CONFIDENTIAL

18th April, 1989

Mr. Paul Gray
Private Secretary to the Prime Minister
10 Downing Street

Dear Paul,

COMMUNITY CARE

Two papers, one on the mentally ill and the other on care of the elderly, are I understand to be considered by the Cabinet Group tomorrow.

I understood from the Prime Minister last Monday that these meetings were still very much Second Reading and that the position would still be open for me to contribute later. I have accordingly not deemed it appropriate to circulate another note to those attending.

I have discussed with the Secretary of State and his officials yesterday the paper on the elderly. I am in basic disagreement with the recommendations in both papers. I promised and I hope you will not mind, to send you personally a very brief note without going over all the ground again.

The Audit Commission emphasised that we needed to tackle the confusion of responsibilities and the fact that there are too many agencies involved without anybody seeming to have and to be held accountable for the overriding responsibility for non-medical care. It also emphasised the perverse incentive being the ease with which residential accommodation could be paid for by way of supplementary benefit. It equally emphasised that fine tuning or treating the symptoms would not meet the needs of the situation.

The paper on the elderly purports to leave existing responsibilities with the local authorities, but adds the new dimension of District Health Authorities running residential care assessments and having an undefined sum of money to allocate to new

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developments, existing agencies and generally to plug the gaps in other provision. They would also arrange packages of care for individuals and facilitate the achievement of these packages.

I repeat that the gatekeeping provision will not work (the Secretary of State does not rule out my own fundamental recommendation to transfer the care element of income supoort to a budget holding authority, but believes it too sensitive at the moment) and will not consequently remove the perverse incentives for people to be pushed towards residential accommodation. The new responsibilities for the Health Authorities will, with local authorities left as they are, compound even more the organisational confusion of which the Audit Commission complains. No authority will be clearly responsible for social care and local authorities will be left to a provider role which I believe is the last thing they want and the last thing they should be left with. No mention is made of making them more accountable. The paper seriously underplays the real dangers of getting medical and nursing involvement in what in most cases of social care are comparatively routine tasks. It makes no mention of the problems of splitting social workers between the Social Services Authorities and the NHS with the consequent overmanning and lack of flexibility and two agencies going into the same homes.

We need the right solution and questions of timing ought not to be paramount, but with the experiments suggested it will be a further 4 years before the Health Authorities are geared up to take on the new responsibilities, a period during which present major problems will intensify and social security payments for residential accommodation will have more than doubled to well over £2 Billion a year. I forebear to comment on asking the DHAs to take on this additional role. We are already asking them to undertake a mammoth programme under the NHS Review and it is wishful thinking to believe that in that timescale DHA responsibilities will be reduced. Even if 250 hospitals go self governing the districts will still be left with running the other 2,000 hospitals.

I am in any case frankly appalled not only by these prospects, but by the prospect of getting them involved for responsibility for social care at all, which I believe is fundamentally wrong

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On the mentally ill I have made my comments previously. The only point I wish to draw attention to is that Wales is held up as having sound strategies for the mentally disabled (All Wales Strategy 1983) and for the mentally ill (Consultative Document 1988). The strategy for the mentally ill is remarkably similar to the conclusions in my own report and builds on the successes of a similar strategy for the mentally disabled, i.e. each County in Wales was asked in conjunction with its relevant Health Authorities to produce a plan for the mentally disabled with money being allocated in support of the plans when approved by the Welsh Office. The proposals for the mentally ill drop any concept of lead authority (quite rightly). Counties and District Health Authorities jointly submit plans to the Welsh Office for a comprehensive service with responsibilities clearly set out and with provision for the co-ordination of services and the spread of good practice. The control of this co-ordination is through the Welsh Office, who limit themselves to setting the strategy and ensuring that the strategy is financed by a partnership of the Welsh DHAs, local authorities and the voluntary sector etc. The details of these are evidenced in each County plan.

These are essentially in line with my own recommendations - central strategy, approval of plans, some central monies being allocated against this approval, clear responsibilities and a distinction between the medical and social care agencies. The strategy for the mentally disabled in Wales is already working and the mental illness strategy shows every prospect of being successful. I cannot see in England why we should not be following the same thinking essentially set out in my report. I understand that any decisions may well and inevitably have inbuilt political factors. I too am equally concerned with the political consequences if we do not tackle the whole question of community care clearly and comprehensively.

Yours sincerely,

ROY GRIFFITHS

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