing, in feeding, and looking after themselves. And there are the very large and very difficult groups of patients who will be suffering from dementia. As many as 20% of those aged over 75 require quite extensive care.

At the same time as an increase in need is developing, there is a decrease in the number of carers. The number of women aged 40-49, who form the bulk of the involuntary carers, is declining, but the percentage of those working is increasing, so the numbers available to care at home, voluntarily, is falling fast. And there will be fewer skilled staff -- women in the age group of 15-25 who form the new entry into the caring professions -- those numbers are also falling, and they have other new careers available to them today.

There will probably be another 100,000 places required in residential and nursing care homes by the end of the century. The belief in many quarters, and expressed by the minister, was that most of these are capable of being treated at home. But the survey by Bradshaw said that only about 7% of those could be treated at home. Another survey suggests that the numbers could be 14% provided that there was adequate community support. But there is not adequate community support and there could not be because the need is vastly increasing, because the skilled staff to provide that support is diminishing, and because the cost is very high if the patient has more than a limited degree of dependency. If patients have any high level of dependency at all, and require skilled staff, it is much more efficient to have the staff centrally, and bring the patients to the staff rather than circulating the staff around among people in their own homes. That may mean the provision of transport arrangements or it may mean an increase in the number of residential and nursing homes, probably both. In fact it is the feeling of very many people that, rather than having too many people in residential



care homes, there are in fact rather more people who are imprisoned and neglected in their own homes because of inadequate community services support.

### **Finding the places**

Where are those extra places going to come from? Over the last five years the growth in the number of places has come from the independent sector rather than public sector provision. And those 100,000 extra places over the next ten years will also be provided by the independent sector. In fact we need five 40-bedded homes opened per week over the next ten years in order to cope with the numbers who will need care. And that will cost between £2 - 3 billion.

At the moment, as far as we can tell there are very few people who are building homes which will charge a fee that can be met from income support. That is because there is no confidence either that the level of money available is sufficient or that the arrangements for the money are adequate, so there is no confidence in the independent sector to build homes for people on income support.

Will the changes envisaged by the Secretary of State in his statement increase that confidence? Probably not, because he has not adopted all of the Griffiths Report. He has in fact adopted only half of it. What he has missed out is that part of it which was described by Griffiths himself as radical. That is, not just giving the local authorities responsibility but making them accountable for the way in which they spend their money and the way in which they achieve objectives.

### **A care minister**

The way Griffiths suggested this should be handled was by the appointment of a Minister for Community Care with sole responsibility for community care, not mixed in with other responsibilities. The minister would have the task of reviewing the local authority plans and of releasing the money only if he was satisfied that those plans met the objectives and priorities of the government, that they had been drawn up in consultation with all the interested parties, and that they satisfactorily involved the development of the independent sector in the provision of care. This arrangement is not in the ministerial statement; it must appear in the White Paper.

The other important reason for having a Minister for Community Care is to get money out of the Treasury during the public expenditure planning process, to ensure that community care is properly addressed. We know that if the same minister is responsible for the acute care services, community care will always lose out. But the community care budget cannot remain a fixed percentage of GDP because of the rise in needs.

In the government's proposals, however, there are two budgets --



the residential allowance and the care allowance. The residential allowance will be the property of the Secretary of State for Social Services, the care allowance will come from the Department of Health. Now we have enough trouble when we go to one minister to persuade him that the levels of income support are not enough. You can imagine what would happen in the future. This is a recipe for buck-passing between two ministers and the local authorities.

### **Enablers or providers ?**

The proposals say that local authorities should act as enablers and make maximum use of the independent and voluntary sectors in order to widen choice. I'm afraid we do not have a great deal of confidence that their training or their ethos enables them to work in that way, or that they will want to work in that way. To encourage them to behave as enablers rather than providers, we must persuade them to divest themselves of all the elements of care provision so they have no option but to act as enablers rather than providers. Let's have self-governing residential homes. Let's take it one step further and require local authorities to sell their residential homes so that they must act as designers and organizers of care and are not tempted at all to act as providers.

Within the Griffiths proposals there was a creature called the Community Care Manager. Such managers would have very specific responsibilities for a caseload in their own area and a budget to enable them to meet those needs. It is very important that they should not be a generic social worker with other responsibilities apart from the care of the elderly or the physically and mentally disabled; because once again, community care could lose out to the other acute needs that they would face, such as child abuse. It is important then that they should have a specific responsibility to meet the care needs of their particular community.

And they must allow choice. Again the minister emphasized the need for choice: we are less confident that such case workers are by nature inclined to promote choice, but that is what they must do. We do not want them to force clients into the sources of care that are cheapest, rather than best for the individual. That I think would be very much the temptation for the community care workers.

Another factor is that of the appropriate place for people to be, whether it is in their own home, or residential care, or nursing care, and whether the people who are organizing that care and are of the right mind to allow choice. What we are asking is whether the Community Care Manager actually needs to be a social worker at all; whether it could not be a person with a different kind of background but with a knowledge of care. People selected for those posts must have the right sort of training and attitudes which will enable them to offer choice, to act as enablers rather than feel they must, on each and every



occasion, act as a provider.

### Getting the budget right

Now we know the local authorities will invite tenders from the homes for their publicly supported clients. Certainly they will find that there are some homes (largely charitable) that can offer very low fees because their capital provision has been met from donations and because they rely on voluntary support staff or because the staff have taken a religious vow of poverty and are not drawing wages. And, of course, they will be able to take advantage of those where they can. They will also find that there are some owner-managers of homes who again have paid off their capital debt, who are willing to work 24 hours a day to provide the cover, who are paying their support staff very small amounts, and who are building up each year a larger and larger overdraft which they hope to pay off when they eventually sell the business. But the need is to develop new places and, therefore, it is reasonable to assume that a very large proportion of the budget must go to homes at a true market price, otherwise there will be no incentive for people to provide those new places which we do require over the next ten years.

The amount of money that is going to have to be paid both in residential care allowance and in the care costs must meet some of the following requirements.

First of all, there will be geographical variations throughout the country, and there are some parts of the country where it is very much more costly to provide a care home. They must allow, therefore, for the investment of the capital, the repayment of the capital and indeed a return on the capital invested to the owner to reflect the risks that have been taken. (Ministers have said that there has been an unplanned development of residential care homes: that's far from the truth. When you're investing all of your savings, when you're taking a large loan from the bank, when the risk of failure of planning is personal bankruptcy, you plan very carefully indeed to make sure that you are meeting a local need).

And the care costs must take into account the fact that the residential care home or the nursing care home will have additional costs over the person remaining in their own home: the cost of fire precautions, the arrangements for the kitchens and for the storage of food (cooked and uncooked), the provision for the sanitary arrangements within the homes -- all of these add extra costs for a residential care home or a nursing home which are not borne by people in their own home. And, in fact, if they had to, it would cost a great deal more to keep people in their own homes.

And they have to make allowance too for the quality of care because the quality of care costs money. For example, birthday parties, Christmas parties, the availability of papers and books,



games, and other items may appear to be non-essential, but are very important in the quality of life for the people in those homes. By the time people come into residential and nursing home care it is very difficult to add a great many more years to their lives, but the independent sector homes will certainly wish to provide good standards of care with the hope that can add a great deal more quality to the remainder of their lives.

#### QUESTIONS AND DISCUSSION

**Peter Westland** (Association of Metropolitan Authorities): I totally agree that the government has missed out on the business of ensuring that adequate money is available and is spent on the right things and that somebody has to be held accountable. I totally agree too that splitting funding between income support, housing benefit, and local authority topping up is likely to be a disaster. Can you imagine getting three different cheques every week? You can't get one at the moment. What's your plan?

**Anthony Byrne:** If we are to have Griffiths at all then we would prefer to have the whole of it rather than half of it. In particular I think a minister who has the task of fighting for money and can be clearly seen as responsible for the success (or otherwise) of community care is a very important feature we would like to see.

The big question then is: 'Is the total amount of money adequate?' Do the government recognize that in this case they are not looking at a budget which will decline as a percentage of GDP but one which must increase?

So we are looking for a single minister that we can hold accountable for the success of community care policies (and he would need to identify what those are); and we are looking for him to apply accountability to the local authorities for the money which they receive to insure that the plans they draw up do meet the government's objectives and their stated intentions of stimulating and encouraging the private sector; and we are looking for the right sort of person to be a community care manager; specializing in meeting and organizing to meet the needs of his local population.

**G. Elliot** (Lodge Care): Tony, you spoke of the independent sector having a lack of confidence in providing new care home facilities. I think the point should be made that at the present time there are no longer any economic incentives to provide these facilities. Land costs alone are enormous and there will be no new types of care homes provided for state sector patients.

**Anthony Byrne:** Yes, I did not make clear the reasons for the lack of confidence, and there are two: one is the totally inadequate amounts of money that are available to meet all of those costs



and I described how funds must be available to meet the capital outlays and the geographical variations. If the independent sector is to look once again at developing care homes for those in need of public support, that sort of funding must be available. The other item is the need for incentives on the local authorities to stimulate and encourage the private sector.

**David Stone** (British Federation of Care Home Proprietors): We are living in a season now when there are more strikes and people suffering inconvenience. Bearing that in mind, can you foresee a situation when we will withdraw our facilities available to those who need it because the government will not provide the money for them?

**Anthony Byrne:** The answer that I can give you is that even if you should, you won't. And that, perhaps, is part of the reason why the government hasn't realized what the extent of the problem is yet -- because so many of you are subsidizing the patients who are in receipt of income support. You are building up your overdrafts, or the other residents of the home are paying higher fees to subsidize them, and that is unjust.

The patient about to be admitted to hospital is about as prepared for the event as the Happy Families player, carrying up for a poker game. The very fact that he is going into hospital confirms that he is ill. He is entering alien territory about which he can make no predictions. The patient often has no real idea why he is being admitted, and he probably thinks the worst.

He is subsequently subjected to the admission routine which means that he is documented in a usually impersonal manner. He is allocated a bed which often has the minimum of privacy. His clothing is removed. He dons the hospital uniform of pyjamas and he often has to take a bath regardless of his state of cleanliness. The ward life unfolds to him: he hears grim tales from the old lads; has the 'deathbeds' pointed out to him; hears about the staff status; has meals at certain times; goes to bed at certain times; is awoken at certain times; is allowed visitors at certain times. And then an entourage of learned persons, wearing white coats, knowing looks and speaking a language unfamiliar to the laity, appears around his bed. The ritual, the glimpses of technology, and the language conspire with his previous expectations and he becomes overawed. His only resource is to become passive, child-like, and helpless, and to give himself totally into the care of the expert. This response is reinforced by the staff and if he does not conform to this role he has sanctions operated against him. So powerful is this process that he will often comply with treatment without objection and consents to various procedures in an unforced



## THE FUTURE OF LOCAL-AUTHORITY FUNCTIONS

**Dr Patrick Carr**

General Secretary, RNHA

I am going to take the opportunity to read a word or two from a book which points out, far better than I could and quite starkly, what the differences are between hospital care and community care. These passages will put my further remarks in context. "... the present hospital system was established in the mid twentieth century but had its roots in history. It was largely responsible for producing a breed of people that spoke in a language unintelligible to the laity, using processes that provoked fear, and convinced people that scientific intervention was the only answer to illness.

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manner."

Community care, contrasts sharply with that system. What characterizes community care, according to these writers, is the following:

"Remove a patient from the hospital and he becomes a client. Initially, by offering him treatment in his own home or within his own community, there is the implication that he is not severely ill".

In the UK the family practitioner evolved from the apothecary and he, of course, has been the key person around whom community care has developed. The client does not need to undergo the rites de passage to a new status -- he does not need to take on the patient role. He may indeed be sick, but that either has not been confirmed or denied. Being on his own ground, he can make his own choices and the professional is the intruder.

So community care is quite rightly contrasted with hospital care and those are the associated norms and values and roles which are associated with it.

The recent flight from hospital-based to community-based forms of care raises a number of issues, however. The first is the commitment to caring for the person in their own home. The government, and people in general, somehow tend to think that this is cheaper although there is no definite research to support that contention (in fact what research there has been has tended to go in a different direction). But the underlying philosophy is that the patient should be cared for in his or her own home. And I believe we all subscribe to that notion; we want patients to be maintained in their own home, having full independence, as long as possible. And I feel that we should all work together to support that particular philosophy as best we can.

The next important concept is that of informal carers. People will continue to be looked after by relatives, by friends, by neighbours; and this network of informal carers is something that props up the community care system and is something, of course, which is said to be in a state of crisis. So here we have a situation where yet greater emphasis is going to be placed on the network of informal carers; though according to the experts in these areas, this is going to put even greater stress on people who are under great stress already.

I think we have to recognize at this point the position of the formal carers, is also one of great crisis. We are fast running out of qualified nurses and in three or four years time we will be in absolute crisis. The delivery of health care by formal carers to anybody (whether its in the hospital system, the community, in nursing or residential care) is going to be fraught with great difficulties and it probably presages the end of the present system.



The next point is the question of multi-disciplinary assessment. One of the things that give rise to the passivity of the patient in the hospital sector and to the developing of a very highly structured professional system was the notion of "We know best: you are here to be examined, diagnosed, assessed, and treated". And the spectre which this raises in relation to community care, is the superimposition of those same attitudes into the community care sector. This is something which I feel we must guard against at all times.

If we are going to have a multi-disciplinary assessment system, which I totally support, then we are going to be visiting onto non-patients in their own homes a new bureaucratic system in which all sorts of people are going to be having a look at these people, assessing their needs, advising them where they should go, and so on. And we do run the risk of transferring into the community this ideology which has pervaded the hospital system and which has reduced people to the state of being 'patients'. So this is something which I feel, despite my support for multi-disciplinary assessment and proper placement, that we will have to guard against.

The next point that Griffiths and the government make a lot of is the need to improve co-operation between health authorities and social service departments. Its quite clear from a recent statement that the health authorities are going to maintain certain statutory functions both in relation to community care in general and also, of course, in relation to the independent sector. And it is going to be imperative for the proper working of any system that health authorities and social service departments work well together.

Now we know from past experience that that has not been the case. In fact, not to put too fine a point on it, usually the obverse is the case. In many areas they don't even talk to each other. So I see that as a structural difficulty. But I also see the independent sector being an honest broker in trying to bring the two sides together. The paper talks about the need for the widest possible consultation with the independent sector and I feel there's a real role here for the independent sector to initiate and to generate dialogue and co-operation between the two statutory sectors with which they are going to be involved: the health sector and social services.

I hope that this a challenge which the independent sector can take up. We will probably have to be pro-active in it, but we shall certainly set about the task with some relish.

Now another point which has to be made is this: there is no disguising the fact that my association and many others were totally opposed to Griffiths -- I would be less than honest unless I said that. We were totally opposed because we did not feel that social service departments of local authorities were the right place to organize community care. Nor did we feel that the people involved there were competent in order to pronounce



upon the assessment or inspection of the whole community care sector. But the die has been cast and we are going to be working hard now to make the new system operate. Nevertheless, we shall not let those causes which we espouse pass by default in the debate which has to ensue.

For example, great play has been made about social service departments being enablers rather than providers. That obviously is one of the hooks on which we shall wish to hang our hats in talking to social service departments and encouraging them to develop what to them will be a new role of being enablers -- people who can make things happen rather than being providers of services themselves.

Now much has been written about inspection. Ninety per cent of my job at the RNHA is taken up with talking to health authorities about standards: but that is because they all have differing standards on everything, whether its the size of bathrooms, the dilution of orange juice or even more esoteric phenomena than that. They all want to do it differently. In England alone there are 191 different authorities, and over the UK there are 230 of them. It takes an inordinate amount of time talking to them, trying to get them to come down to some national norms in relation to staffing, size of rooms, and so on.

But what troubles me most is that they set these guidelines from a background where nobody runs the ruler over them. In other words, there they are, telling us what to do, when everything in their own cupboard may not be too wholesome. The Secretary of State has missed the opportunity here to talk about inspection in the whole care sector, not just the independent sector, not just the voluntary sector. We want the whole care sector monitored.

Crown immunity persisted until hospitals and local authority homes started having salmonella outbreaks and until people noticed their unacceptable standards in relation to fire precautions. Then, crown immunity began to be eroded. But it still exists in relation to checking the quality of the service which they provide. I think its quite obscene that local authorities should be telling the independent sector and the voluntary sector what to do when, in fact, nobody is pointing out to them what they should be doing. If we are to have quality control for patients, for residents, for clients, let's have it for everybody.

So those are some of the issues which I see arising from the Secretary of State's statement. The die is cast: we must accept it, we do accept it. We've got to go forward with a positive attitude. You know the notions we espouse: multi-disciplinary assessment, national inspectorate, protection of individual rights and needs. We must take all of those issues into the debate and fight for them as hard as we possibly can. And we must be pro-active in stimulating the debate between social services and health authorities and I see a real role for us as honest brokers.



So that's it from the structural point of view. From the caring point of view, there are three philosophical notions which I believe should colour any consideration of the future of community care. First, those who work with people in the community should try to be generalist rather than specialist. In our approach to the care of the person in the community, whether that be at the residential end of the spectrum or at the non-residential end, we should attempt to be generalist and not look at things in terms of specialisms.

A second philosophical consideration is that we should attempt to be pluralist, in other words we ought to be aware of the range of settings which exist in the community and also the range of disabilities which people have, and we should try in assessing patients to marry those up. The best thing about proper assessment is that it will enable the person in need to have that need met in the best circumstances. That is pluralism working at its best.

The third thing, and perhaps the most important philosophical notion that we should carry into the debate, is that whatever we do must be person-centred. We must look at the care of the person in the community -- at their needs, not at our needs, not at the doctors' needs or the nurses' needs or the bureaucracy's needs. We ought to be considering what the person's needs are and looking to satisfy them.

And I believe if we do all that we shall have the best possible outcome for the people who matter most --the people we serve.

#### QUESTIONS AND DISCUSSION

**Anthony Byrne:** In the statement by the Secretary of State he suggested that the local authorities should set up a regulatory unit which would inspect their own homes and that should be set up at arm's length from the management of those homes. Is this an opportunity, do you think, for us to get together with the Association of Metropolitan Authorities or with the Association of Social Services Directors to see if we can find a national system of accreditation for nursing and for residential care homes which would be independent and at arm's length from both of us?

**Stephen Campbell (Association of County Councils):** There will be many on the local authority side who will welcome future co-operation with the RNHA and perhaps many other bodies as well. Perhaps we should all look for some sort of a plain guide for consumers in the future -- maybe a star system like the hotels run, in which we could all indicate what are the basic features that are or are not present so that people can make their own choice with the money and resources that they have available.



Dr Carr: The best way forward on this is not completely clear, but we will work on it in a very positive way; and I do believe that we have got an honest broking role with councils. We will be the first to sit down with everybody concerned and try and tease out the very fundamental issues which have to be settled in the years ahead.

I was very glad that Ken Clarke put in the phrase "at arm's length" about the inspectorate. I think that's absolutely crucial and that is a measure of acceptance of the need to have an independent inspectorate. It doesn't go far enough but perhaps we can take it further. And I believe that we have a role jointly to get into dialogue with directors of social services on what we can do in relation to this whole area. At the end of the day, I am sure we can come up with such a proposal and I would welcome it and we should be more than willing to engage in an enterprise like that.

One of some of the pre-conditions for his care jobs to work. It is only now we are beginning to engage the issues of detail. For that reason I think that we have to look back at the context in order to see what some of those issues are.

Secondly, it is difficult to separate out issues of funding from broader issues in the development of this area. We must look at the background against which we must view specific funding issues rather than coming up with simplistic proposals put together without looking at circumstances and trends. I shall therefore start by considering some principles, trends and their implications.

#### CIRCUMSTANCES AND TRENDS

##### Diverse need, variety in potential sources of help

First, our long-term care system looks at odds with its function in meeting diverse needs. When we look at clients in their own homes in any of the major long-term care groups, one is struck not by the similarity of individuals but by their diversity. One is struck by the complexity of the need-related circumstances of many; by the complexity of individual aspects of circumstance as well as by the variety of their combinations. Also we are increasingly seeing in our studies of long-term care systems at work that greater proportions of the recipients of more than average amounts of care services are becoming more and more highly volatile in their needs-related circumstances; more highly volatile in ways that make extremely important the relations between acute and long-term care systems.

Many of you know from your own experience of the variety in the times of day and night at which care is most needed, the variety of the care tasks required, the minimal frequency with which the tasks should be performed, the predictability of the most effective times for undertaking them, the duration of each episode of caring, the nature of the relations between dependent



## RATIONAL FUNDING POLICIES

**Professor Bleddyn Davies**  
(University of Kent)

My paper reflects two assumptions. First, we should not focus too much on detail when we read the Griffiths Report. It was a short piece of work with a commendably clear logic which led to some important firm proposals, some more tentative suggestions, and statements of some of the pre-conditions for his core logic to work. It is only now we are beginning to engage the issues of detail. For that reason I think that we have to look back at the context in order to see what some of those issues are.

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and their families, the pressure on potential family carers, and so on. These are circumstances which must be taken into account if we are to match resources to needs in community-based care. But we look in vain for good arrangements for tailoring arrangements to the diversity. We have no one with the responsibility, authority and accountability to match the whole range of community resources to such individual needs. As in several other countries we have suffered a development bias in the evolution of our services. We have used our growth in resources to increase the levels of provision, to increase variety, to increase the quality of services, but not to increase the capacity at the field level to match resources to needs. So we call our system "fragmented" because we lack effective mechanisms for co-ordinating their elements. If we had such mechanisms, we should merely recognize service complexity but see this complexity as potentially contributing to the capacity to match resources to needs.

A second characteristic is that the care tasks which in total consume most resources are non-technical. They do not require enormous inputs of training and can be performed by many. Therefore there are many arrangements possible for performing them. That of course increases the potential for variety. The variety would improve the effectiveness of our activities if we could exploit this variety to respond adequately to the needs-related circumstances of individuals.

Putting together these two characteristics suggests a powerful bias in our system as it is at present, against providing care with community-based services rather than in residential homes. Its scale is only now beginning to be discussed as we collect experimental evidence which shows what outcomes are possible with good case-managed community care.

One feature of the developmental bias is becoming clearer as we research the allocation of resources, needs and outcomes in community-based care, who is admitted into residential care, and so on. The evidence shows that even those who get much more than the typical quantities of community-based nursing and social services are getting those services at a cost below what the resource costs to local authorities would be of providing care in residential homes. By international standards we are not intensive providers of community-based care. There is a gap between the cost of the community services provided and of residential care. We could narrow the gap without making community-based care more expensive than residential-based care.

A second feature is that there are shortcomings and anomalies in the targetting of community-based services. Current targetting leaves many family carers with quite unfair levels of burden. The proportion of those carers who are under such stress that psychiatric treatment may be required is greater than I had expected before our results from representative samples became available. The prevalence of the stress partly reflects the absence of adequate mechanisms for matching the whole range of



community service resources to the needs of individuals.

A third feature is that services have not adjusted the tasks they perform and when the tasks are performed to the characteristics of those at greater risk of residential care. Therefore larger inputs of service do not have big effects on some of the potential outcomes which might most reduce the probability of admission to residential care. In other words, services typically have patchy, and often negligible or low marginal productivities with respect to outcomes. For instance, when one is looking at the effect on informal carers, it is only among those who have very high stress levels that social services seem to reduce stress levels when they put in more rather than less resources. Mostly, variations in services don't appear to make much difference to stress levels, though they do make a difference to people's appreciation of support services.

Examples could be multiplied. Anyone interested in knowing more about what we have discovered should write to me for papers. The point here is that to achieve high marginal productivities for the important outcomes is critically important if we believe that a higher proportion of those in considerable need should be catered for in community-based settings rather than residential-based settings. Agencies will have to work hard to raise them.

#### **Rising proportions with substantial incomes and assets**

A third important characteristic is as important to the future as the others which I have mentioned. This is the rising proportion of the elderly with substantial incomes and assets. Increasing proportions of customers will therefore be more demanding. Many will avoid the systems which have been developed under the assumption that most clients are recipients of public funds. Reliance on public funds will decrease in the future. This will make the whole management and development of the system much more difficult to achieve if we continue to assume that the most important vehicle for the provision and financing will remain big, collectivist, politically accountable agencies holding the commanding heights of the financing, supply and planning of social care. We must attempt to make all the care markets work well, including those whose consumers and providers are currently only indirectly connected with and affected by local authorities or the national health service, for instance, private providers of home care and special housing.

Some work by colleagues and I shows that even by 1980 there were substantial numbers of the population who were ineligible for means-tested services. However, most of them could not afford to pay from income (discounting assets) for long-term care. Those ineligible for means tested services but unable to pay for more expensive forms were not geographically concentrated in more prospering areas. It is assets which are more geographically concentrated. Some of our research suggests great increases in the value of housing owned and occupied by elderly householders. The values are on average high in some regions.



So should we require elderly persons in some circumstances to use a proportion of other share in the value of their owner-occupied housing to help to finance their long-term care? I suggest that this is a path which we shall surely follow, but one which is so dangerous that it must be trodden with great care. We would not want to get caught in a vicious spiral in which we should be forced to define rules about the divestiture of assets, of increasing formality and stringency and thereby get enmeshed in deeply unpopular political and administrative action enforcing assumptions about the obligations of the family; obligations which many would be unwilling to accept. This is an area for which no system of rules could possibly work effectively and without controversy.

#### POLICY PROPOSALS

So what should we do about these things and what are the funding implications? The first suggestion is about creating a mechanism for matching resources to individual needs. Griffiths took up the idea of concentrating the responsibility, authority and accountability for performing the core tasks of case management on care managers. Care managers should be appointed for all clients for all substantial consumers for which the social services department was to provide care finance. The case management was to be free of charge, so encouraging consumers to use their services irrespective of their eligibility for means-tested services. Other official reports have advocated much the same with varying degrees of specificity. The provision is now accepted: a new conventional wisdom.

Some experiments have been outstandingly successful; transforming the quality of life and care of recipients of community-based services without worsening the lot of family carers, and doing so without increasing costs.

However, discussions one reads and hears are disturbingly vague about the prerequisites for achieving these gains. The discussions are most disturbingly vague -- and sometimes wrong headed -- precisely among those who must clearly work through the arguments and understand the implications of evidence; among managers in local authorities and some of those who write material which they are most likely to read. There is a big gap between the sophistication of some of the best written arguments available about how to fit case management arrangements to contexts and what one hears from managers, even those most interested in the issues. And to build post-Griffiths arrangements on some of the ideas one hears would disastrously miss the key opportunity to get things off to a good start. It would be disastrous to start badly and to have to patch and mend later.

Naturally, managers must readily comprehend the features of the new concepts which they recognize. They too readily identify what they are already doing with what Griffiths and others are



talking about. But there is more to it than that.

Partly it is that we academics, whose job it is to codify the state of knowledge as well as to disseminate it, have partly failed to understand the implications of one another's results, and so are providing confusing messages. But I suspect also that local authorities have not got the local devices to receive the new messages being beamed at them. Too many messages are being broadcast too quickly. The local authorities, having seen themselves as provision and financing agencies and not primarily as agencies which are there to cultivate a good system of provision by others haven't really developed the analytic capability at a policy level to take in enough of the important messages. It is a serious problem. Consortia of authorities are needed to help in the clear dissemination of ideas. The national government must take a proactive role. So must pressure groups and other organizations.

My second policy proposal is that we should strengthen the policy framework for the limited use of insurance devices for helping users to contribute to their costs of long-term care. Long-term care insurance is technically feasible. But it is a very frightening area for insurance people to get into. The languages of social care seem strange. At first sight it may seem to them difficult to limit "moral hazard" -- the temptation of beneficiaries to exaggerate their needs. The risks which insurers face are unknown. I believe that the US history during the last five years is instructive. The state authorities in the mid-1980s did what they could to stimulate interest from the insurance industry. But insurance companies reasonably complained that the legal framework for the regulation of insurance was not such as to encourage them to move into long-term care, that they were not being helped by sharing with the state the unknown risks of heavy claims, and so in keeping premia affordable by a large part of the potential market. It was quite different when I went back a year ago. The States had begun to amend the regulative frameworks. Long-term care insurers were adopting case management devices in one form and another to help to limit moral hazard. The growth in the number of subscribers was fast. And a whole variety of new models had been developed.

We should study the American experience closely. Already British insurers are offering policies. Since higher proportions of elderly persons are modestly asset rich (reflecting owner-occupied housing) rather than having high incomes many of the British developments tap housing equity. Our main preoccupation now should be to ensure that we curb the tendency for systems to be led by supply institutions and financing mechanisms. Care management free of charge can contribute. However -- my third proposal -- we also require disinterested and expert financial brokers to serve the variable needs of consumers. In a mixed financing economy of welfare, where consumer needs are complex and diverse, expert and disinterested financial brokers are as important for ensuring system equity and efficiency as expert and disinterested supply brokers, the care managers proposed by



Griffiths.

Such devices are no panacea. They can make only a limited contribution here. Of course, there is no alternative to a heavy commitment of public funding. Most important, the politically accountable lead agencies at local and national levels must develop new metaphors which encourage them to focus on appropriate ends and means in a fast-changing mixed supply and financing economy of welfare with many interrelated markets with many participants who will have no direct relations with the lead agencies themselves, but for the disbeneficial effects of whose actions the agency will have some responsibilities. The lead agencies will be more like departments of state with responsibilities for trade and industry policy. National and local government should work through the implications of being lead agencies for trade and industry policies for community care. I am sure that a contemporary Adam Smith would agree.

REGULATION AND INSPECTION



## THE REGULATORY OPTIONS

Lady Wagner

Of all the issues that divided the members of the review committee on residential care, it was the question of how to deal with the system of registration and inspection that caused us the most difficulty.

The written evidence showed that it had attracted a great deal of criticism. The major problems were easy enough to identify: too much emphasis on the physical features of care establishments rather than on the quality of care, inconsistencies between different registration authorities, variations in the levels of skills and experience, and most notably the fact that local authorities often required higher standards than they themselves maintained in their own establishments. And this seemed to many members of the committee to be a gross injustice. Now, of course, there is the question of the private sector.

### REGULATION AND INSPECTION

And since the government has accepted the Griffiths proposals in part, local authorities will now assess who should, or should not, receive residential care -- thus giving them financial power as well as registration and inspectorial powers.

In trying to bridge the difference of opinion between those who felt that only an independent inspectorate could resolve this injustice and those who felt that the responsibility must remain with locally elected representatives and that it would be a grave error to undermine the power of local authorities we endeavoured to look at the criticisms in some historical perspective. It was, of course, during the life of the committee that some of the worst scandals in residential care erupted, with the media highlighting bad practice in the private sector and reports on Mye Haven, Brent, and Camden in the statutory sector making headlines. The thinking of the committee was very much affected by these revelations although we had already received very disquieting evidence in letters sent to us by residents.

### A unified inspection process

Contrary to some reports we did not call for an independent inspectorate. Although the fact that we said that local authority, voluntary, and private residential establishments should be subject to the same system of inspection and that no service-providing agency should undertake the inspection of its own establishments may have been taken by some to mean just that,



they did not read the report carefully enough.

## THE REGULATORY OPTIONS

However, we went on to suggest that an element of peer review should be built into the inspection process. This could be provided by suitable persons with current or very recent residential experience drawn from all three sectors -- local authority, voluntary and private -- who would act as assessors or observers. Assessors would receive a fee for their services and precautions would be needed to avoid any conflict of interest.

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If, as seems likely, one of the casualties of the acceptance by the government of the Griffiths recommendations will be the eventual phasing out of local authority homes, this will entail the loss of a great deal of knowledge and experience that has been built up. Inevitably this will mean that local authorities eventually will have no employees with direct residential experience. There are some who feel that this could be an advantage provided the management skills of local authorities are enhanced and that they are balanced by others who have practical experience.

I think the request that local authorities will be asked to establish inspection and registration units at arm's length from the management of their own services and to involve independent outsiders in these arrangements is right on line with the thinking of the review committee. But I always said that the report was a beginning and not an end; we made a suggestion as to how this might be done, but it was not fully worked out on the committee. The proposal now is for inspection and registration units at arm's length, but a lot of work needs to be done on this, and all three sectors will want to know very clearly how it is going to work. It may sound ungracious to have won a point only to ask for more details, but in welcoming this development I hope that all three sectors will be involved in the working out of the arm's length concept.

### **National guidelines**

The committee also recommended the Department of Health to draw up national guidelines for the registration and inspection of residential establishments in all three sectors which -- while allowing for a legitimate local diversity -- should pay equal attention to matters relating to standards of accommodation, quality of life and qualifications of management and staff. There is no doubt that these recommendations have financial implications but if we are to have a residential care service of which we are not ashamed this should not be seen as a difficulty and is of fundamental importance.

Residential care is, as you all know, a very complex business. The Wagner Committee did not wish to see local authorities becoming managers only; they have a wealth of experience behind them built up over a much longer period than is the case with the private sector. Where standards are high in the statutory sector they are among the very best.



aims cannot be held to account for failing to achieve them. There  
The local authorities have been the recipients of all the  
guidance and directives issued over the years by the DHSS, and I  
am alarmed at the thought that this body of accumulated wisdom  
and knowledge might be put at risk in the rush to put right the  
defects in the system of which we are all aware.

### **Private sector divisions**

Just as worrying is the lack of a united professional private  
sector. It is sad that the different combination of initials  
provides only material for jokes on the back of the social work  
journals. I was reminded of this when looking at advance copy of  
the Social Services Inspectorate review of the arrangements for  
health care in local authority homes for elderly people. The  
review was asked for by the local authorities themselves who  
realized that the guidelines that had been issued in 1977 were no  
longer adequate. Their findings can, of course, be applied to the  
private sector as well. Sad, but inevitable in the way the  
system works at present, is that although the private sector is  
now larger than the statutory sector they have perforce made no  
input into this review. They will be present when the discussion  
takes place but would not otherwise have been involved, although  
the matters under review are of the utmost importance to all in  
residential care.

The lack of any unified structure within the private sector has  
other unfortunate effects. I had personal experience of this  
writing the report. Initially, without thinking I suppose, we  
started by addressing the statutory sector without considering  
how our recommendations would be seen by the private sector. The  
problem is, partly, that there are few officers-in-charge in the  
private sector; if that term is to refer to all managers of homes  
one is immediately into a large communications problem. In a  
world where the art of communication is the key to success it is  
important to be aware of this. The Wagner Development Group has  
grasped this essential point and all the development work that is  
going on across the board is involving all three sectors.

### **Self-evaluation**

Because the issues of registration and inspection have come to  
seem so all-important, it is too easy to think that if the  
problem of registration and inspection are solved then all will  
be well. I must emphasize that registration and inspection are  
only the framework and not a sufficient answer to the problems of  
maintaining and improving standards of care.

I will, if I may, digress for a moment and briefly describe the  
three-fold system of self-evaluation that we on the committee saw  
as an essential adjunct to the issues of inspection. We wanted  
every establishment to have a written brochure or prospectus  
which will provide the basis for each resident to have a contract  
with management. This, we thought, was essential in order that  
inspection may be effective. An establishment without declared



aims cannot be held to account for failing to achieve them. There also needs to be a detailed statement of the means by which the aims and objectives are to be achieved which should reflect the expressed wishes of residents and staff. Thirdly, and most importantly, there must be provision for a periodic performance review in which the establishment's aims, its methods, and its success in achieving them are evaluated annually. We recommended that staff, residents, and relations should be involved in this review.

The Wagner Development Group was set up by the National Institute for Social Work immediately after the report on residential care was published and, happily, trust and foundation money (but no government money) was found to enable it to function. Its aims are to ensure that the review of residential care is fully considered, that conscious decisions are made about its recommendations, priorities set, and a programme of work identified. It has been meeting now for over a year. Membership is drawn from education, trades unions, the private, the voluntary, and the statutory sectors, and the Department of Health is represented.

At the last meeting of the group, inspection and registration was the main item on the agenda. The issue of how the balance is to be fixed between local determination of standards and the imposition of consistent national standards from the centre was discussed. There was no dissent from the idea that the SSI should have a more interventionist role and that this should not affect the rights of clients and relatives to participate in and comment on the setting of standards as recommended in the three-fold self-evaluation system just mentioned. The formation of regional structures might be a way forward, with assessments by peer review as one of its features.

### **Obstacles to success**

One of the defects of the present inspection system is the over-emphasis on the physical features of care establishments rather than on the quality of care. The Wagner Development Committee is at present doing work to identify the indicators by which to measure quality achievement. The primary responsibility of management is to provide a quality service and the service providers themselves must be responsible for monitoring that achievement in respect of quality assurance and control. The difficulty at present is that management of residential services are so fragmented that there is a lack of basic factual information for managers. If the private sector were to become more unified, less a group of trade associations and more a professional body, it could do much to help itself.

One has only to look at the way the independent sector in education works, with professional associations such as the Headmasters' Conference imposing standards and wielding influence. Another example, perhaps even nearer home, is the way in which the National House Builders' Federation are setting out



to impose a code of conduct on their members engaged in providing sheltered housing.

If management were given the tools to enable it to provide a quality service effectively, then a possible system might be for the SSI to validate and monitor the local systems used in terms of national standards, ethical considerations relating to users, and professional standards; and for them to publicize and implement good practice. I see no reason to depart from the recommendations we made in the report. Indeed, now that our first recommendation has been accepted -- namely that local authorities should take the lead in the strategic planning of residential services within their own boundaries -- it is even more important that they should implement the others as soon as possible. The recommendation that local authorities, voluntary, and private residential establishments should be subject to the same system of registration and inspection should be acted upon.

So must the recommendation that the Department of Health should urgently draw up national guidelines for inspection of residential establishments and should give equal attention to the quality of life and the qualifications of management. Both Anthony Pittaccio of the BFCHP and Peter Rickard of the NCHA are, I think, in agreement with that. Where we differ is over the argument for an independent national inspectorate which Mr Rickard believes would ensure that the right sort of care is delivered to those in need of it, I believe that this may be a logical development in the future, but I do not believe that it would result in better care for residents at the present time. I would prefer to see a more gradual approach with a more active and interventionalist role given to the SSI based on a regional structure. It could become all too easy to believe that all was well in the care field because there was a national inspectorate on the same lines as the school inspectorate. But schools have governing bodies or are under the control of LEAs. It is right that the powers of local authorities should be circumscribed by the imposition of national guidelines and a strengthened SSI, but there must still be a local dimension and now we know that there will be. With all their accumulated knowledge and experience, local authorities must still have a role to play in conjunction with other interested parties.

I have not mentioned either the inherent difficulty of recruiting and training sufficient experienced inspectors were the idea of an independent inspectorate to be implemented; nor the financial implications. Both are important, though not as important as safeguarding the true interests of consumers of residential care.

#### **The onus on the independent sector**

We are in a period of transition. Clearly the balance of residential provision is shifting from the statutory sector to the independent sector. This, I believe, puts a very great onus on the independent sector to seize this tremendous opportunity, to put past differences behind them, to unite, to become more professional so as to be able to influence future developments



instead of merely having to react to them.

No-one should be surprised that this has not yet happened. Over the last decade there has been such a dramatic increase in the amount of residential provision available, partly owing to funding through supplementary benefits, and partly because of the growing numbers of elderly people. There is now likely to be something of a pause in this growth, which could provide the right opportunity for a period of consolidation.

I would just like to make one final point: there is a lot of talk about the cost-effectiveness of residential services but that is not all that matters -- we are talking about something much more difficult to measure and that is how to ensure that not only the physical needs of residents are met, but that when they have made a positive choice and moved into residential care this proves to be a positive experience. And we must not forget that this is what the whole argument about registration and inspection is finally about.

medical and domiciliary services likely to be required, including efficient domiciliary services, good quality residential care and the availability of suitably trained staff.

The government has commissioned several reviews aimed at improving the provision of care. The most notable one, of course, being Griffiths, and the government also has before it the report presented by Lady Wagner and her team, and the "Community Care -- Strategy for Improvement" presented by the Joint Care Committee on behalf of the residential care sector.

Sir Roy stands for efficiency, high organisational ability with proper management of care needs as well as financial and human resources. Lady Wagner emphasises high standards of care, the safeguard of human dignity, and in order to achieve those ideals, a training programme for staff. Both Lady Wagner and Sir Roy are strong on consumer choice.

"Strategy for Improvement" shows that the private sector supports wholly the notions of sound management, of high standards of care and of consumer choice -- for these are the very bedrock of private sector philosophy. We remain firm in our belief, as sustained by our experiences, that the only way of truly safeguarding these basic principles is via the independent route. By that we mean an independent inspection system and an independent assessment of care needs, although we would concede to Lady Wagner that there is perhaps a need for much more discussion on this matter.

The Secretary of State has now made a statement on the government's new proposals for the future organisation and funding of community care, and it shows that it has, in the main, looked favourably on Sir Roy Griffiths' recommendations. Our immediate reaction is one of doubt as to whether the new proposals, as correct as they may be in principle, will in practice improve the standard of care in the community. Certainly, they will not do so unless the system is put under the



control of sound management, and we also see a danger that some existing problems, such as regional variations and budgetary

**A PRIVATE-SECTOR VIEW**

There are many points in the statement that need to be clarified. **Antony Pitaccio** poses many questions, and I do not have time to (Chairman, BFCHP) answer them. I have a letter from Mr Kenneth Clarke in which he says he will be happy to consider meeting us once the government proposals are in the public domain, and we therefore look forward to discussing some of our anxieties with him.

Now, of course we welcome the government's key aim to enable people to live a full and independent life in their own home for as long as it is possible for them to do so: we all want that. But what concerns us about domiciliary care is that the present

It is an obligation of government to ensure that the highest possible standard of care is available to its citizens. To achieve this, it is necessary to secure the provision of a full range of all medical and domiciliary services likely to be required, including efficient domiciliary services, good quality residential care and the availability of suitably trained staff.

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control of sound management, and we also see a danger that some existing problems, such as regional variations and budgetary control could worsen.

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Now, of course we welcome the government's key aim to enable people to live a full and independent life in their own home for as long as it is possible for them to do so: we all want that. But what concerns us about domiciliary care is that the present network of domiciliary care services cannot cope, either qualitatively or quantitatively, with the demands made upon it today. We therefore look on 1991 with some apprehension, because we believe that it is unlikely that the network of domiciliary services can be fully extended and operating efficiently by that date, and thus capable of responding to the enormous new demands that will be made of it.

Any company in the private sector operating without a clear appreciation of its operating costs, and without any idea of its value to the consumer will be doomed to failure. We therefore find it somewhat extraordinary that the government intends to transfer a huge sum of money from a service that has been tested against these targets, to the support of one which has yet to be fully costed and evaluated or its management skills proven.

The BFCHP, along with other organizations in the independent sector has always maintained that residential care is less costly and offers better value for money than full scale domiciliary care. Our claims have been met with disbelief. We are, therefore, pleased to note some early recognition at government and local authority level that domiciliary care is no longer a cheap option costing far less than residential care. We are confident that once a real costing and evaluation of domiciliary care services has been carried out, including all the administration costs, our claim that it is more costly than residential care will be proven.

Another point that concerns us is that, having accepted that local authorities would need adequate resources for their new responsibilities, all that the minister says so far about these resources is that they will be the ones to be transferred to local authorities which the government would otherwise have provided to finance care through social security payments to people in residential care. Now, we are concerned about that, because it has to be said that by severely limiting the income support paid to people in residential and nursing care today, the government does not seem to have the proper means to assess the day to day cost of care. We therefore look forward to the government's further and detailed explanation of its projected



community care budget.

We trust, for instance, that the government has not assumed that a streamlining of domiciliary services will result in a reduction in care home occupancy. Historical trends would not support such an assumption. The statistics show that the percentage of elderly people in residential care in Great Britain has fluctuated insignificantly since the turn of the century, when it stood at 4.8%. The increase in recent years in the number of care homes in the private sector has not been solely due to government funding, as some might argue, but rather to meeting the care needs of an increasing elderly population with which local authorities could not cope and which governments should have foreseen and planned for. Furthermore, the percentage of elderly people in residential care in several European countries, such as Belgium, Holland and Germany is twice that of Great Britain and those are countries who still pride themselves on their domiciliary care services. Private residential care in this country, therefore, serves people well and it will continue to do so. Without it the provision of care for the vulnerable in our society would be in severe crisis. Our residents have privacy when they want it, they have company when they want it, they have shelter, warmth, food, 24-hour care cover. So why must the prospects of going into a home be portrayed as being so dreadful?

Furthermore, residential care is part of community care and should never be regarded otherwise. We are a continuation of domiciliary care, not an alternative; and people come to us when they need residential care. It is good to see, therefore, that when a questioner in the House of Commons pointed out to the Secretary of State that the number of totally dependent elderly people will rise by 100,000 by the year 2000 he replied that he agreed entirely with the analysis of the growing demand and went on to say: "Today we are dealing with a policy which will increase local authority ability to provide social services support to those people and their friends who look after them in the community or to pay for them to go into residential nursing, as many of them will, because that is the best way in which to care for them."

Of course, we encourage government to support, in as many ways possible, those caring people who look after a handicapped or elderly person in their own home. They desperately need such support, and we welcome the minister's statement that it will become available to them. We also welcome the minister's perception that many will go into residential care, because it signifies to us that he is aware that a very large number of those people looking after an elderly relative, parent or friend in their own home, are themselves past retirement age or have heavy family commitments and are no longer able to cope.

Also, having agreed with the analysis of the growing demand, the minister has no doubt made an assessment of the additional number of residential places which will be required and will ensure the availability of such places, which is largely dependent on a



healthy independent sector.

Now some of the questions that the new funding proposals raise are crucial. On the assumption that in 1991 board and lodging payments will be made to those in need of residential care, with realistic care costs being met by the local authorities, what is the likelihood of a two-tier system emerging when comparing residents funded under the new system with today's so-called protected residents? Will local authorities be willing to top up on the present-day (unrealistically low) level of funding for so-called protected residents? Will there be a cut-off point on the funding of domiciliary care, especially given the acceptance that it is no longer a cheaper option?

Local authorities will be asked to establish an inspection system of their homes and the domiciliary care services which they are to provide. We welcome this. But how will that be paid for and what value placed on it, considering that the local authority will be assessing its own provision of service? Under the new system, local authorities will not only inspect and register residential care homes but will be funding that provision from them. Will this at long last mean the end of paying income support to residents in unregistered homes?

The key feature of the government's proposals is the co-operation between the authorities and between the authorities and the providers of care services. Experience has shown that one cannot always rely upon this type of co-operation and when it fails it causes enormous problems. The private residential care sector wishes to work in harmony with registration authorities. But where we find it difficult to do so is when we are looked upon as an extension to social services. We wish instead to be recognized for what we are -- we are a major industry, the major provider of residential care, the suppliers of an indispensable service, and a leading employer. We want to be taken seriously and we wish our experiences and skills to be recognized and valued. We wish to be consulted when policy decisions are made.

Many of the problems between the registration authorities and the private sector stem from the weak 1984 Act. It has proven too woolly to be implemented properly and has encouraged differences in its interpretation. These problems have been further intensified because of untrained and inexperienced officials who had as much difficulty in understanding and working through the Act as we did. We therefore ask: will there be a repetition of this in 1991? A new army of social workers (and goodness knows where they're going to come from) as well as existing officials will have to be trained. When will training start? When will recruitment start? And will representatives from the independent organizations be invited to take part in that training? And so on.

On the question of co-operation I wish to echo the words of a director of social services in North Wales whom I had the pleasure of meeting at a conference there recently; he said: Co-



operation means that there must be no hidden agendas between social services and private care homes. Communications must be clear. Local authorities must apply the same rules throughout and be consistent. The proprietor or manager of a care home must by right have a written response from the authorities on matters where there are doubts about an officer's advice or opinion. Now we welcome those statements from a director of social services, for it is clearly a step forward. And, perhaps one day, co-operation between the authorities and the private sector may reach the same heights as it has in several other European countries. There, the authorities do not even inspect care homes unless they are accompanied by a representative of one of the private organizations: the findings are then discussed together and actions agreed. I suggest that if that happened in this country it would do away with many of the tribunal cases.

I also had the pleasure to attend an annual conference of of an organization similar to the BFCHP in Germany recently, and the list of speakers included the health minister and health spokesman from other parties and three representatives from local government. Organizations like the BFCHP in those countries hold regular meetings with government and other European countries as a matter of course. Why then can't this happen in the UK ?

On the question of care needs and consumer choice, of course we agree that need must be carefully assessed, with real sensitivity. When that need has been established, we must be mindful of the fact that well-intentioned measures can at times have the opposite effect on those concerned. Therefore, having discussed the need fully with the patient, leave him or her the choice of accepting the measures suggested or to decide an alternative course without any pressure being brought to bear.

It is interesting to reflect on a survey carried out by BFCHP. On 1,000 placements chosen at random in residential care homes, only 4% could feasibly be looked after in their own home. When asked why they were in residential care they gave the following reasons: loneliness; inability to look after themselves properly and not wishing to be a burden on others; friends and relatives no longer able to cope; fear of being alone; and that they did not wish to leave it too late (in other words they wished to chose the care home themselves while they were still in a condition to do so and to assess the quality of the care they could expect if needed). There, of course, we are talking mainly of residents who pay their own fees, and it is sad to reflect that real freedom of choice for everyone can never be a reality -- because it is unlikely that any of those reasons that motivate people so strongly will in future qualify them for income support in residential care. Yet they are care needs and they reflect consumer choice. They also show how important it is to assess care needs carefully and knowledgeably, and we have to ask, do local authority social services possess the full range of qualifications to enable them to do so ?

We doubt it. Assessment cannot be left to well-meaning people



alone, but must involve trained staff as well. And, therefore, we're not really happy with that situation. Neither do we favour multi-disciplinary assessment because it lacks dignity and is prone to disagreement. We are of the opinion that assessment of care needs, to be truly objective, must be independent of the care providers and of the funders. We believe that, as in Germany, for instance, care needs can be better assessed by a nursing professional in consultation with the patient's own doctor.

As to the assessment of standards, they should not be limited only to residential care homes but domiciliary services should also be subject to regular inspections. Furthermore, we believe that all inspections in all sectors should be carried out by an independent agency with authority to demand the closure of unsuitable homes and the cessation of poor domiciliary services. The BFCHP does impose a code of conduct on its members and it subjects its members to an independent inspection carried out on national lines. A great deal of interest has been shown in our inspection system, we believe it is efficient and could form the basis of a new national system which would be less costly to operate than the present £28 per bed we have to pay to the authorities, as well as permitting more inspections if necessary. We at the BFCHP are deeply concerned that homes that we have expelled or refused to take into membership can continue to operate. We want to see the closure of all homes whose standards give cause for concern and we shall be pleased to share the experiences we have gained through our own inspection system with the authorities. As Lady Wagner said, and as we have always said, the biggest failure of the 1984 Act is that it still permits bad care to exist in homes that have met all registration requirements.

The year 1991 is the year when the Care Sector Consortium will have completed its work in establishing the competences required to carry out the various tasks in all sectors of care. The private, voluntary, and statutory sectors are all working together in establishing competences required in care work and the private sector is also taking the lead in establishing the competences required in care home management. We trust that the result of this work will set the guidelines which will determine the suitability of people to manage care homes and will do away the present unsatisfactory system of leaving it purely to conjecture.

For some time, in fact, there has been a strong feeling amongst our members that proprietors, managers, and senior officers in the overall field of care should have proper and rightful status. Back in 1985 the BFCHP took the initiative to spearhead a series of meetings, attended by representatives of a wide range of statutory and voluntary bodies, to debate the need for an Institute of Care Management. We have worked out the strategy for establishing such an Institute. But we are now at a standstill because of lack of funds. An application for funds was made to government but was unsuccessful (in Holland, however, an



organization of care home managers and proprietors had just recently been given a grant of £150,000 by their government towards the funding of a similar project).

The Institute of Care Management would not offer courses of its own making but would establish a criteria for membership which took into account the experience and qualifications of applicants. The Institute would comprehend the public, voluntary, and private sectors in terms of legal status; and the residential care, sheltered housing, and domiciliary care agencies in terms of provision. It will become a forum for excellence and stimulator of high standards in care. It would encourage co-operation between the managers of all sectors with the registration authorities. And we believe the need for such an Institute, which would also act as a professional register for all managers and proprietors, is greater today than it has ever been. We ask government to follow the good example of the Dutch government and make available a grant to speed up the establishment of the Institute as a matter of urgency.

The one good thing that the delay in government's decisions on the Griffiths' Report has done is to make possible much debate. Perhaps care has not been so openly debated as it has been during the last 18 months. And all those concerned with care have been able to formulate clear ideas of what they believe to be the best way forward. Whatever the government's decision it was bound to please some and disappoint others. Out of these debates, however, has come the recognition that co-operation between the various parties is essential to secure a better quality of life for the elderly, handicapped, and infirm. Indeed, unless the outcome of all these reviews and debates is translated into those terms, they would all have been quite pointless. We in the private residential care sector will play our part in securing that improvement in quality.

There are 12 consultants in all, whose backgrounds are in health or social work. All have held senior posts within their respective organisations and each has responsibility for one clearly defined geographical region of the country. Each liaises with the elected regional representatives of BFCRP, who act in an advisory capacity with regard to constitutional issues and also provide the link person between the consultants and the organisation's Leicester headquarters.

Although local authority approval is a legal pre-requisite to operation, the criteria used vary throughout the country -- as does the form and content of subsequent visits. Indeed some homes receive no further inspections other than the one for registration whilst others have placed on them restricted conditions of operation. One serious practice issue in Scotland at the moment seems to be whether residents have tables with corners or whether they should be round tables and this is the depth to which some of the registering bodies will stoop in order to place these restrictive practices into operation. Not surprisingly, establishments tend to cluster in areas of the



## SELF-REGULATION IN CARE PROVISION

**Robert MacGillivray**

**British Federation of Care Home Proprietors**

One of the most crucial elements in professional care practice of an individual or organization is the ability to receive constructive criticism from fellow professionals. In 1988 this concept became reality for the British Federation of Care Home Proprietors when, for the first time, the need for independent inspections was recognized fully and the task contracted out to membership consultants.

This process was essential to the development of BFCHP as an organization whose commitment is to exercise the highest possible standards of practice amongst its membership. Essential also was the strategy of membership consultants being wholly independent assessors with no allegiance either to the organization commissioning the inspection or to the proprietor of any individual establishment. This contributes greatly to the measure of objectivity with which the inspections are completed and results in BFCHP being offered a comprehensive account of each home visited with the clear emphasis being placed on the quality of care offered.

### **Organizational Structure**

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Although local authority approval is a legal pre-requisite to operation, the criteria used vary throughout the country -- as does the form and content of subsequent visits. Indeed some homes receive no further inspections other than the one for registration whilst others have placed on them restricted conditions of operation. One serious practice issue in Scotland at the moment seems to be whether residents have tables with corners or whether they should be round tables and this is the depth to which some of the registering bodies will stoop in order to place these restrictive practices into operation. Not surprisingly, establishments tend to cluster in areas of the



country where local authorities and proprietors form partnerships in care and work towards a common aim -- the provision of high-quality residential care for client groups. This issue of collaboration is crucial as, for example, an elderly person today is 20% more likely to be receiving a full-time residential service than in 1981. This, coupled with ever-tightening financial restraints on public-sector funding paints a bleak picture for consumers in areas where public sector growth cannot meet the demand for places, and where there is a reluctance on the part of the registering bodies to encourage private home ownership. In addition, unnecessary bureaucratic machinery brought to bear on all private-sector agencies assists only in making the operation of smaller, extended family type homes an increasingly difficult task to undertake.

The BFCHP system of inspection is simple to administer, concentrates on the social and caring provision of each home, offers a network of professional support to member homes, and is cheaper to operate. And, in addition, it incorporates a degree of corporate decision making with a high degree of consistency of approach. The inspection of a home in Dundee will be completed using the same approach and regime as a home in Doncaster.

### **The Inspection Process**

Any home applying for BFCHP membership does so in the following way. Firstly, an application for membership is sent to BFCHP's headquarters with the appropriate fee (homes operating 3-12 beds would pay £50, 13-25 beds would pay £70, 25 and over would pay £90); a copy of the proprietor's application form is forwarded to the appropriate membership consultant for that geographical area. The consultant arranges with the proprietor a date and time for the visit to be made, which is usually within four weeks of the consultant's receiving the application form for membership. The consultant, following the visit, but at the earliest opportunity, completes the checklist, attaches supplementary comments, and forwards the information to headquarters for action. In the event of a home's meeting the criteria detailed in BFCHP's code of practice, a membership certificate will be issued.

One common problem experienced by many home owners is that of professional isolation. BFCHP campaigns against this by organizing regular regional meetings of its membership. BFCHP has in its organization a wealth of expertise, and it uses membership consultants who can offer support and advice at short notice.

Should a prospective member's home not meet the criteria of the code of practice, two avenues may then be used: in the case where there are severe shortfalls in the service offered, such as overcrowding of rooms, insufficient staffing levels, or a breach of the conditions of registration, membership may be refused out of hand. In such circumstances, the alterations necessary to bring the home to an acceptable standard may undermine the viability of the establishment as a business entity, making re-



application for membership an unlikely prospect. In extreme cases, it may also be considered necessary to inform the registering body of the findings of the inspection, in particular where it is felt that there is a high degree of risk to the safety of residents in that establishment. (Registering bodies have in fact asked BFCHP to inspect homes where there are serious concerns about the standard of care on offer. This strategy of co-operation for the common good can only serve to enhance the well-being and the quality of life for residential service users).

### Some Examples

Now, an example of a home where membership was refused out of hand. These points are points which a consultant has made; these are the reasons for membership being denied. Only 18 inches of space was available either side of a person's bed, which made it very difficult for even able-bodied residents to get in or out of bed. Members of staff found it impossible to assist disabled residents. This situation was a direct result of too many people occupying a small bedroom. Some residents had limited access to washing facilities; some had none at all. A former office is now used as an additional bedroom, and no alternative reception area was made available. It was suggested by the proprietor to the consultant that the interview part of the inspection be completed in a resident's bedroom. A goodwill report by the fire department concluded that additional fire escapes were necessary. This work had not even started. There was a general smell of stale urine throughout the home. Bedrooms were spartan with no personal touches; this situation was also found in communal living areas, where people were arranged in rows of 10. Residents walked physically upstairs to bedrooms via a 2-directional staircase. This practice places both residents and members of staff to an unacceptable level of risk.

This home was eventually closed as a result of registration being withdrawn. More commonly, homes may have their application for membership deferred until such time as shortfalls in standards are attended to. This action is used without prejudice either to the home or to the proprietor. Two time scales are involved in such an action of deferment: a period of three months may be allowed for home where one or two practice issues require attention, and perhaps minor physical alterations. A six-month deferment may be used where larger physical alterations are necessary with a more detailed analysis of practice being suggested. Generally, homes which have membership deferred reach the criteria for membership within the allotted time scale. After either deferment period is completed the home in question is then re-inspected.

Here is an example of a home whose membership was deferred. "An inadequate system of drug-recording is in operation which does not detail clearly when medication is administered and to which resident. Bedroom doors are not knocked prior to entry; on one occasion, the consultant was shown into a bedroom, where an elderly person was undressing. Insufficient clothing was made



available to residents; considering that the physical needs of the individual were such that their level of dependency was high, work is required to redress this unbalance".

Of course, proprietors do disagree with individual consultants. In such cases an appeal structure exists. Following the lodging of the reasons for disagreement, a consultant from another region may be called upon to complete another inspection and to make these findings known to BFCHP's professional standards committee. (The decision as to whether membership is granted or not is made on the evidence presented. BFCHP is as independent from its consultants as the consultants are from BFCHP).

The membership consultant, like many relatives, arrives at the door of a strange home for the first time. What sort of reception is he likely to receive? Are refreshments offered? How courteous is the proprietor? Attention then focuses on the check list and the inspection which covers four broad areas; a physical assessment, a care assessment, assessment covering professional conduct, and the opportunity for the consultant to make any other comments or notes as necessary.

To fulfill the expectations of the code of practice the premises must be clean, safe, and well-maintained with a good standard of freshness, decoration and function. It is essential that each home inspected satisfies the expectations of applicable pieces of legislation. No inspection should continue where a registration certificate cannot be produced. (However, this certificate in itself is in certain cases issued to homes where there are legislative breeches; this event is a sad indictment of the respective registering bodies. It is clear, therefore, that nothing can be taken for granted on a visit of inspection.)

Following completion of the physical assessment part of the checklist, the consultant will have an idea of the quality of life experienced by each resident. Consideration will be given next to the overall atmosphere of the home. Is it relaxed? Do residents interact with each other with ease? How do members of staff deal with residents and their care? Are visiting hours unduly restrictive? There is an expectation that residents should enjoy a lifestyle in which there is choice and acceptance of personal values -- an environment where the needs of the individual predominate over the need for routine. How do staff view their role within the home? Are they fulfilling a caretaker's role? Do attitudes appear institutional or is there active involvement in a planned way to meet the challenge of improving the quality of someone's life?

A detailed examination of drug administration, recording, and the use of individual prescriptions over stock medicines is then undertaken. Staff should be aware of line management accountability.

Similarly, proprietors should understand the role of the registering bodies and who within that organization is their



contact. The status of residents in care can change minute by minute; there is an expectation that accurate records are kept to monitor these changes and that staff have the necessary knowledge to know when to seek advice from other professionals, for example when to call in a general practitioner, when to liaise with a district nurse etc.

Discussions with residents on an individual and group basis allow the consultant to explore the relationship between the residents, the staff team, and the proprietor. All resources have their limitations and it is useful for proprietors to recognize the limits that apply to their particular establishment. This, along with accurate record keeping, will allow for future needs assessments to be completed. It may be that another resource is required where, for example, the present need is far more complex than the service that can be offered within a particular home. The staffing levels of the private sector is perhaps one of the most controversial issues facing home owners today. Discrepancies exist throughout the country in calculating staff numbers and in the ratio of trained to untrained staff. BFCHP members are expected to maintain a level of staffing which will offer to residents a safe environment, with the facility available to participate in activities where more intensive staff input will be required. An account of staff numbers, their qualifications, and length of experience will be gained by the consultant during the course of his visit. Duty rotas will be inspected to confirm that on any one day there are sufficient staff to carry out the required duties and there is appropriate management support, and that off-duty time is calculated in advance.

This area of inspection also covers the administrative responsibilities of running a home. Are references taken up on prospective members of staff? Are other reasonable steps taken to ensure that staff employed within the home have no history inconsistent with caring for people?

Staff training is discussed in detail. Some of the country's more isolated homes find great difficulty in seconding members of staff to training courses which are unfortunately few and far between. Others, in more populated areas, have representatives who, along with the registering bodies, conduct rolling programmes of training for members of staff working in the private, voluntary, and statutory sectors. It is useful for consultants to speak to members of staff on training issues and on how well-equipped they consider themselves to be in tackling the tasks at hand. Similarly, the proprietor or officer-in-charge should have a clear idea of what training the staff team require and how this is tackled.

BFCHP is active in progressing training issues via its educational sub-committee and at regional meetings, where at least one topic of the day's agenda is devoted to improving care practice. It is important that member homes, those deferred from membership, and those that are refused membership, gain



constructive criticism about issues affecting the care of residents within their particular establishments. Following an initial interview with the proprietor, a tour of the home, and discussions with residents and members of staff, a plenary session is used to give the consultant and the proprietor the opportunity to discuss important issues. Not only do issues which detract from good care practice warrant discussion, but practice which is positive and contributes to an improved quality of life for residents should also be discussed. This is vital not only as an aid to staff morale, but also as a means of support and encouragement to the proprietor. BFCHP's headquarters then communicate with the home and give the decision of the professional standards committee as to whether membership is awarded or not as well as notifying the proprietor of any points which require attention.

The mixture of private, voluntary, and statutory sector care is here to stay. The common good lies with meaningful collaboration between the respective agencies involved in care.

A separate agency, independent in its function, accountable to government, but using the expertise of the caring agencies involved, should assume responsibility for registration and subsequent visits of inspection of caring establishments. Such an agency should not only provide a service which ensures that there is compliance to statute within each establishment, but can also act as a professional body to whom all working in the field of care can refer for clarification on practice issues. This agency would enlist the expertise of all service providers. No one agency has the sole franchise in care: no one organization can assume the responsibility in awarding registration. In addition, future needs in care are likely to become more complex as time goes on. A separate regulating agency would be able to offer advice to all service providers in relation to what the need is and how best to satisfy the requirements of disadvantaged client groups in Britain today.

## QUESTIONS AND DISCUSSION

**Question:** British Rail was nationalized in 1948, but even now they still fall short of standardizing the whole of their operation throughout the UK. Standardization of a big operation can take forty years. The second point I was a bit alarmed about was if we thought as a body such an institute of care management was a suitable one voice spokesman for the whole of the care industry I am appalled that £150,000 could not be subscribed privately. With the private sector having 200,000 beds and each bed being worth a capital value of £30,000 you are, in fact, talking about £6 billion, and I find it absolutely appalling that a £6 billion industry could not raise £150,000.

**Robert Macgillivray:** I could, perhaps, take up the first point



that you mentioned. I think that what we have to look at is the two sorts of inspection which are generally applied in the country today. The first sort is the systems which are used by local authorities and by health authorities. They vary greatly, and the consequence of such a variation is that people who are wanting to establish a private care home or a private nursing home prefer to locate in the local authority areas sympathetic to the aims and objectives of private providers. That's a wholly unnatural situation and causes a significant imbalance in private care provision between different parts of the country. We should be able to provide high quality care to people who require it most, irrespective of the geographical location of the home.

The other point I would like to make about a natural inspection procedure is that there would be frequent opportunities for consultants to meet and to discuss the findings of the various geographical areas in the country that they are responsible for, as happens already in BFCHP. This introduces for the first time an element of corporate decision making which can only be an aid to obtaining a furthering of good practice across the whole country.

#### REACTION TO THE PROPOSALS



## THE OVER-COMPLEXITY OF REGULATION

Mike Gardner  
Home Life Care

I would like to mention one or two things about the discussion today on community care. I think there has been rather too much suggestion that it consists purely of residential and nursing home care, but clearly there is a great deal more.

But more importantly, let us look at how we go forward into the expansion of community care. At central government level we have the DSS, concerned with the Registered Homes Act, Income Support, and so on; we have the DoS which is concerned with planning; we have the Home Office concerned with fire regulations; and we have the DFI trying to undo much of what those other departments are doing to make sure that there are not too many difficulties for the system to actually work.

### REACTION TO THE PROPOSALS

I do feel a bit beleaguered and under siege when I begin to see who else is watching us apart from those four central government departments; we move to the local level and we have the Health authorities, 201 of them; there are 116 social services departments; and there are many hundreds of district councils; we have the Health and Safety Executive; the Family Practitioner Committees; and even within those statutory agencies we find a whole lot of departments such as fire departments, environmental health officers, building regulations people, planning departments, and so on.

My work in setting up five rather large purpose-built homes must have kept a considerable number of bureaucrats in employment. And as Kafka pointed out in his novels, each official can talk knowingly of his own department, but mention something from another department and he will not knowingly but won't understand a word of it.

In addition to all the statutory bodies I have mentioned there are the industry associations, and a mass of professional lobbying organisations, the local authorities' associations, and the associations representing the professional interests.

The interesting thing is that there is no consistent representation in all this, somehow everybody believes that they are taking care.

So I would make a plea that if we can find some alternative means



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In addition to all the statutory bodies I have mentioned there are the industry associations, and a mass of professional lobbying organizations, the local authorities' associations, and the association representing the professional interests.

The interesting thing is that there is no consumer representation in all this, somehow everybody believes that they are taking care.

So I would make a plea that if we can find some alternative means



of looking at this, we should start with the consumer and then work to everybody else's input after that. I think there is a feeling within the statutory authorities that they believe that all that stands between civilization and chaos is the existence of the registration authorities; I think that is a bit of an insult to people who are in the business and putting their money at risk if they cannot provide an attractive service. The Registered Homes Act hasn't necessarily ensured standards of care. If we had not had a residential homes act would it really have made much difference?

The government and local authorities have gone to great lengths, to produce guidelines on residential care. I think we should be looking to local authorities to prepare similarly clear specifications for domiciliary care. If they prepare guidelines and give a lot of attention to what is required in the residential sector then I don't see that they couldn't do it for the domiciliary sector. But I would make a plea: please don't let us have a welter of jargon which nobody can understand. It must be fairly clear because that is the only way in which the private sector can respond. If they can prepare a clear specification then at least we know what we are supposed to do, and can predict what the cost is going to be, settle the logistics and the practicalities of it all.

Just a few more points. When I was in social services, every new piece of legislation that came out about caring for people related to social services or health and ignored housing. Yet I think that the major issue in dealing with old people's needs is the actual provision of housing and to think that somehow you can provide facilities and ignore the obvious requirement of decent housing is quite mistaken. Again, part of the problem is the fact that there is a whole different department, a whole different agency involved.

On assessment, I do not know whether social workers can devise a points system like they had for granting tenancies of council houses. Even if so, I'm sure it will be a very protracted business. Multi-disciplinary assessment is very fertile ground for disagreement, delay, and distress.

Finally, when I worked in education I used to sit on a multi-disciplinary panel, to interview people who wanted boarding education. Usually this was granted if they had some good social reason but, of course, they had to go through a long drawn-out process. But people are different, and want different things in life; we've got to allow for people if they opt for a particular way of life, and to make sure we can meet their needs. I hope that under the proposed new system, the local authorities will do this instead of trying to make the individuals they are responsible for conform to officials' ideas of what is best for them and most convenient for the administrators.



## REACTION TO KENNETH CLARKE'S PROPOSALS

**Dr Colin Barron**

The new community care proposals are good news for the Treasury and bad news for just about everyone else. The government has decided that they don't want to pay for 24-hour care for our dependent elderly. They would prefer them to be looked after more cheaply in their own homes by an underfunded, undermanned, and, therefore ineffective community care service. Don't kid yourself that these proposals are all about providing a better service; they're all about saving money.

When I was young doctor the first question I asked patients was "where does it hurt?" In future, I think the first question doctors will ask is "are you paying by Visa or American Express?"

The government obviously thinks that domiciliary care works. But it doesn't - and I know because I've seen it at first hand. There's no point in having someone looked after well for one hour a day if they're sitting helpless for the other twenty-three. There simply aren't going to be enough people around to look after all these elderly in their own homes.

And what is more there aren't going to be enough social workers to carry out all the necessary assessments. If Lady Wagner's (quite separate) proposals are accepted we're going to need between 10,000 and 20,000 extra social workers just to become officers-in-charge, quite apart from all the number who are going to be needed to make all these assessments.

So it could be really bad news for the relatives of elderly people.

In the future relatives may be told that they have to look after their elderly relative at home because the local authority simply doesn't have enough money for a place in a private residential home.

Of course, the most worrying thing is that local authorities have been given the purse strings. For years the local authorities have been dying to get their hands on private care homes and now it has happened. It is bad news for the private care home industry. First of all, hostile local authorities will delay payment to private homes. A local authority often takes



months to pay their bills; this alone could cripple private care homes. The local authorities are also likely to haggle over actual levels of payment. They may well want to look at profit figures and then set a payment level they consider 'appropriate'. It will also give them an opportunity to hold private care home proprietors to ransom over trivial details or for political reasons that are irrelevant to the actual delivery of care. So within the next few years a lot of private care homes are going to go out of business.

Yes I know that elderly people are better off than they were -- but still at the moment half the residents in private homes are paid for by the DSS, and there are some parts of the country where the proportion is much higher (in Scotland it is about 75% and there are some homes where every single resident was paid for by the DSS).

What's going to happen to these homes in a few years? Perhaps we will see a two-tier system where if you've got plenty of money and a private pension you'll get into a lovely residential care home, single rooms, bathroom en suite, and steak au poivre on the menu, but if you are on state funding it will be dormitories, commodes, and fish fingers for tea.

In conclusion, these proposals will leave the local authorities with their thumbs on the windpipe of the private care home industry and in some parts of the country the temptation to squeeze will be too hard to resist.

If you will refer to Kenneth Clarke's statement you will see that it says: "it will be important that local authorities should have clear plans for the development of community care services, worked out in collaboration with health authorities and the independent sector. I shall expect all authorities to have such plans and shall ensure that they are open to inspection by my social services inspectorate. I also propose to take powers to call for reports on local authorities' community care services."

Now it would seem to me, therefore, that Kenneth Clarke is going to try to regulate local authorities in the new powers they are to be given. It is up to us to make absolutely certain that is the case -- and, in particular, that the local authorities account for their expenditures, because they're not only going to be the enablers they're also going to have control over a budget which they can apply that money as they please. It is up to us to make sure they apply it properly.

We all know of the ideological problems which some of the local authorities seek to have. We've got to make sure that there is proper regulatory control over them, and that their main objective is to get full value for money. And it is also important that the homes which many of these local authorities will be putting people in, even those presently in the non-



A NATIONAL REGULATORY AGENCY

**Peter Rickard**

National Care Homes Association

We've heard from the many speakers today of the problems that might occur with the government now plumping to put local authorities in charge. But there are certain pointers in Kenneth Clarke's statement which hopefully will mitigate some of the possible consequences that the last speaker has just talked about, and I think these things must be emphasized.

The government's proposals are certainly not written in stone -- these proposals can be amended before the White Paper, and the White Paper itself can be amended before becomes legislation. It is up to the private and voluntary sectors to make sure that safeguards are put on the local authorities if that is the way we are to go. They must be the enablers and not the providers; that is the main issue. Tony Byrne suggested the local authorities were going to have free rein, I but that is not necessarily the case.

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We all know of the ideological problems which some of the local authorities seem to have. We've got to make sure that there is proper regulatory control over them, and that their main objective is to get full value for money. And it is also important that the homes which many of these local authorities will be putting people in, even those presently in the non-



registered sector -- the homes with four or less beds -- are in fact registered and checked. Those homes have got to be checked. If there is even one person that is suffering some ill treatment, these homes ought to be regulated, and Lady Wagner herself recommends the same.

We all know we need more money, though the government have not committed themselves to give more. But we've got to make sure that when funding is disbursed by local authorities that the dependency of the people in each home is fully reflected. It's no good paying £140 if you are dealing with people with senile dementia. We're going to have to make sure that the proper funding is given to each home depending upon the dependency of the residents.

I'm very keen on having a national regulatory agency. The agency, which is still a feasible possibility within the framework of the present proposals put through by Kenneth Clarke, would formulate coherent national policies, priorities, and standards; execute those policies and ensure those standards; ensure that need assessed is met in the most cost-effective manner consistent with the rights, dignity and, where possible, the choice of the individual concerned; ensure that regional or local divergence from national norms are genuinely necessitated by particular local conditions and are not the product of capricious attitudes on the part of local or regional officials or elected representatives. It must also promote training and commission research; monitor and control the standards and performance of all national, local and other authorities active in the field, including voluntary agencies, and private sector providers of such services, and must have powers to enforce its requirements. Such powers would include registration and inspection of all homes subject to appeals procedures.

The government will be worrying about the funding of this. I can assure you that the NCHA has, in fact, put a paper out which shows quite clearly that the funding could come from the present bed fees, across all sectors, and would be much fairer right across the board.

What we need is common standards. We haven't got common standards at the moment: they vary so much that we don't know whether we're coming or going. Half the time of my association is spent helping people who have problems with either social services or health authorities because they're imposing quite arbitrary rules which are quite ridiculous. We've got to have some common basic standards and from there we want to go on to improve those standards.

In order to have common standards and to improve them it follows that you must have an independent inspectorate. The government have suggested that "local authorities will be asked to establish inspection and registration units at arm's length from the management of their own services, which should be responsible for checking on standards in their own homes, and to involve



independent outsiders in the arrangements." The statement also noted that the government believed that "for the present, existing strategy function should remain unaltered." I think they do mean "for the present" and the minister today confirmed that the system was still open for discussion. We as a private sector can change things to bring about a national inspectorate, in fact, possibly even a national agency. It is up to the people representing the private and voluntary sectors to make absolutely sure that now the government have put the local authorities in charge of community care that they do not also continue (in the long term at least) to be providers as well; and that appropriate limits are placed on them. We must also do what we can to make sure that we get an independent national agency which will take on the inspector role so that we all know where we stand.

I suggest that we get our act together and lobby government. We have time; it is quite clear from what we've heard that there is a chance to alter important parts of the government statement.

Prof. [unclear]: I was really starting with the benefit of their experience. All of the institutional structures, which are very difficult to change once established, are fairly young and flexible here. If we put up a good arrangement now we can avoid the problems you mention; if we don't it could be that we will have the same difficulties. So, on the other side of the Atlantic there are some big investments, big efforts going on; but that has happened only because the existing services had got worse and worse.

Valerie Thompson: In the light of the government's statement in response to the Griffiths' Report, I would like to know what Dr Barron's opinion is about the implications for specific services which are provided within the framework of community care, such as speech therapy services.

Dr Barron: Well, we cannot really see what is going to happen to them because it all depends on how much funding is going to be made available. The local authorities may be able to go ahead now and re-organize slightly, but it all depends on the actual level of funding. Until it is made clear what that level of funding is going to be I don't really think there's going to be much change.

Mike Gardner: Once again, we need a proper specification of what services should be available. When local authorities put certain things out to tender, whether emptying the dustbins or whatever, they have to prepare a specification. That is a good discipline. So why not do it in this even more sensitive area? I think if they can list these services like speech therapy, occupational therapy, and so on, people will come along with fresh thinking as to how we might achieve them.

Geoffrey Bulmer (Public Finance Foundation): An important point to stress is that there is no perfect system; and it's very easy to criticize any system that is put forward. The present system has its disadvantages and obviously a system involving local authorities will have its disadvantages.

Somebody has to take the political decisions as to how much of



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**Marion Burns:** I was very interested to hear Professor Davies's obvious respect and interest in what he considers to be a good community care practice in North America. I am terrified to think that we could be following the North American model. I've just returned from the United States and discovered nursing homes there without the equivalent of our SCNs or even, incredibly, medical cover. So if we follow North America, is our residential care going to become like this?

**Professor Davies:** I hate to create the impression that I was advocating we copy everything that happens in the US. In some cases, they have got themselves into a most terrible mess. But we can really learn a lot from some of their techniques. We are really starting with the benefit of their experience. All of the institutional structures, which are very difficult to change once established, are fairly young and flexible here. If we put up a good arrangement now we can avoid the problems you mention: if we don't it could be that we will have the same difficulties. So, on the other side of the Atlantic there are some big investments, big efforts going on; but that has happened only because the existing services had got worse and worse.

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the tax-payers' money is going to be spent in support of community care and whose benefit its going to go to. Those decisions can either be taken entirely in the centre or you can involve local government. I think the disadvantage of it all being in the centre is that you then work on very rigid national rules. There can be advantages in local decision -- for example, there will be opportunities for local negotiation, relating the rates to the needs of individuals in individual homes.

I suspect that the private sector associations will have to learn to live with local government and I think it comes down to how best to improve that relationship. There are certainly some opportunities for getting together with local government in making the case for supplementary funding from central government and making an objective case, a well-founded rather than a purely emotional one. There is a lot to be done still to get the facts together in an objective way to make the case nationally for extra resources.

One of the questions worth thinking about is whether there should be some clear default path for central government to be able to take over or to establish some new agency where local authority manifestly falls down on the job. Sir Roy Griffiths didn't recommend that in his report and it may be that government thinks that actually the default paths will be strong enough, but there is a recognition in Mr Clarke's statement that they will be looking selectively at local authorities' plans. They presumably prefer ad hoc arrangements to some elaborate national system, and I suppose they will be expecting to influence the local authorities that do not seem to be doing very well to improve this service. But I think its best to work on the basis that such failures will be in the minority and hopefully very few indeed.

**Peter Rickard:** I think you will get in the main local authorities co-operating and, of course, they will have to submit their plans to central government before they institute them in April 1991. As you say, the problem is if one or two local authorities do not conform, what are the sanctions that the government can place on them? This is why we would have liked to have seen a national agency. In any event, there has to be some sort of safeguard. It is the people in need of care in that particular local authority area that are going to suffer if we do not get it right. So I would like to see very strict regulations and some safety net put on local authorities to ensure that they live up to the expectations.

**Dr Barron:** I think its going to be very difficult for the government to restrain the worst local authorities. In Scotland, at least one health board has a Rambo attitude towards the private sector, but there is very little the government can do about it if so much power is vested in them.

**Question:** Could Professor Davies clarify another point? I understood that he claimed that the costs at home at each level



of dependency are actually less than in a residential home or a nursing home. Presumably, this was the government's understanding because they think they can keep people out of homes and save money that way. But many of the residential home owners are claiming its cheaper to look after people in residential homes. Who is right?

**Professor Davies:** No, I wasn't claiming that. There are factors such as quality of life and quality of care that are hard to compare, making it very difficult to get precise equivalents between such different modes of care. What determines the costs of good community-based care is not the same as what determines the cost of care once someone is in a home. Therefore, there are people in some circumstances who can be supported very economically at home, and without overstrain in family carers, although they would be very costly people to care for in homes. So I would certainly say that there are very many for whom it would be a good deal more expensive to obtain equivalent care in a home, but nevertheless, with good care management, skilled care a better and more cost effective pattern of community-based care is certainly possible.

#### CONCLUDING REMARKS

**Mike Gardner:** My final thought is: can we please work on the basis of what can we do right now to simplify the procedures and to reduce the bureaucracy which goes with the Registered Homes Act?

Also, I would say to every social services department that there is a measure of goodwill from within the private and independent sector which ought to be taken up. The problem is how we are going to get this message back to the local authorities. It is early days but I really do hope that associations, divided as they are into different organizations, will take the initiative to try to establish contact with the association of directors of social services or asocciation of county councils or whatever so that we can try to march in step.

**Peter Rickard:** I think that a lot of work needs to be done to establish the cost of community care. It has been said before today, but it is still absolutely important, that we really don't know what the cost of keeping someone in the community really is. Nobody knows. Our initial indication is that it is going to cost in the region of £275 a week to give someone two hours' nursing per day on a five-day week. This compares astronomically with the present income support to care homes. I think it's time that proper research was done into what it's going to cost for domiciliary care and to compare that with the cost currently in care homes; this is so important.

**Dr Eamonn Butler:** We have had lot of very constructive comments and suggestions, ways forward for the future and comments on what



the government is proposing. Remaining are all sorts of issues that we still have to discuss; the arm's length concept, regulation, assessment, inspection, and indeed whether local authorities should continue to provide services at all.

The minister seemed to be saying this morning that there was plenty of scope left for rethinking such relationships, and that there was still scope for quite a number of safeguards to be built in between now and the publication of the white paper. There is an important opportunity for us to get our act together and to make sure that those safeguards do appear in the final proposals.