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PRIME MINISTER

17 May 1989

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COMMUNITY CARE TRUSTS

I have reviewed all possible options on community care over the last nine months. Many proposals in Roy Griffiths' report have merit. Yet I remain convinced that a pure local authority solution will fail to deliver an efficient service on the ground. Caroline Cox is right to be concerned. Involvement by community nurses and GPs would be minimal. But a health authority model also has many pitfalls.

I believe we can achieve the best of both worlds - with good value for money - through locally based Community Care Trusts. These self-governing trusts would be driven by key local individuals and professionals (health and social), committed to the care of the elderly. The philosophy behind the trusts is exactly the same as the philosophy behind the Government's reforms in housing, health, education and training. The state continues to provide the funds while the people who are closest to the problem on the ground will manage them.

This does not need to be a 'big bang' solution. Trusts could be introduced gradually on a voluntary basis.

Will Trusts work?

Community Care Trusts are not merely an abstract idea. A number of mental health and community health units have already expressed interest in applying for self-governing status (eg Newcastle) following the NHS White Paper.

In Bromley, the local authority and health authority have agreed a joint strategy to manage the mental health service

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(under the lead agency of the health authority) and the mentally handicapped service (under the lead agency of the local authority). Services for the elderly are being examined currently. Each service would be managed by a trust. The District General Manager of Bromley Health Authority explains the benefits in a recent letter **(Appendix 1)**.

The London Borough of Bexley is thinking along the same lines **(Appendix 2)**.

How will Community Care Trusts operate in practice?

Christopher Heginbotham (Kings Fund College and a consultant to several local authorities) and Peter Thurnham have jointly submitted a helpful paper describing the operation of the trusts **(Appendix 3)**.

Much more work is required on the detailed mechanics. But the principles are clear:

- **Arrangement of Care**

  Trusts would be responsible for

  (i) case management (ie developing a package of care for those in need) and

  (ii) buying domiciliary care or arranging top-ups for residential accommodation.

- **Provision of Funding**

  Following the NHS reforms, each DHA's duty will be to buy the best service it can from a range of hospitals. Hospitals for their part will have to satisfy districts

that they are delivering the best and most efficient services through a contractual relationship. Community Care Trusts would operate in a similar way. Each trust would arrange a block contract with at least one local authority and one district health authority for a defined range of services for a given population base.

Trusts could be set up for

(i) the care of the elderly;

(ii) mental health;

(iii) mentally handicapped; and

(iv) physically disabled.

- **Incentives for Efficiency**

Value for money could be achieved by 'targetted specific grants' (similar grants are proposed by Kenneth Clarke in Annex 3 of the Cabinet Office paper). These grants would only be available to local authorities and DHAs who have set up approved community care trusts. One possibility would be to link the grant to the level of income support claims in the catchment area. Claims are likely to be lower if the community care trust is giving a good service.

- **Management Flexibility**

Trusts would be able to set their own pay scales and conditions of service.

- **Transitional Protection**
  In the short-term, the income support entitlement for residential accommodation could be preserved. In which case, trusts would focus on domiciliary services only.

What are the benefits?

- The title 'Community Care Trusts' would be welcomed by many.

- Future reforms will not merely be driven by mechanistic changes to income support.

- The voluntary sector would be the driving force behind the trusts.

- A trust would be more responsive to the needs of individuals and their informal carers.

- The services would be one step removed from local politics.

- Collaboration between social services departments and DHAs would be assured.

Likely Ministerial Views

Since Kenneth Clarke has lost the initiative on community care, he is unlikely to raise his head above the parapet unless encouraged to do so. But he should be guardedly positive.

Sceptics of this scheme are likely to raise three questions:

(i) Why would local authorities agree to devolving power?

We could not expect all local authorities to support community care trusts. This proposal is evolutionary. Many authorities will agree if the incentives are reasonable.

(ii) Would the Community Care Trusts become new lobbyists for funds?

Central Government will not be directly involved in negotiations about funding.

(iii) Will the Trusts merely duplicate the work of local authorities?

No. Roger Hampson would like to see the staff numbers in Bexley's social services department falling from 1,000 down to 200. Child services would continue as before (150) leaving the balance of staff (30-50) responsible for setting overall specifications for service delivery, inspection, registration, contract delivery and budgeting. Over time, all fieldwork and service provision could be devolved.

Recommendation

Kenneth Clarke and Nicholas Ridley should be asked to prepared papers on 'Community Care Trusts' for the next meeting.

Ian Whitehead

IAN WHITEHEAD

APPENDIX 1

Bromley Health Authority

DISTRICT HEADQUARTERS
Farnborough Hospital, Farnborough Common,
Orpington, Kent, BR6 8ND. Telephone: 0689 62422
Fax: 0689 62423

Ref: GNVG/RW

IN CONFIDENCE

Mr. Ian Whitehead,
Policy Unit,
10, Downing Street,
London, S.W.1.

9th May, 1989.

Dear Ian,

I thought that I would write to try and clarify some of the issues that were raised when we spoke recently about the notion of community care trusts. As you know, I have been working closely with our Local Authority and with appropriate voluntary agencies to try and streamline the provision of services to the mentally ill, the mentally handicapped and the elderly.

The guiding principles that have underpinned our thinking are:

1) That the service provided should be tailored as far as possible to individual need.

2) That access routes to services should be simple.

3) That one agency should accept responsibility for commissioning the full range of services.

4) That where voluntary bodies have traditionally "experimented" with new types of service provision, this role should not be stifled.

The White Paper helped to reinforce tentative conclusions that we had reached, namely that whilst it was important to have clearly defined responsibility for service commissioning and for assuring the quality of service provided, there was, in theory at least, no reason why a District Health Authority or a Local Authority should be service providers. This thinking leads inevitably to then considering whether a not for profit company, or indeed a community trust, might be established to provide some or all of the services for the groups mentioned above. You will have seen from the report which we commissioned on our community mental health programme that both these issues were examined in some depth.

BHA
BROMLEY HEALTH AUTHORITY

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In essence the benefits that we see from adopting the trust/not for profit organisation model are:

i) that it enables the lead agency to concentrate on specifying the range and type of service required. This applies whether the lead agency is the District Health Authority or Local Authority;

ii) that if the trust/company has delegated authority to provide an individual case management service, then that trust/agency would be free to purchase services from a third party, such as a voluntary agency, if the services in question were more appropriately provided in that way. This would ensure that a multiplicity of providers was secured.

iii) that a case management approach enables the type of service provided to be changed if an individual's needs alter in due course.

iv) that the lead agency is able to concentrate on ensuring both quality and value for money.

You will have gathered from the above that we have concluded that the lead agency status should vary according to the group for whom services are to be provided. Our approach has been pragmatic and we have recommended the following split:

Mental Illness services	-	District Health Authority
Mental Handicap services	-	Local Authority
Services for the Elderly	-	Joint Board of Health and Local Authority

The latter appears to deny the concept of one clearly defined lead agency. We would envisage that the service specifications would be jointly agreed between Health and Social Services, but that the trust model would then be implemented. The service would thus be provided by one body on behalf of the commissioning authority which would in this instance be a joint body. The Joint Consultative Committee thus assumes a meaningful role at last, as it would logically be the forum acting on behalf of both the District Health Authority and the Local Authority. It would thus move away from its traditional role as dispenser of joint finance monies. As an aside, we have already discovered that the Joint Consultative Committee has a more meaningful role now that our strategy for mental health has been agreed.

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We are furthest advanced in the mental illness field and other steps are tentative. We believe, however, that the service which is emerging will be more responsive to individual needs and more cost effective if we are able to pursue the trust model.

If you want me to clarify anything further, please do not hesitate to contact me.

With best wishes.

Yours sincerely,

G. N. V. Green
District General Manager

APPENDIX 2

DIRECTORATE OF HOUSING AND PERSONAL SERVICES
Bexley Civic Offices Broadway Bexleyheath Kent DA6 7LB 01-303 7777
DX 31807 Bexleyheath Fax 01 301 4937

Bexley London Borough

RH/GRT/60/1001 2600

m/r extn 9 May 1989
y/r date

The person dealing with this matter is Roger Hampson

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Mr Ian Whitehead
Central Policy Unit
10 Downing Street
London

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SOCIAL CARE

(1) Bexley London Borough has been able to use existing powers, and the present social security rules, to establish a joint service for mental handicap with the Bexley Health Authority, using a new agency to deliver care. Existing budgets have been dedicated to a Joint Fund. The effort needed to achieve this, was however, enormous. Since such schemes are financially dependent on social security payments, it is difficult to see many authorities undertaking the work involved, given the present uncertainty over the response to Griffiths. Bexley has deferred further consideration of a major scheme for elderly people, partly for this reason.

2. By 1995 (say) it is possible to see social care being organised at the local level by a very small statutory agency, which would assess needs, set overall budgets, make contracts with service delivery groups, and inspect the actual care. The statutory agency would either be a much reduced version of the present Social Services Department, or a body outside local government. Demographic changes mean that more will need to be spent on social care. These extra funds should not go to inefficient structures.

3. However, such a new world could not be achieved overnight. Not least because the mixed economy of independent service delivery organisations, to tender for services, does not exist and would take time to establish. A medium term strategy is therefore needed, which moves towards the principles of better

specification of care needs, and a wider range of organisations competing to meet those needs.

4. Griffiths would not encourage the establishment of new service delivery organisations. Indeed, it would do the reverse, since all local authorities would receive extra funding, whether or not they could demonstrate vigour and initiative in creating more competitive services, jointly with health authorities.

5. Joint Finance is inadequate as a means of encouraging proper collaboration between local and health authorities. The sums are small, and the transaction costs are high. Proper care for elderly people in particular will not be achieved without much better collaboration.

6. The Community Trust idea can resolve these problems. Authorities could be encouraged to establish a local Community Trust, and to dedicate budgets to it for client groups. The Community Trust would then contract out service delivery. Increased central government funding, equivalent to the funds now channelled through the social security system, would be available to Community Trusts, but not otherwise available to local and health authorities or organisations contracted to them. This would establish a powerful incentive to authorities, which could be reinforced by the gradual clawback of part of the extra funding from authorities' budgets.

7. A key reason why only a few authorities imaginatively exploit the present system is uncertainty about future arrangements. A clear timetable for the gradual transfer of responsibilities to optional Community Trust, and explicit statements about funding arrangements over several years, would enable innovation to take place, and large scale joint agreements between authorities to be negotiated. As new supply organisations are created, and find their feet in the more adventurous areas, they will begin to knock on doors in the sleepier or more overwhelmed places, with tested solutions to the problems of delivering care by contract.

8. It would be a mistake to assume that re-arrangement of the responsible authorities will in itself create new supplier organisations. A central initiative would be needed to promote the establishment of nation-wide non-profit care organisations, and to encourage the large charities to create development wings, who can assist their local branches in tendering for service delivery. Again this will only happen if there is certainty about the future pattern of care.

9. A Plan of Action is required with a timetable for gradual voluntary implementation within a clear incentive structure, which will lead to extra resources, balanced between residential and non-residential care, flowing first to those authorities who can show imagination and initiative, leading the way for more general implementation.

RHampson

ROGER HAMPSON
CHIEF SOCIAL SERVICES OFFICER

10.5.89

APPENDIX 3

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COMMUNITY TRUSTS : THE SOLUTION TO THE COMMUNITY CARE DILEMMA

Paper prepared by Peter Thurnham MP

Executive Summary

This is a summary of a fuller paper to be published.

1 Background

The White Paper `Working For Patients' and the Griffiths report on community care - `Agenda for Action' - contain two key features: the development of care management which seeks to ensure the provision of health or social care appropriate to the needs of each person; and the market principle of purchaser/provider. It is reasonable to assume that future policy on community care will be similar to that in `Working For Patients' and `Agenda for Action' with a diminution of the role of local government. This means :

(i) greater freedom (for service managers and institutions) to `buy-in' the most relevant care from appropriate providers;

(ii) less direct service provision by DHAs and SSDs;

(iii) more opportunity for `self-government' of hospitals or community services.

The Wagner Report emphasises the wish of people to remain in their own homes wherever possible; to have housing appropriate to their needs into which services are provided; and to be as involved in decision-making and as independent as their disabilities allow.

Some services are already run by housing associations and voluntary organisations. Opportunities now exist for more radical transfers of service to occur. Although as yet no clear solution has emerged to the dilemmas in community care the publication of the White Paper opens up a range of possibilities.

There are however two significant problems with Griffiths' proposals:

i) formalisation of local authority responsibility which would be difficult to change again in the medium term; and

ii) the lack of any clear proposal for effective co-ordination between statutory and voluntary

agencies and thus the lack of a 'one-stop' service provision, and the lack of coherent budgeting.

2 Community Trusts

The proposal in this paper is for Community Trusts. These would be similar to NHS self governing hospital trusts and linked by purchaser/provider contracts to (at least) one DHA and to (at least) one social service department (SSD). Each community trust (CT) would have responsibility for community services for elderly people and mentally handicapped people, and possibly for mental health services.

Some DHA community units, and some mental health units are considering self governing status. These might be merged with the Community Trust in a composite agency providing all community care. An alternative name for community trusts might be self governing community units (SGCU) (to accord more closely with the NHS Review White Paper) especially if an eventual merger is considered of between those community units which become self-governing and community trusts as proposed here.

The CT would :

(1) provide some services and at the same time develop a more competitive/pluralist approach

(2) catalyse, develop, tender and contract with a range of private and not-for-profit agencies (which might include informal carers, foster families and existing statutory agencies)

(3) case management of the care requirements for each individual. The CT would be a `one-door' referral.

3 Advantages of the Community Trust proposal

The proposal has significant advantages over previous suggestions for community care.

The **Community Trust** :

* is a simple straightforward idea and fits with approaches which a number of local authorities are already contemplating;

* ensures the key concepts of the Griffiths Report, but

* takes responsibility away from LA, SSDs whilst leaving some public accountability through contract;

* brings together in one organisation

responsibility for services for all priority groups, and overcomes problems of coordination between different agencies;

* overcomes boundary problems where these are not coterminous;

* encourages DHA and SSD agreement on contracts;

* gives government control over the membership of the controlling (CT) board;

* provides an incremental solution which is consonant with the NHS Review and which allows further developments if necessary (e.g. merger with self governing community units of DHAs);

* enables DoH to review provision annually through established regional review mechanisms;

* is likely to be acceptable to local authorities given a small financial incentive;

* is highly flexible and encourages competition amongst providers;

* allows a controlled small expansion in funding of community care whilst at the same time incorporating an incentive to achieve value for money.

4 Relationship of Community Trust to DHA and Local Authority SSD.

The key proposals in the Griffiths report are :

a. care management, which may include case management; and

b. the purchasing of care from a range of private and voluntary organisations.

To date discussions have centred on how one or other statutory agency might contract out (or buy-in) components of a service; or how DHAs might establish purchaser/provider contracts with a SGH to provide health care. These developments are welcome but can be taken a stage further. A DHA might contract out mental health care to a Mental Health Trust, for example, which would itself then contract with a range of private and voluntary organisations to provide some components of care.

Similarly a Community Trust would contract to provide certain services and undertake certain functions of both a DHA and a SSD, but would also contract with a range of private and voluntary providers for components of care. In this way a CT can provide some services directly on contract to the DHA/SSD and at the same

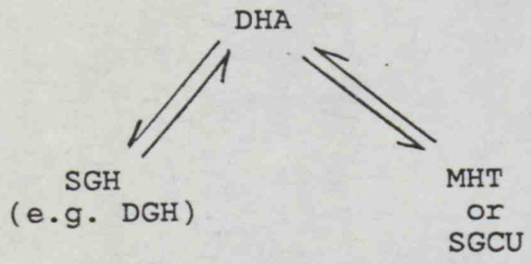
time ensure wider competition amongst service providers. This will thus offer greater choice and responsiveness to patients and service users and provide the opportunity to test value for money through a multiplicity of providers.

There is thus a double purchaser/provider regime established with the following advantages:

(i) during transition the Community Trust can run some services directly
(ii) scope exists for encouraging competition amongst 'secondary' providers

Diagrammatically the structure of these relationships can be shown as below.

Fig. 1 White Paper Proposals

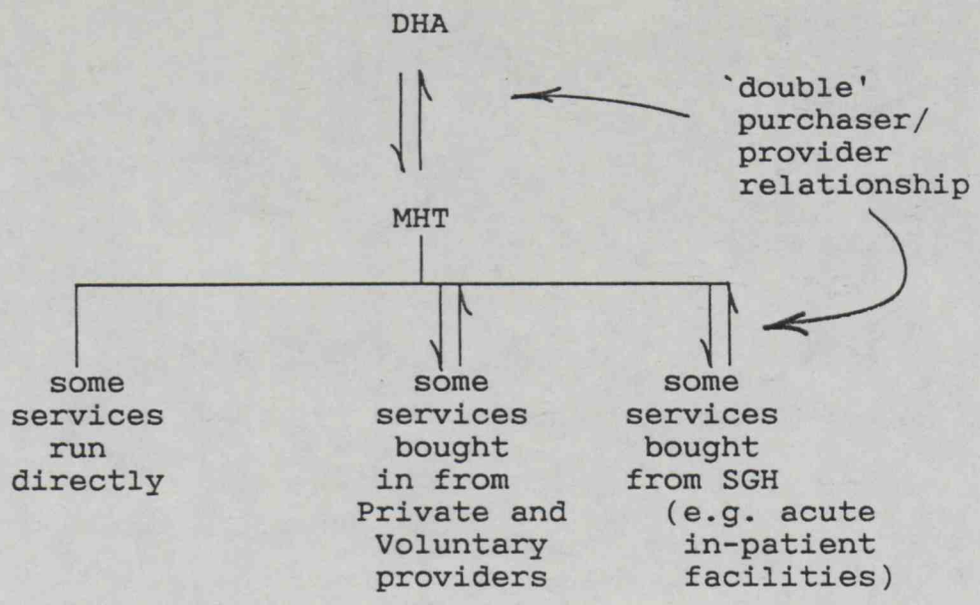


⇌ indicates a purchaser/provider contract

——— indicates a directly accountable relationship

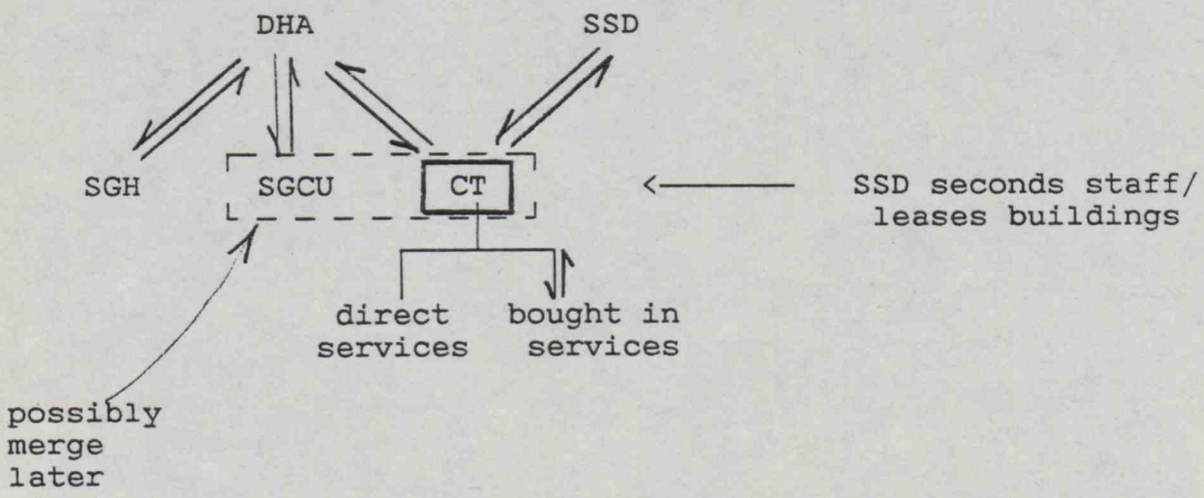
SGH self-governing hospital
MHT mental health trust
SGCU self-governing community unit
DGH district general hospital

Fig. 2 Example of a Mental Health Trust



[Note: the directly provided services would diminish over time]

Fig. 3 The Community Trust

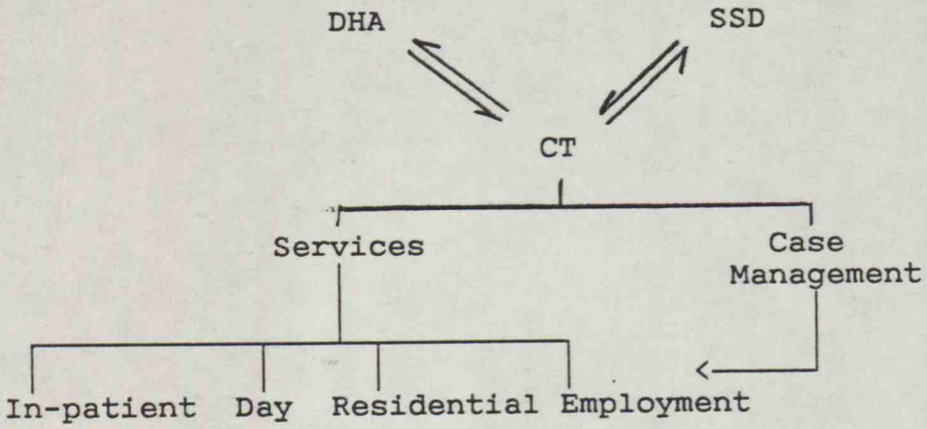


The CT would have two distinct but inter-related functions:

(i) case management - assessing client needs and obtaining appropriate care;

(ii) catalysis and development of a range of relevant service providers with which to contract.

Fig. 4



The CT would encourage and catalyse a range of private and voluntary service providers.

5 Community Trust status and organisation.

The CT would have a board of 5 executive and 5 non-executive directors, with a chairman appointed by the RHA on concurrence of the Secretary of State. To enable accountability to the main DHA and SSD non-executive directors could be nominated DHA members and members nominated by the local authority, potentially either elected Members or other representatives. The balance would be made up of local key individuals . The Chairman would need to be satisfied that all members have a personal commitment to community care, particularly care of elderly and handicapped people, and have specific skills which can enhance the work of the Community Trust. The CT status would be that of an independent non-statutory body with the power to set its own terms and conditions for staff.

6 Financing of Community Trusts

A CT would obtain finance from both the DHA and SSD under contract to provide a general range of services to a defined population. Additionally in the early stages the CT or bought in residential care services would be able to claim social security payments. The transfer of local authority residential care to the CT will thus effect a saving to the local authority as social security payments would cover part of current SSD expenditure. This requires two further steps:

6.1 a gradual claw-back of the surplus through amendment to the local authority block grant to a

level which still provides the local authority SSD will a small bonus. This continuing bonus will act as an incentive to local authorities, and could be directed (by Government circular) into improving other services, notably child protection. Such a development during late 1989 or early 1990 would be timely and attractive to local government.

6.2 changes to social security rules. Current board and lodgings, residential care allowances and nursing home payments should be split between the three components of (i) income support, (ii) housing benefit equivalent, and (iii) the care element. Development of CTs would be an incentive to bring in legislation to deal with this matter. Eventually the care element would be given to the CTs to top up income support/ housing benefit, enabling the case managers to `steer' people to relevant and appropriate forms of care.

In the early stages the current system would remain. However the CT would have substantial resources from both DHA and SSD and could begin experimenting with direct payments to carers or/or day care, both to improve support for carers and disabled people in their own homes, and to prevent unnecessary admissions to residential care. Payments would take account of the individuals other income, notably from attendance and mobility allowances and invalidity benefit.

A further saving is likely to be obtained over time as patients who do not need 24 hour nursing care from qualified staff are transferred to less expensive, possibly non-nursing residential facilities and such savings could be used to sustain a greater number of people in less expensive ways. In other words the CT enables all DHA, SSD and social security money to be retargetted locally in a coherent way by making care more relevant. Over time it would also be possible to top slice the block grant to a local authority with any parallel increases in social security payments. Eventually this would lead to the CT becoming independent of the local authority except for overall accreditation, registration and certain statutory duties.

7 Role of Local Authority

The local authority SSD would contract with the CT to provide, initially, the existing level of SSD services. The local authority might second staff and lease buildings permanently. Experience in Bexley, where a variant of this model has already been adopted for mental handicap services suggest that secondment is a sensible first step and overcomes staff reluctance or opposition. Over time staff leave and are replaced by

directly employed staff with new pay and conditions.

The local authority would continue to undertake:

a. any civil commitment under the National Assistance Act 1948 or Mental Health Acts 1983 (England and Wales), 1984 (Scotland and Northern Ireland); including employing Approved Social Workers if necessary.
b. monitoring and accreditation such as that required by the Registered Homes Act 1984
c. Statementing of disabled children in accordance with the Education Act 1981.

Although the CT would remove direct responsibility (and finance) from local authorities (LAs) it is likely that LAs will find the proposal acceptable; because

1. many wish to see improved coordination of care;

2. many are worried about the potential cost to them of hospital closures discharging mentally ill and handicapped people to the community.

3. they will be able to pass a proportion of budgetary responsibility for residential care onto social security. If government can arrange a suitable claw-back mechanism, local authorities would be slightly better off for a period (which can be determined by central government) and possibly allowed to keep some resources for improvements in child protection and other statutory duties associated with community care (e.g. NAA 48, statementing, ASW etc.)

8 Joint Planning

In the early stages of CTs, joint planning and joint finance would be the function of existing statutory Joint Consultative Committees. JCCs would become advisory bodies to CTs until legislation gave the CT overall planning and consultative status for joint consultative matters - if this was to be considered desirable. The very existence of CTs would have forced the DHA and SSD to agree clear contracts for service provision with the CT. The contracts thus override any agreements made by the JCC.

CT plans will be reviewed annually when the contracts are reviewed and an annual cycle of programme review would be instituted. Joint finance would have to be absorbed into this system obviating the present ad-hoc arrangements for project funding.

ANNEX

Service Development

1 The Service Triangle

Where a third party is involved with service provision for which a statutory authority is accountable there are three major elements to be considered. This is often described as `the service triangle'.

Fig 5.

Resources/purchase of service
(Case Management)

Quality Assurance
(Case management)

Service Provider

Wherever possible these three elements should be kept separate. Case Management may be with the purchaser or with quality assurance; exceptionally all those may be combined as long as the service provision is separate.

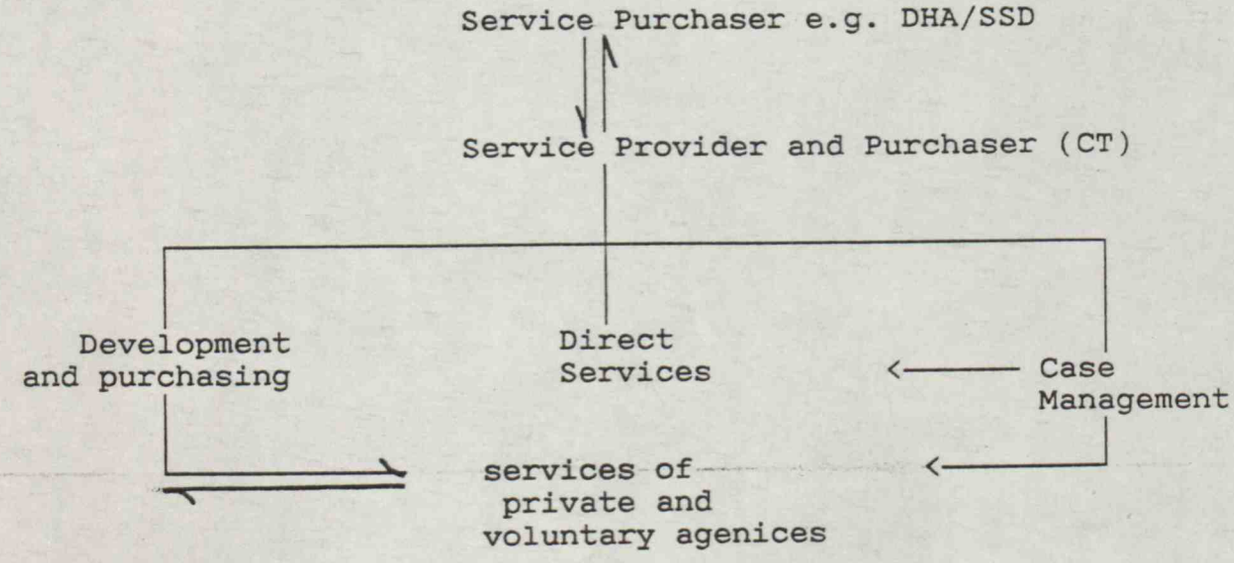
2 Service Development and Case Management

In order to ensure services are provided a community trust must either

(i) provide services directly, or
(ii) buy-in from one of a range of agencies

In some cases (ii) will require that new agencies be catalysed/established.

The service triangle becomes :



The important point is that case management is undertaken in the CT (not in the SSD) and the CT is encouraged to contract out as much of its services as possible over some given timescale. This allows all services for a particular client group to be delegated from a SSD to the CT.